
Nonpharmacologic Treatment of Behavioral Disorders in Dementia

There are a variety of “agitated” behaviors displayed by patients with Alzheimer’s disease that are either poorly or not at all amenable to pharmacologic therapy. Better understanding of these behaviors and the patient’s needs allows caregivers to provide the patient with the highest quality of care.

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There are a variety of “agitated” behaviors in patients with Alzheimer’s disease (AD) that are either poorly or not at all amenable to pharmacotherapeutic management.¹ In a case where the patient is displaying agitation by wandering, making unreasonable and constant requests, hoarding objects or exhibiting inappropriate hostility, the first step is to determine the cause of the behavior so a suitable therapy can be administered.

The patient’s agitation may be a reaction to internal cues (hunger, thirst, pain, illness), external cues (demands of the environment, the caregivers) or to the effect of AD on the patient’s grasp of reality. In order to treat AD patients, it is important to understand how they experience life through the filter of dementia.

Global Deterioration Scale

Awareness continues to grow about nonpharmacologic approaches to agitation as more is learned about the actual nature of AD.² Reisberg’s studies have led to the refined Global Deterioration Scale (GDS) and the Functional Assessment Staging

(FAST).^{3,4} Reisberg demonstrates that AD patients lose their faculties and abilities in the exact reverse order they once acquired them. For instance, the first thing newborns are able to do is hold up their heads. This is the last ability an AD patient loses. Smiling at a known or friendly face is the next step in a baby’s development and the second to last step in an AD patient’s regression and so on and so on.

Exploring this concept further, Reisberg’s recent research has shown this reversibility can be seen from a neuro-physiologic point of view.⁵ The regression not only affects cognitive and intellectual functions, but developmental, sociologic and emotional ones as well. At the risk of simplifying the issue, the best way to understand AD patients at stage five of GDS, for instance, is to approach them, or at least their needs as if they were between the ages of five and seven (Table 1).

Functional Assessment Staging

With this approach, the most attentive, appropriate and respectful care by clinical or family caregivers to an AD patient in FAST stage 6(e) would be the same given to a two to three-year-old

Table 1

Global Deterioration Scale (GDS)

APPROXIMATE AGE	ACQUIRED-LOST ABILITIES	ALZHEIMER STATE (FAST) [See Figure 1]
12+ years	Hold a job	3 - INCIPIENT
8-12 years	Handle simple finances	4 - MILD
5-7 years	Select proper clothing	5 - MODERATE
5 years	Put on clothes unaided	6 - MODERATELY SEVERE
4 years	Shower unaided	a)
4 years	Toilet unaided	b)
3-4 1/2 years	Control bladder	c)
2-3 years	Control bowels	d)
		e)
		7 - SEVERE
15 months	Speak 5-6 words	a)
1 year	Speak 1 word	b)
1 year	Walk	c)
6-10 months	Sit up	d)
2-4 months	Smile	e)
1-3 months	Hold up head	f)

child. This includes security, warmth, tenderness, proper food and shelter.

For a three-year-old child and for an AD patient regressed to that level, however, activities must also be provided that will stimulate creativity and plea-

different approach must be taken in cases of AD. Treatment must be based on understanding AD, what the patients are going through and their needs. In fact, not caring for patients in this way creates unhappiness for the

1. **Determine the cause of agitation.**

If the behavioral disorder is new, evaluate the patient's actions and try to determine the cause. If the behavior is not recent, search for what caused it in the past and more importantly, what has helped in the past.

2. **Determine who is agitated.**

Investigate who is really agitated in a particular situation. Is it the patient or the family and staff that is perturbed by the patient's behavior?

3. **Ensure the patient's physical environment is appropriate.**

Management of the patient's surroundings should be one of the first treatment steps taken. The patient's physical surroundings should include good lighting including, night lights, big and well-placed

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sure such as drawing, playing with a ball or listening to stories. If an AD patient lives long enough to reach stage 7(d) he or she might need a transitional object (a favorite blanket or stuffed animal) or even a pacifier to go to bed (Figure 1).

This approach seems contrary to all geriatric principles that emphasize not infantilizing our older patients, but a

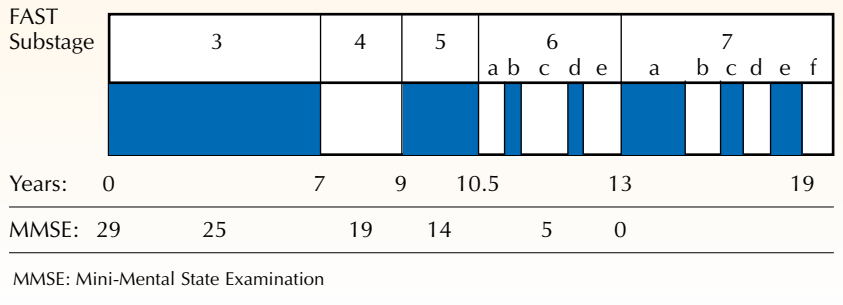
patient, which leads to frustration, then agitation. Understanding the patients' needs and satisfying them is an important nonpharmacologic approach to behavior disturbances in AD patients.

Nonpharmacologic Treatment

Some principles to follow in cases of agitation in AD patients:

FIGURE 1

Functional Assessment Staging (FAST)



calendars, schedules, clocks and familiar objects from home. The patient should also be provided with free access to family members and plenty of space to move.

4. **Particular attention must be given to the external caregiver's approach.** The patient should receive reassurance, respect, identification and reorientation at every contact with the caregivers. Regular re-evaluations should be

Do not underestimate the power of physical activity. Regular exercise helps to discharge undirected energy, promotes better sleeping at night and increases a sense of well-being.

made of the patient's limits in order to readjust the demands. "Mismatches" between patients and staff should be solved quickly.

5. **Talk to AD patients.** It is very easy to forget to talk to AD patients, particularly if they are aphasic and do not talk back. Yet nothing is more reassuring and soothing for patients than being talked to in a natural way. Conversation about current activities on the ward, past interests or news from their family are normalizing, therapeutic and can help create a bond between caregivers and patients.
6. **Resist the natural tendency to ask information from the patient.** Questions such as "what is the

matter" or "why are you upset" can be difficult for patients to answer and can increase their confusion. Give information instead by saying "you are upset" or "you are not feeling well and I will help you," which convey a better message.

7. **Develop adequate communication strategies.**⁶ Face the patient directly and keep up the normal exchange of ideas found in a conversation. Keep sentences short,

simple and direct. Use and repeat nouns rather than pronouns. Continue the same topic of conversation for as long as possible and give the patient time to comprehend what you say. Help the patient become "unstuck" when he or she uses a word incorrectly by suggesting the correct word and then repeating the patient's sentence using the right word. Structure simple and easy questions the patient can answer. Do not hesitate to use hand signals, pictures or facial expressions, if necessary.

8. **"Depersonalize" the patient's agitation, aggression and violent acts.** Caregivers must never feel or believe that such behavior is aimed

at them or that the patient does not like them.

9. **Do not underestimate the power of physical activity.** Regular exercise helps to discharge undirected energy, promotes better sleeping at night and increases a sense of well-being.
10. **In times of crisis, do not underestimate the power of distraction.** Redirecting patients to another area or activity, such as offering them food, can deactivate an aggressive outburst.
11. **Maintain consistency.** Whatever approach or nursing care plan has been decided for a particular patient, make sure it is consistently applied during the three shifts.
12. **Families are the best allies of professional caregivers.** In periods of agitation, the presence of familiar and loved faces has a reassuring effect on the patient.

Conclusion

These guidelines should assist caregivers in obtaining a better understanding of a patient's needs and illness, allowing the caregivers to provide the highest quality of care.

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