

Management of apathy in the long-term care setting

Management of apathy is a very important issue in the long-term care because many residents with neurodegenerative disorders suffer from this syndrome. In Alzheimer's disease, apathy is the most common behavioral syndrome and may occur already in people with mild cognitive impairment (MCI). Apathy also occurs in dementia with Lewy bodies, in Parkinson's disease and in Huntington's disease. In amyotrophic lateral sclerosis, apathy is characterized by increased initiation apathy but reduced emotional apathy. Apathy is also a significant syndrome in alcohol-related dementia and in vascular dementia. Vascular lesions may be also responsible for occurrence of apathy in persons with type 2 diabetes.

People with apathy are sometimes considered to be depressed. However, it is now well recognized that apathy is a separate syndrome from depression although these two conditions often occur simultaneously. Depression may cause loss of interest and diminished activity but is perceived as sadness. In contrast, apathy is a neutral feeling for the apathetic person, because it is an emotional deficit state. Apathy influences daily functioning more than depression.

Apathy increases mortality, disability, caregiver burden, and may cause weight loss. Apathy may be a barrier to successful engagement in rehabilitative activities and may increase health care cost and need for care. There are no medications that are specifically indicated and approved for treatment of apathy, although anti-dementia medications may have some beneficial effects. Therefore, use of non-pharmacological treatments is the best strategy for management of apathy.

The first step toward eliminating presence of apathy in long-term care residents should be regular assessments of residents for the presence of apathy. Apathy is often not recognized, because apathetic residents do not complain and do not perceive their apathy as a problem. Caregivers may not recognize apathy because apathetic residents are easy to manage and do not cause any problems for staff or other residents. Assessment of residents could use diagnostic criteria developed by an international task force (Tab. 1) or one of several scales for measurement of apathy. Assessment of residents should keep in mind that apathy is often combined with periods of hyperactivity.

Once the presence of apathy is identified, non-pharmacological interventions should be employed. The type is not as important as quality and duration. Ideally, the activities should be tailored to the severity of dementia and provided as a continuous activity programming, 7 days/week. Therapeutic activities should be provided for everybody and benefit all residents. Presence of apathy in a resident population could indicate insufficient activity programming in this setting. Especially important is providing activity for residents with advanced dementia because these persons are often isolated in their rooms, sitting in a hallway, or sitting on periphery of an activity they cannot participate in. Specialized programs, e.g., Namaste Care, which provides combination of pleasant environment and loving touch, may decrease apathy in residents with advanced dementia at the end of their lives.

	For a diagnosis of apathy, the patient should fulfil the criteria A, B, C and D
A	Loss of or diminished motivation in comparison to the patient's previous level of functioning and which is not consistent with his age or culture.
B	<p>Presence of at least one symptom in at least two of the three following domains for a period of at least four weeks and present most of the time</p> <p>Domain B1: Loss of, or diminished, goal-directed behavior</p> <p>Domain B2: Loss of, or diminished, goal-directed cognitive activity</p> <p>Domain B3: Loss of, or diminished, emotion</p>
C	These symptoms (A–B) cause clinically significant impairment in personal, social, occupational, or other important areas of functioning.
D	The symptoms (A–B) are not exclusively explained or due to physical disabilities (e.g. blindness and loss of hearing), to motor disabilities, to diminished level of consciousness or to the direct physiological effects of a substance (e.g. drug of abuse, a medication).

Modified and shortened from Robert P, Onyike CU, Leentjens AF, Dujardin K, Aalten P, Starkstein S, et al. (2009) Proposed diagnostic criteria for apathy in Alzheimer's disease and other neuropsychiatric disorders. *Eur Psychiatry* 24: 98-104.

Tab. 1. Proposed criteria for diagnosis of apathy.

Additional recent programs that decreased apathy include environmental modifications and use of social robots. Environment modification study found that clarity and strength of environmental stimulation were significantly associated with lower apathy levels. Study using humanoid and pet robots, found that both robots decreased apathy but also increased delusions in the group treated with the humanoid robot and increased irritability in both robot groups.

In addition to non-pharmacological strategies, review of medications used by the residents could be also useful but should not be limited to discontinuation of antipsychotics because low doses of atypical antipsychotics may actually decrease apathy. Apathy is a major factor which decreases quality of life of long-term care residents and eliminating it should be a high priority for all care providers.

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