Non-Pharmacological Treatment for Persons with Cognitive Impairment and Dementia

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Objectives

The following learning objectives apply:

• After this presentation, the learner will discuss four Behavioral and Psychotic Symptoms in Dementia (BPSD) in persons with Alzheimer’s disease and other dementias.

• After this presentation, the learner will be able to discuss possible reasons for troublesome behaviors in persons with Alzheimer’s disease and other dementias.

• After this presentation, the learner will list four non-pharmacological interventions for BPSD.

• The learner will have the ability to determine if antipsychotic medications an acceptable therapy for the treatment of behavioral and psychotic symptoms of dementia (www.alz.org).

• The learner will have the ability to determine if non-pharmacologic alternatives to antipsychotics help in the treatment of BPSD (www.alz.org).
Why Discuss the Symptoms?

Discussion of the symptoms is critical to forming a solid understanding of BPSD.

• Alteration in processing new information

• Alteration in integrating new information

• Alteration in retrieving new information
Theories and Models of Dementia Care

There are three theories and models of dementia care; they are:

• Need-Driven Dementia-Compromised Behavior Model
• Progressively Lowered Stress Threshold Model (PLST Model)
• Self-Identity Role Model
Need-Driven Dementia-Compromised Behavior Model

The first theory and model of dementia care, the Need-Driven Dementia-Compromised Behavior Model explores:

• “Disruptive” Behavior = Expressing a Need
  • Appropriate response can improve the person’s quality of life

• Unmet needs
  • Psychosocial: inclusion, attachment
  • Physiological: comfort, pain management
  • Environmental: noise, temperature
  • Social surroundings: people (too many or not enough)

• Simple Pleasures Project
  • Appropriate activities could reduce wandering, vocalizing and aggression
  • “Disruptive” Behaviors lessen in an environment with recreational items and socialization.

  ➢ Colling & Buettner (2002)
Theories and Models of Dementia Care

The second theory and model of dementia care, The Progressively Lowered Stress Threshold Model (PLST Model) strives to address and reduce the friction of stress in older adults with dementia.

• PLST:
  • Stress threshold is set and stabilized by adulthood
  • As dementia progresses, stress threshold decreases
  • Behavior changes and increased anxiety
  • Environmental conditions modified for persons with cognitive decline
    • Easy to process cues from the environment
    • Environment becomes less stressful
  • Caregivers now understand the behavior
  • Strategies to meet the persons needs
  • Evaluate the intervention

  ➢ Smith, Gerdner, Hall & Buckwalter (2004).
Six Essential Principles of Care in the PLST

There are six essential principles of care in the Progressively Lowered Stress Threshold Model:

1. Maximize safe function
   • Familiar routines
   • Limit choices
   • Provide rest periods
   • Reduce stimuli
   • Identify and anticipate physical stressors (pain, hunger, thirst)

2. Provide unconditional positive regard
   • Respectful conversations
   • Simple and understandable language
   • Touch
Six Essential Principles of Care in the PLST

3. Use behaviors to gauge activity and stimulation
   • Monitor for anxiety
   • Intervene before behavior escalates

4. Teach caregivers to “listen” to the behaviors
   • Monitor the language pattern (repetition, jargon)
   • Monitor the behaviors
   • Behaviors that tell you how the person reduces stress when needs are not met

5. Modify the environment
   • Safe mobility
   • Promote way-finding and orientation through cues

6. Provide support to the caregiver(s)
The third theory and model of dementia care, the Self-Identity Roles Model is based on memory and “self-perception”.

- **Self-Identity Roles Model**
  - Identity maintained by memory
  - As dementia progresses, identity fades
  - Devaluing environment = “malignant” environment

Physical/Functional Interventions

There are multiple physical and functional interventions that may be addressed.

• Adequate nutrition and hydration
• Regular exercise
• Maintenance of ADL’s
• Proper rest and sleep
• Appropriate bowel and bladder routines
• Proper dental hygiene
• Current vaccinations
• Regular assessment, monitoring and management of comorbidities
• Automobile driving safety, mild dementia

➢ Dubinsky, Stein, & Lyons, (2000)
Environmental Interventions

Additionally, there are environmental interventions to consider.

• Home like environment (Reimer, Slaughter, Donaldson, Currie, & Eliasziw, 2004)
  • Greater privacy, encourages meaningful activities, permits more choices
  • Less decline in ADLs, more engaged

• Aromatherapy reduces disturbed behavior, promotes sleep and stimulates motivation (Thorgrimsen, Spector, Wiles, & Orrell, 2006)

• Manipulation of the environment (alarms, circular hallways, visual or structural barriers) (Peatfield, Futrell, & Cox, 2002)
Psychosocial Interventions

There are several psychosocial interventions, one or more of which might prove to be effective.

• Reality orientation is effective in mild stage dementia (Bates, Boote, & Beverley, 2004)
• Cognitive therapy more effective than no therapy but may be patient specific (Forbes, 2004)
• Validation therapy may be of value (Neal & Briggs, 2003)
• Recreational therapies, music and art may be effective (Gerdner, 2000)
• Music therapy may reduce behavioral problems (Lou, 2001)
• Teaching caregivers how to change their interactions and use problem solving skills is effective in reducing caregiver burden (Burgener, Bakas, Murray, Dunahee, & Tossey, 1998)
More Psychosocial Interventions

*Other psychosocial interventions include:*

• Routine activity
• Separate the person from the trigger
• Assess for pain, constipation or other physical problems
• Medication review
• Travel with them to where they are in time
• Don’t disagree, argue
• Maintain eye contact, get to their height, and allow space
• Speak slowly and calmly in normal tone
• Avoid finger-pointing, scolding or threatening
• Redirect
• Leave the room if you are the problem
Behavioral Interventions

Caregivers should include behavioral interventions; there are many and they include:

- Top Three: Agitation, Aggression and Wandering
- Sign of illness or something in the immediate environment
- Unrecognized pain
- Progressively Lowered Stress Threshold is a framework which optimizes function, minimizes disruption, and helps the caregiver.
  - Adapting the environment
  - Adapting routines
  - Help the patient with dementia use his or her functional skills
  - Minimizes potentially triggering reactions.
The Family Caregiver Alliance offers these recommendations to enhance communication:

1. Set a positive mood for interaction
2. Get the person’s attention
3. State your message clearly
4. Ask simple, answerable questions
5. Listen with your ears, eyes and heart
6. Break down activities into a series of steps
7. When the going gets touch, distract and redirect
8. Respond with affection and reassurance
9. Remember the good old days
10. Maintain your sense of humor

https://caregiver.org
Handling Troubling Behavior

Handling troubling behavior is very challenging.

• Ground rules:
  • Try to accommodate not control the behavior
  • We can change our behavior or the physical environment

• Check with the doctor

• Behavior has a purpose

• Behavior is triggered

• What works today may not work tomorrow

• Get support for yourself

➢ https://caregiver.org
Wandering

Wandering is common – and dangerous.

• Why?
  • Boredom, medication, looking for someone
  • Thirst, hunger, need to use the toilet
  • Need for exercise

• Make time for regular exercise
• Install locks that require a key, position locks high or low
• Use a barrier to disguise the door
• Place a black mat on your front porch (looks like an impassable hole)
• Install a home security system
• Put away coats, purse or glasses
• ID bracelets, sew ID labels into cloths
• Alert your neighbors

➤ https://caregiver.org
Incontinence

When addressing incontinence, like many concerns when caring for older adults with cognitive impairment and dementia, a routine is helpful.

• Toileting routine (every two hours)
• Schedule fluid intake, avoid diuretic drinks
• Use signs for the bathroom
• Commode
• Incontinence pads
• Easily removed clothing

➢ https://caregiver.org
Agitation

Agitation is very common.

• Irritability, sleeplessness, verbal or physical aggression
  • Triggers?
  • Loss of control?

• Reduce caffeine, sugar and junk food
• Reduce noise, clutter or number of people
• Maintain structure and routine
• Gentle touch, soothing music, reading or walks
• Keep dangerous objects out of reach
• Allow independence
• Distract with a snack or activity
• Have vision and hearing checked

➢ https://caregiver.org
Repetitive speech or actions

*Repetitive words, statements, questions or activities are harmless, but when misunderstood, can be annoying.*

- Triggered by anxiety, boredom, fear or the environment
- To successfully address, try:
  - Assurance and comfort
  - Distraction
  - Avoid reminding them that they just said that
  - Don’t discuss plans until right before the event
  - Place a schedule for the person
  - Learn to recognize certain behaviors

> https://caregiver.org
Paranoia

Paranoia is very real to the patient and can cause great discomfort.

• Accept and try to understand the “reality” the patient is experiencing
  • Do not argue or disagree

• If it pertains to missing items:
  • Money - use a change purse, wallet, or purse with dollars and coins for easy access
  • Help them look for the object then use distraction
  • Learn favorite hiding spots

• Explain to family members that suspicion and paranoia is part of the illness

• Use nonverbal communication or reassurance such as a touch or a hug

  ➢ https://caregiver.org
Sleeplessness/Sundowning

Sleeplessness and sundowning are worse at the end of the day, caused by exhaustion or changes in biological clock.

• Increase daytime activities, discourage inactivity and napping during the day
• Be careful with sugar, caffeine and junk food
• Afternoon and evening hours should be structured but quiet and calm
• Use lights before night time, decreases shadows which helps with confusion
• Use night lights

Sleeplessness/Sundowning

• Safety is paramount: use gates, lock the kitchen door and put away dangerous items
• Last resort, talk with the doctor about medication to help the agitated person relax and sleep
• A caregiver’s rest and sleep are critical to proper care
  • Ensure you get enough rest and sleep!

➤ https://caregiver.org
Eating/Nutrition

People with dementia forget that they are hungry or thirsty.

• Dentition, medications  
  • Weight loss, irritability, sleeplessness, bladder or bowel problems and disorientation

• Make mealtimes routine and keep a schedule

• Make mealtimes special

• Eating independently more important than eating neatly

• Finger foods, precut and seasoned, “sippy cup”

• Allow plenty of time

• Nutritious high calorie snacks, fresh fruits, vegetable trays

  ➢ https://caregiver.org
Bathing

Like eating and proper nutrition, “good hygiene” is also frequently forgotten.

- Highly private activity and can frighten, humiliate and embarrass
  - Baths or showers
  - Mornings or nights
  - Favorite scent or lotion
  - Respect modesty
  - Careful of the environment, safety is paramount
  - Never leave unattended

➤ https://caregiver.org
Additional Problem Areas

The list of problem areas can be overwhelming for caring for persons with Cognitive Impairment and Dementia. A few include:

- Dressing: loose fitting, comfortable clothes, easy zippers, minimal buttons
- Remove seldom worn clothes from the closet
- Lay one piece of clothing out at a time
- Remove soiled clothes from the room
- Don’t argue!

➢ https://caregiver.org
Hallucinations or Delusions

*Hallucinations and delusions are not uncommon.*

- State your perception of the situation, do not argue
- Keep rooms well lit, avoids shadows
- Reassurance and simple explanations
- Distractions may help

➤ https://caregiver.org
Sexually Inappropriate Behavior

Anticipatory and proactive planning for treatment are helpful.

• Masturbating or undressing in public, lewd remarks, unreasonable sexual demands, sexually aggressive or violent behavior
• Behavior is caused by the disease
• Talk with the doctor about change in treatment plan
• Develop an action plan before the behavior occurs
  • i.e. at home, around others
• Try to find the trigger

➢ https://caregiver.org
Other Behaviors

*Other behaviors can include:*

- Verbal outbursts: cursing, arguing, and threatening
  - Anger or stress
    - Stay calm and reassuring
- Shadowing usually occurs late in the day
  - Distraction or redirection
  - Give the person a job
- Uncooperative
  - Feeling out of control, rushed, afraid, or confused
  - Break each task into steps and explain each step before you do it
  - Allow plenty of time

[https://caregiver.org](https://caregiver.org)
If using antipsychotic therapy, it is important to:

• Identify and remove triggers for BPSD
• Initiate non-pharmacologic alternatives as first line
• Assess severity and consequences of BPSD.
  • Low risk = non-pharmacological therapies
  • High risk, frightening hallucinations, delusions or hitting = antipsychotic trial
  • Risk and benefits
  • Short term intervention
Advance Care Planning and End of Life Interventions

*It is vitally important that we, as caregivers, know and understand the following:*

- Nationally, only 51% of all nursing home residents have an advance directive \(\text{(Mezey, Mitty, Bottrell, Ramsey, & Fisher, 2000)}\)

- More than 90% of the four million Americans with dementia will be institutionalized before death \(\text{(Smith, Kokmen, & O’Brien, 2000)}\)

- Older adults with dementia have higher mortality rates compared to older adults without dementia and often die of complications of immobility, infection, and heart disease \(\text{(Ostbye, Hill, & Steenhuis, 1999)}\)

- End stage dementia can last as long as 2-3 years and distressing signs and symptoms occur at this time \(\text{(Brookmeyer, Corrada, Curriero, & Kawas, 2002)}\)

- Lack of evidence on palliative care for this population \(\text{(Sampson, Ritchie, Lai, Raven, & Blanchard, 2005)}\)
  
  ➢ \(\text{(Fletcher, K., Evidence-Based Geriatric Nursing Protocols for Best Practice)}\)
“Shoulds” at End of Life

There are countless items families SHOULD consider and address when approaching end of life issues.

• Making decisions about end of life “should” happen early in the disease
• “Should” complete advance directives or talk about their choices
• Families “should” be aware that laws regarding advance directives vary from state to state
• Physicians and health care providers “should” educate families regarding the choice of burdensome treatments in the advanced stages of dementia
• Families “should” (MUST) conduct/complete open and honest conversations
References

References


