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# Anxiolytic Medications and Dementia Care

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**Behavioral and psychological symptoms of dementia (BPSD) will ultimately affect nearly all patients living with dementia, according to Mercier et al. In the face of this challenge, "most patients receive inappropriate or downright harmful pharmacologic interventions," they remark. One drug category of interest is anxiolytics.**

## Anti-anxiety drugs

Benzodiazepines boost the impact of an inhibitory neurotransmitter, gamma-aminobutyric acid (GABA), in the brain. This mechanism slows down neuronal activity, producing "anxiolytic, sedative, hypnotic, skeletal muscle relaxant, and anticonvulsant effects" (Lippincott® Nursing Center®).

Examples of benzodiazepines include: Lorazepam (Ativan), Oxazepam (Serax), Alprazolam (Xanax), Clonazepam (Klonopin), and Diazepam (Valium).

Adverse effects of benzodiazepines include confusion, impairment of short-term memory, severe depression, and respiratory distress. As noted in the blog, Anxiety and Depression in Dementia, benzodiazepines, tricyclic antidepressants, and other drugs can actually cause BPSD, especially in patients whose condition is frail.

## Benzodiazepines – adverse events

Saarelainen and colleagues found in a matched study examining patients who had Alzheimer's disease that use of benzodiazepines was associated with a higher risk of death.

Looking at patients with dementia, Taipale et al. concluded that benzodiazepines raise the risk of pneumonia by 30%. They caution that patients who have advanced dementia already face a heightened risk of pneumonia, and pneumonia is "one of the leading causes" of hospital admissions for patients with Alzheimer's disease, as well as a cause of death. Hypoventilation caused by sedation and higher likelihood of esophageal reflux and aspiration are contributing factors, they suggest.

Another drug class is Z drugs. Like benzodiazepines, Z drugs boost the impact of GABA, and they are most commonly used to treat sleep disturbance. Among their hazards, they are specifically linked to a risk of fracture in patients with dementia, report Richardson et al.

Benzodiazepines and Z drugs are "not recommended, as they carry risks of addiction, confusion, paradoxical reactions, and falls, to which the elderly are more prone than the rest of the population," comment Mercier et al. Benzodiazepine use may be necessary under "exceptional circumstances" such as hospitalization or for short-term use, in their opinion.

This advice concurs with best practices employed by GuideStar Eldercare practitioners: If benzodiazepines are determined to be absolutely clinically essential, we approach them with extreme caution and limit length of use—followed by Gradual Dose Reduction.

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# Anxiolytic Medications and Dementia Care *continued*

## Antidepressants

If antidepressants are used, careful selection of the class of drugs is important. Cautious use of selective serotonin reuptake inhibitors (SSRIs) can be appropriate in some clinical situations (e.g., Zoloft).

Serotonin-norepinephrine reuptake inhibitors (SNRIs) are contraindicated because they can cause agitation. Examples of these drugs to avoid are Cymbalta, Effexor, and Pristiq.

## Non-pharmacological approach first

In the presence of BPSDs, Mercier and colleagues advocate for a non-pharmacologic approach as the first-line treatment approach. Caregivers can work to limit excessive environmental stimulation, such as excess heat, noise, disturbing images, or several people talking at once. Clear, simple communication and person-centered care strategies can also help. (Learn more about strategies for ADL care.) These strategies are especially useful for what Mercier and colleagues call "secondary BPSDs" that relate to difficulties receiving, processing, and responding to environmental stimuli.

## "Start low, go slow"

Mercier et al. also recognize that when symptoms are severe, and/or when a patient is experiencing extreme distress, pharmacologic treatment may be necessary. They advocate for the "start low, go slow" approach with any psychotropic drug regimen, carefully monitoring for any adverse effects such as excess sedation or cognitive changes.

"It is strongly contraindicated to add a second psychotropic drug if the first has not shown any beneficial effect," they advise. Their approach is to introduce a new drug slowly, while implementing simultaneous Gradual Dose Reduction of the first drug.

While there is no one-size-fits-all answer to medications for severe or acute BPSD symptoms, there are cautions and best practices informed by research. Anxiolytics pose serious risks to patients who have dementia and are not a first-line treatment for anxiety or BPSD.

***For more information about best practices and clinical management, feel free to contact us.***

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