
Screaming and Wailing in Dementia Patients (Part II)

Screaming is a behavioural problem that indicates great distress in patients which can also be very disturbing and a considerable source of stress, not only for the other patients but also for caregivers. After exploring its possible causes in Part I, this article addresses the principles and examples of therapeutic approaches and interventions, with particular emphasis on nonpharmacologic approaches.

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I hesitated a long time before writing Part II. It was far easier for me to ask myself questions about the causes of screaming and wailing that we do not understand in dementia patients than it was to find the answers. I had already discovered that studies and research on this specific type of behaviour are very rare and, consequently, scientific documentation is minimal. In addition, I thought then—and still do—that seeking the causes was fundamentally the best way to answer this behavioural problem.

There are, however, some therapeutic approach principles that are important to remember and, no doubt, examples to be given. It should also be remembered that we are discussing patients with moderately severe to severe dementia who are, by definition, unable to explain why they are screaming.

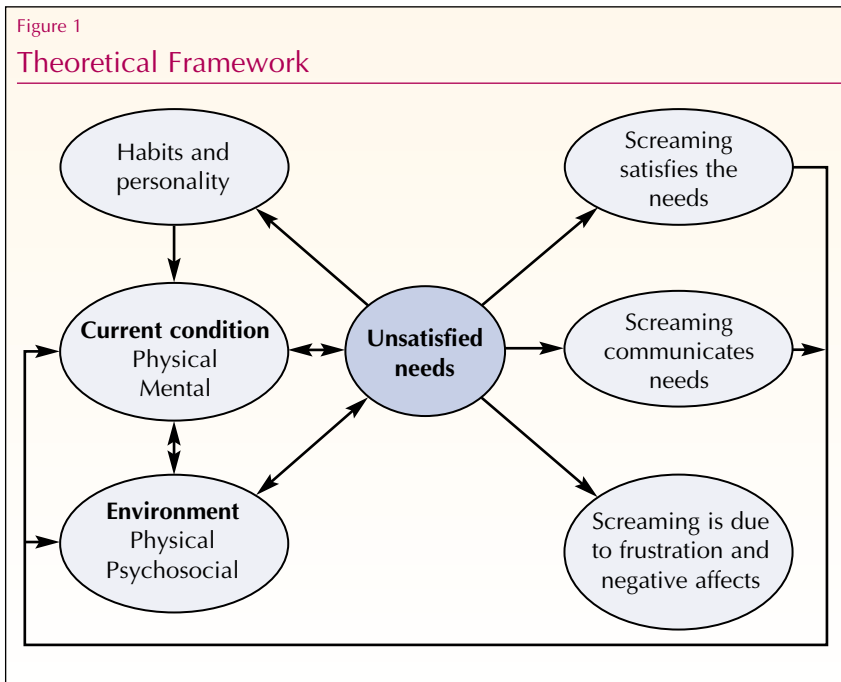
Theoretical Framework

No one has been able to explain how to analyze behavioural disorders as clearly as Dr. Jiska Cohen-Mansfield. Dr. Mansfield's many publications place unsatisfied needs at the core of the dynamic surrounding behavioural problems, screaming and wailing being one example (Figure 1). The source and causes of dissatisfaction are found in the patient's personality, current physical and mental condition, and environment. In advanced dementia, the unsatisfied need will be expressed in one of the following ways:

- a behavioural problem that will satisfy the need;
- a behavioural problem that will communicate the need;
- a behavioural problem that results from frustration or other negative effects that interact with the lowering of inhibitions.

Figure 1

Theoretical Framework



Let us see how the theory applies to screaming.

Screaming Fills a Need

By its very nature, dementia means that the patient’s world shrinks and becomes increasingly empty. To this can be added sensory deficits (loss of sight or, even more, loss of hearing). A patient may possibly feel the need to fill his world with noise, which we interpret as screaming. That is the only explanation I can find for the fact that, on several occasions, we have been able to stop screaming and wailing by correcting these deficits. A hearing aid and/or improved corrective lenses can therefore sometimes help stop screaming.

The mental or spiritual void, if I may use this expression, is even

more common and will lead to deep feelings of loneliness and boredom in many patients. In this instance, screaming may of course satisfy the need but, to be honest, it is more logical to think that it is a means of communicating the feeling of loneliness.

Screaming Communicates a Need

Physical pain. I know I will be told that it is self-evident that everyone thinks of pain when someone screams, but unfortunately this is not the case. Dementia patients do not often do it “habitually.” As a clinician, therefore, this has to be kept in mind constantly. Particular attention should be paid to arthritic pain, which will make its presence felt during hygiene care or when

getting dressed. A good way to remember to think about pain in our patients is to enter it on the chart as a fifth vital sign. In other words, when vital signs are noted, we should automatically include signs of possible pain (facial expression, positioning of the limbs, etc.) We must also remember another pain that can be present more often than thought—hunger.

Mental pain and depression. It is surprising, at least in my experience, just how rarely we think of screaming as an expression of depression or of a major affective disorder. It is true that screaming is often nerve-racking for everybody and disturbing to the other patients and the staff. The label “behavioural disorder” comes quickly to mind and, if medication is used, it will invariably be a neuroleptic. As will be covered later, I have had far more success with antidepressants than any other type of medication in these patients.

Loneliness and/or deep anxiety. Dementia, with its inherent confusion, disorientation, etc., can bring with it deep feelings of loneliness or anxiety at having been abandoned, even though many people may be around. Screaming can then be understood as a call for help. Many therapeutic approaches can be used to meet this feeling of loneliness; I will just mention a few of them.

Speaking to the patient is obviously the simplest way to meet this need. But it is easy to think of that when the patient can talk to us. When the patient is aphasic or confined within his dementia, the patient will hardly ever communicate. We must remember this and force ourselves to communicate with the patient on a regular basis. It should be mentioned that studies, as well as common sense, show that touching the patient (on the hand, forearm, etc.) or massaging the patient while talking has far more impact. Even if it is tempting to want to isolate patients who scream practically all the time and get them away from the other patients, the opposite solution often gives the best results. Placing them closer to the nurses' work station, where there is a lot of action and movement to and fro can alleviate the feeling of loneliness.

On a clinical level, patients with advanced dementia often have emotional needs similar to those of young children. It is therefore not surprising that a transitional object (a doll, a stuffed animal, etc.) which, because it is a symbol and the extension of someone who loves and protects, can reassure a child and can also have the same effect for the patient lost in dementia. In the same way, but more directly, large pictures or posters on the wall of family members, or the

“new family” of nursing staff, can prevent patients from screaming.

While transitional objects can be useful, pets have proved their worth even more. Regular zootherapy can be an excellent solution, and we have obtained excellent results specifically with screaming patients by having permanent “live-in” cats in certain units. Sometimes, it is not the presence of “a” dog that reduces a patient’s wailing, but that of “their” dog. Again, life-size pictures of a favourite dog can work wonders. I have even seen a patient who never stopped screaming, despite all the pharmacologic approaches that were

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tried, until the day one of his life-size china sculptures that bore a strong resemblance to a dog he once had was placed beside his bed. Although it obviously did not move or show any signs of life, the china dog nevertheless reassured the patient and he stopped screaming completely. Sometimes only sounds can have an effect, and audiocassettes of the sea or birdsong can prove useful.

Frustration. Patients may be frustrated because they are overstimulated. There are too many

stimuli around them or their “life space” is being encroached upon. That can create a feeling of deep anxiety and cause them to scream. The obvious action at that point is to move the individual away from the television, places where too many people pass by, etc. But, to be honest, the opposite condition is usually the norm and very often the cause of the screaming and wailing is because the patient is under-stimulated and bored. A radio or, even better, an audiocassette with his favourite music can be useful. Television can have the same effect, though I have seen TV aggravate screaming as many times as it has soothed the

patient. Caution is therefore advised.

Familiar, uncomplicated and repetitive manual activities have proved useful in many cases of behavioural disorder, including screaming. Folding towels or socks occupies the patient and may give him a feeling of being useful and a sense of self-worth. Just recently, large aprons with multiple pockets that have to be buttoned or zipped have been created for patients with slightly more advanced dementia. The

Table 1

Principles of a Nonpharmacologic Approach

- Observation
- Assessment of past and present
- Identification of unsatisfied need(s)
- Adapt the intervention to the patient's needs, personal characteristics, environment
- Try several alternatives and assess the approach used

patient will unbutton and rebutton the pockets, sometimes for hours on end, thus filling the emptiness in his mind in a very real way. For less severely affected patients, magazines or catalogues that they obviously won't read, but will leaf through can have the same effect. On the more active side, walks or even regular light exercise have sometimes served as a channel for the anxious energy that made them scream, and the behaviour stopped. Finally, experiences directly involving members of the family have had a certain degree of success. Audio- or videocassettes with members of the family talking together and sometimes talking to the patient have had worthwhile results. The best results have been obtained with audiocassettes that play continuously for the time desired in which a member of the family seems to have a "telephone conversation" with the patient that contains questions, comments and news, with all the appropriate pauses.

Disorientation. If we become disoriented for a few seconds, minutes or even longer when we are in a strange city or woken suddenly, we all feel a frustration that can easily turn to painful anxiety. Just imagine being in that state day after day, night after night. It is hardly surprising that simple disorientation can be a source of screaming and crying. In addition to everything mentioned above, we must obviously not forget the basics—large clocks, calendars, posters with the patient's full name within view—and, obviously, make it a habit to reorient patients who scream every time we interact with them.

So far, as in Part 1 of this article, we have followed the main principles of a nonpharmacologic approach (Table 1). The most difficult of these principles is the last one: patience. A patient's continuous screaming and wailing is a symptom that is so frustrating and upsetting for everyone that we look for the speediest solution. As will be covered further on, this will not happen with a pharmacologic approach

and the nonpharmacologic approaches which, in the final analysis, are fairly effective, create a paradox. We must give a specific approach sufficient time to work and, at the same time, know when it fails so we can try other approaches.

Pharmacologic Approach

At the risk of repeating myself, and certain exceptions aside, patients' screaming or wailing is a symptom that is far too complex to resolve by simply using a pharmacological approach. The exceptions, as indicated above, are pain or hidden medical problems, such as chronic infection, gastrointestinal problems, constipation, etc. Once these have been eliminated, I always try to see whether simply reducing tension or anxiety might be the solution. A trial with lorazepam 0.5 mg, or oxazepam, 10 or 15 mg, once or twice daily and/or at bedtime, tells us this fairly rapidly. These drugs can usefully be replaced by trazodone 25 mg.

If this approach is unsuccessful, my second alternative would be an antidepressant, as explained above. Citalopram with a target therapeutic dose of 20 mg/day or venlafaxine, with a usual target dose of 75 mg/day, are two interesting choices. There are others, of course, but it is important to remember to avoid drugs that have harmful side effects (anticholinergic effects, in particular) in elderly dementia patients and

that, whichever antidepressant is selected, it may easily take up to six weeks to become effective at the therapeutic dose.

It is only as a third option, even though it is the first choice of many clinicians, that I would try neuroleptics. Atypical agents are obviously strongly recommended because we want to avoid anticholinergic and extrapyramidal side effects. For patients with advanced dementia, usual maximum daily doses are risperidone 1 mg, olanzapine 5 mg, and quetiapine 100 mg to 150 mg.

Conclusion

It has not been easy to write on this subject, because the scientific literature is sparse and the research even more so. Despite the aid of pharmacological tools, experience has shown that the first approach should be nonpharma-

cologic. This means trying to understand what the patient may be experiencing or feeling, and trying (using a great deal of imagination) to find a specific solution for a specific patient. That is why the few solutions suggested in this article represent only a tiny portion of those possible. The approach must always be based on one or more specific needs that have not been met for a given patient, in specific circumstances. The purpose of this article is therefore to stimulate clinicians' imagination and creativity so that they will make an effort to find the right solution for their patients who are suffering. Faced with a dementia patient who can only communicate by constantly screaming and wailing, it is easy to feel discouraged and at a loss. We then have to remember the main principles that underlie the

best type of care to be given to this type of patient:

- something can be done for individuals with dementia;
- many factors can cause excess disability in individuals with dementia;
- individuals with dementia have residual strength;
- the communication between individuals with dementia and others is often difficult but it can be enhanced to improve the quality of interaction and comprehension;
- the behaviour of individuals with dementia represents meaningful feelings and needs, even if they are not expressed in conventional and understandable ways; and
- many aspects of the physical and social environment affect the functioning of individuals with dementia.

Suggested reading:

1. Groulx B. Screaming and Wailing in Dementia Patients (Part I). *The Canadian Alzheimer Disease Review* 2004; 6(2):11-14.
2. Cohen-Mansfield J. Theoretical frameworks for behavioral problems in dementia. *Alzheimer's Care Quarterly*, 1(4):8-21.
3. Cameron J, Cohen-Mansfield J. Use of non-pharmacological interventions among nursing home residents with dementia. *Psychiatric Services* 2002; 53(11): 1397-401.
4. Cohen-Mansfield J, Billig N. Agitated behaviors in the elderly: a conceptual review. *J AM Geriatr Soc* 1986; 34:711-21.
5. Cohen-Mansfield J, Deutsch L. Agitation: subtypes and their mechanisms. *Semin Clin Neuropsychiatry* 1996; 1:325-39.
6. Burgio L. Interventions for behavioral complications of Alzheimer's Disease: behavioral approaches. *Int Psychogeriatr* 1996; 8(supp.1):45-52.
7. Cohen-Mansfield J, Werner P, Marx MS. Screaming in nursing home residents. *J AM Geriatr Soc* 1990; 38:785-92.