First Line Treatment: Non-Pharmacological Approaches in Dementia

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Biomedical view of dementia

Lyman (1989) suggested that the biomedical view of dementia includes three features:

- First, dementia is pathological and individual, an abnormal condition of cognitive impairment, dysfunction, and mental disorder.
- Second, dementia is somatic or organic in etiology, caused by progressive deterioration of brain regions that control memory, language, and other intellectual functions, resulting in stages of increasingly severe impairment.
- And third, although there is currently no cure, dementia is to be diagnosed, treated, and managed according to medical authority.

Personhood

- The person with dementia experiences two kinds of change, going on in tandem.
  - First, there is the gradual advancing failure of mental powers such as memory, reasoning, and comprehension, much of which can be attributed directly to the brain being less efficient.
  - Second, there are changes in the social-psychological environment, in patterns of relationship and interaction

Personhood cont.

- This perspective emphasizes modifiable conditions that affect the illness experience, in contrast with the biomedical model's deterministic view, which attributes the individual's functioning and behavior problems to the neuropathology of dementia.

Personhood cont.

- Yet this requires making a decision about the way in which we understand the afflicted - we must decide to see him or her as one whose behavior can be affected by others, who has a valid experiential world, whose behavior can be driven by meaning, who may be tormented by his or her disabilities and what they mean, and as one whose sense of pride, dignity, and the need to avoid humiliation can remain alive long after many cognitive abilities have declined.

Personhood cont.

- A more comprehensive approach to AD involves the understanding that a balance between resources and deficits, outer and inner demands can be accounted for at each step or stage of the dementing process (Hagberg, 1993).

Four principles

1. The human value of people with dementia, regardless of age or cognitive impairment, and those who care for them.
2. The individuality of people with dementia, with their unique personality and life experiences among the influences on their response to the dementia.
3. The importance of the perspective of the person with dementia.
4. The importance of relationships and interactions with others to the person with dementia, and their potential for promoting well-being. (The fourth principle emphasizes the imperative in dementia care to consider the needs of carers, whether family and friends or paid care-workers, and to consider ways of supporting and enhancing their input to the person with dementia. This is increasingly described as 'relationship-centered care'.)
Positive Person Work

- Recognition - need to acknowledge them as a person, affirm their uniqueness.
- Negotiation - consult with person about desires, preferences, and needs.
- Collaboration - do not cast person into a passive role.
- Play - exercise in spontaneity and self-expression.
- Timalation - involves sensual or sensuous, want to provide contact
- Celebration - any moment at which life is experienced as intrinsically joyful

Positive Person Work cont.

- Relaxation - essential, has low level of intensity
- Validation - accept the reality and power of experience, involves empathy
- Holding - in a psychological sense, want person to know that experience will pass and that they will not disintegrate.
- Facilitation - helping person do things otherwise not able to by providing missing parts.

Positive Person Work cont.

- The previous items are often done by the caregiver or agency serving the individual with AD, the two below are aspects that the caregiver has to be humble enough to recognize, appreciate, and receive.
- Creation - person spontaneously offers something to social setting.
- Giving - person expresses concern, affection, gratitude, makes offer to help.

Not helpful at all

- Treachery - using deception to distract or manipulate, force into compliance.
- Disempowerment - not allowing person to use abilities they have.
- Infantilization - patronizing the person
- Intimidation - inducing fear through threats or physical power
- Labeling - using a pattern of behavior as a main basis for describing the person
- Stigmatization - treating person as if they were a diseased object

Not helpful at all cont.

- Outpacing - providing information, choices, etc. at too fast a rate for person to understand
- Invalidation - failing to acknowledge subjective reality of person’s experience
- Banishment - excluding a person psychologically or physically
- Objectification - treating person as if they were a lump of dead matter
- Ignoring - carrying on in presence of person as if they were not there.
- Imposition - forcing a person to do something, denying possibility of choice.

Not helpful at all cont.

- Withholding - refusing to give asked for attention
- Accusation - blaming person for actions that arise from lack of ability, misunderstanding
- Disruption - roughly intruding on a person’s action or inaction
- Mockery - making fun of a person’s actions or remarks
- Disparagement - telling person they are incompetent, useless, worthless
Models of non-pharm intervention

- Cohen-Mansfield (2004) does an excellent job of explaining the three theoretical models have generally been applied:
  - 1) the “unmet needs” model;
  - 2) a behavioral/learning model;
  - 3) an environmental vulnerability/reduced stress-threshold model.

Models cont. (Unmet Needs)

- Significant proportions of nursing home residents who present inappropriate behaviors suffer from sensory deprivation, boredom, and loneliness.
- Therefore, providing sensory stimulation, activities, and social contacts are among the most commonly described interventions.
- A more insightful approach would be to prevent the patients from reaching the point of unmet need and to assist these persons in

Models cont. (Learning)

- The behavioral model assumes that a connection between antecedents, behavior, and reinforcement has been learned
- A different learning experience is needed to change the relationship between antecedents and behavior (the ABC model= Antecedents-Behavior-Consequences; where antecedents operate through stimulus control, and the consequences reinforce behavior, or reinforce certain behavior related to specific antecedent/stimuli).
- Many problem behaviors are learned through reinforcement by staff members, who provide attention when problem behavior is displayed.

Models cont. (Environment)

- Treatments of reduced stimulation levels or provision of relaxation techniques (e.g., massage) are based on the assumption that the dementia process results in greater vulnerability to the environment and a lower threshold at which stimuli affect behavior.
- Therefore, a stimulus that may be appropriate for a cognitively intact person may result in overreaction in the cognitively impaired person.
- According to the concept of progressively lowered stress threshold, persons with dementia progressively lose their coping abilities and therefore perceive their environment as more and more stressful. At the same time, their threshold for encountering this stress decreases, resulting in anxiety and inappropriate behavior when the environmental stimuli exceed the threshold for stress.
- An environment of reduced stimulation is supposed to limit the stress experienced and thereby reduce the level of

Why use non-pharm interventions?

The reasons for using a nonpharmacologic interventions approach to treating inappropriate behaviors in dementia include the following:
1) it aims at addressing the psychosocial/environmental underlying reason for the behavior, as documented in previous research;
2) it avoids the limitations of pharmacological interventions, namely, adverse side effects, drug-drug interactions, and limited efficacy; and
3) when medication is efficacious, it may mask the actual need by eliminating the behavior that serves as a signal for the need, thereby reducing the already compromised communication by the elderly person and limiting the caregiver’s ability to properly care for him or her.

Helpful steps for BPSD

BPSD = Behavioral and Psychological Symptoms of Dementia
1. Identify the target BPSD
   - There needs to be a clear definition of the problem to be addressed. The more clearly this is defined, the more likely caregivers will be able to identify a clear course of action.
   - Collaboration with the caregiver is essential.
   - Better to tackle one BPSD at a time.
Helpful steps cont.

2. Gather information about the BPSD
   • How often; when does it happen; where does it happen are all essential questions.

3. Identify what happens before and after a target BPSD.
   • Often caregivers believe the BPSD happens ‘out of the blue’ — careful observation of events immediately preceding the BPSD can identify trigger factors.
   • BPSD are rarely simple and there are usually several factors involved. By understanding the

Helpful steps cont.

4. Set realistic goals and make plans.
   • Involve individual with dementia as much as possible and work with caregiver to set goals.
   • Start with small achievable goals and proceed step by step.
   • Tailor the plan to the individual and the caregiver.
   • Be practical and allow plenty of time for change to occur.
   • Work with the caregiver to anticipate problems that might occur.
   • When possible, generate alternative plans.

Behavior Analysis Protocol
Steps in Writing a Behavior Plan

• Statement of the problem
• State who has been informed of this problem and how you are meeting regulatory standards in your immediate response to the problem
• State the goal of the plan
• Describe the behavior (detailed description not interpretation). Note that the description of the behavior is not always the same as the problem i.e., John yells (behavior), others are agitated (problem)
• Note any observed patterns in the behavior attained in the behavioral log

• State a working hypothesis as to the cause (trigger(s)) of the behavior
• Describe the intervention in detail and how it might involve staff on all shifts; and if relevant the family or authorized person(s)
• State who will be responsible for the overall application/oversight of the intervention plan
• Who will implement the intervention on each shift
• Who will chart the implementation of the intervention and how often

Behavior plan cont.

• Indicate if a behavioral log will be used to observe the intervention
• If anyone needs to be trained in order to implement the intervention, who will be trained; who will deliver that training; and when will it be completed
• State the duration of the intervention
• Who will inform authorized family/guardian and medical professionals that the behavior plan is in progress
• State when the team will meet over the intervention period and who will convene this meeting
Behavior plan cont.

• What percentage of the behavior do you anticipate the intervention will address
• State what percentage of the remaining behavior would be acceptable (if any) and how you plan to address the remaining behavior
• Indicate the date(s) when the team will meet to assess intervention outcomes and what measures (methods) will be used to assess the outcomes
• Who will write the report of the intervention outcomes, enter the report into the chart, and inform all authorized parties

Behavior plan cont.

• When will the team meet again to evaluate if the plan needs to be changed
• Enter the behavior plan and outcomes into the care plan
• If the intervention was determined to be unsuccessful, the team should meet to discuss why the plan failed and consider the relevance of other behavioral triggers and a new intervention strategy.

*developed by Paul Raia, Ph.D., Alzheimer’s Association, Massachusetts and New Hampshire Chapter

Depression

• Need to recognize the different presentations of depression in the older adult.
• Increase and encourage activities that the person can enjoy. Identify activities enjoyed in the past and modify as appropriate. Pleasurable activities decrease depression in dementia.
• Confirm that the activities are really those that the individual enjoys. Ask the individual what they like.
• Plan pleasant activities to be conducted with someone whose company the person enjoys.
• Provide a bright and cheerful environment

Agitation and Aggression

• Intervene early by recognizing a problem situation and attempting to intervene before it becomes a problem.
• Keep the individual away from situations and individuals that are provoking.
• Use a reassuring and gentle voice.
• Approach slowly and calmly from the front. Tell the individual what you are doing.
• Use touch judiciously – this largely depends on the person.
• Establish a calm and quiet environment.
• Avoid arguing while the person is agitated – this almost

Wandering

• A confused person will often forget that he or she is supposed to be at a particular place and so frequent reassurance is important.
• If the person is able to understand what is going on, try to involve them in the planning. With more confused individuals it may be easier not to introduce them gradually, but to make the move as quickly as possible and without any fuss.

Repetitive questions/mannerisms

• Caregivers often find this extremely irritating or distressing. Reasoning with the individual or confronting them, however, is generally futile.
• Sometimes ignoring the repeated questions will work but I find that more often it just irritates them more.
• Sometimes the person may be unable to express what is actually worrying him or her. Caregivers have the opportunity to react healthily to this emotional aspect.
• Distraction can be helpful by giving a new and specific task to perform. Caregiver must not
## Recreational, adjunctive, social therapies

- Exercise (physical activity) is thought to be one means of attenuating cognitive decline and improving cognitive ability. Also has the potential for increasing pleasurable activities, socialization, and improving overall health.
- Music therapy – has been shown to reduce anxiety and restlessness; help with sleep; and reduce hostility. Also often has a beneficial aspect for cognition.
- Art therapy – Meet Me at MOMA program
- Religious activities
- Pet therapy – often a calming and soothing effect. Clinically shown to improve socialization, reduced the agitation that often spikes in the early evening hours for people with dementia, and decreased problem behaviors.

## Creative therapies

- The creative therapies in particular are getting a lot of research attention these days. There are some very interesting findings. Here is a brief list of some of the potential outcomes:
  - Positive emotional responses
  - Reduction in agitation
  - Greater social engagement/interaction
  - Change in cognitive processes
  - Increased verbal fluency
  - Functional improvements

## Creative therapies cont.

- Increased food intake
- Weight gain
- Increased mobility
- Greater physical strength and balance
- Improved mood and attention span
- Less stress (caregivers and receivers alike)
- Elevated quality of life
- Greater understanding of the human condition

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