失智症之行為與心理症狀--以非藥物治療及活動的處理方法

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如何有效提升對認知障礙症(癡呆症)院友照顧

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Outline

- Definition & facts about BPSD
- Problematic Behaviour Vs Responsive Behaviour
- Non-pharmacological Intervention
- Conclusions

Definition & Facts about BPSD

Definition of BPSD

- Behavioural & Psychological Symptoms of Dementia

- Symptoms of disturbed perception, thought content, mood or behaviour that frequently occur in patient with dementia

(International Psychogeriatric Association consensus group, 1996)

Definition of BPSD

Behavioral symptoms

Usually identified on the basis of observation of the patient, including physical aggression, screaming, restlessness, agitation, wandering, culturally inappropriate behaviors, sexual disinhibition, hoarding, cursing and shadowing.

Psychological symptoms

Usually and mainly assessed on the basis of interviews with patients and relatives; these symptoms include anxiety, depressive mood, hallucinations and delusions.

Definition of BPSD

Neuropsychiatric Inventory (Cummings et al., 1994)

NEUROPSYCHIATRIC SYMPTOMS (NPS) AND THEIR DESCRIPTORS

Symptom	Medical Record Descriptors	NPI Comparison Category
Agitation/aggression	Combative, hitting, grabbing	Agitation/aggression
Depression	Mood disorder, suicidal ideation, mood change, depression with psychosis	Depression or dysphoria
Withdrawal/lethargy	Decreased socialization, fatigue, social isolation, apathy, social deficit, isolating self in room, sedation	Apathy or indifference
Refusal/resistance	Refusal or resistance	(Aggressive refusal is included in agitation/aggression category)
Psychosis/delusions	Delusional disorder, psychosis not otherwise specified, schizophrenia, catatonia	Psychosis and delusions are separate categories
Aberrant motor	Wandering, behavioral disturbance, nose picking, crawling, restlessness, smearing stools, picking at skin	Motor disturbance
Sleep disorder	Insomnia, sleep apnea, sleep-wake cycle disturbance, drowsiness, awake most of night	Nighttime behaviors
Calling out	Calling out, moaning in sleep	
Anxiety	Anxiety	Anxiety
Inappropriate touching	Inappropriate touching	Disinhibition
Hypomania	Hypomania	Elation or euphoria

Prevalance of BPSD

A number of studies looking at the occurrence of BPSD in nursing home populations have found these symptoms to occur in up to 90% of patients (see Table 1).

Table 1. The prevalence of BPSD. Reprinted with permission from Finkel, 1998.

Sign or symptom	Reported frequency (% of patients)
● Perceptual	
– Delusions	20–73
– Misidentifications	23–50
– Hallucinations	15–49
● Affective	
– Depression	up to 80
– Mania	3–15
● Personality	
– Personality change	up to 90
– Behavioral problems	up to 50
– Aggression/hostility	up to 20

Time Course of BPSD

- 80–97% of patients with AD are affected by at least one NPS at some point in their illness
- 86% BPSD appear as single episode
- Onset 5 years after onset of dementia (range 4.3-7.3, sd=3)
- MMSE at onset of BPSD = 5-12
- At disappearance = 0 - 6
- Overall duration 12 = 24 months
- Duration of each episode 9~ 19 months

(Steinberg *et al.*, 2008; Hope A etal, Br. J. Psych 1999)

Cost of BPSD

- BPSD is a major component of cost of AD
- 30% of overall cost in care of AD invested in BPSD management

(Beeri MS,2002)

Impact of BPSD

On Client

- Physically restrained
- More likely to receive antipsychotics
- Accelerated decline **1.4** points faster per year on MMSE
- Higher institutionalization rate

On Staff

- Physical abuse 92% of the time
- Verbal abuse 90% of the time
- NH staff find aggression stressful if the aggression perceived as threatening

- Vocally disruptive patients
-Wandering
- Withdrawn behaviour

Problematic Behaviour

Vs

Responsive Behaviour

Problematic Behaviour Vs Responsive Behaviour

Hitting/ Kicking

Screaming/ Incessant calling out

Sexual disinhibition (verbal or physical)

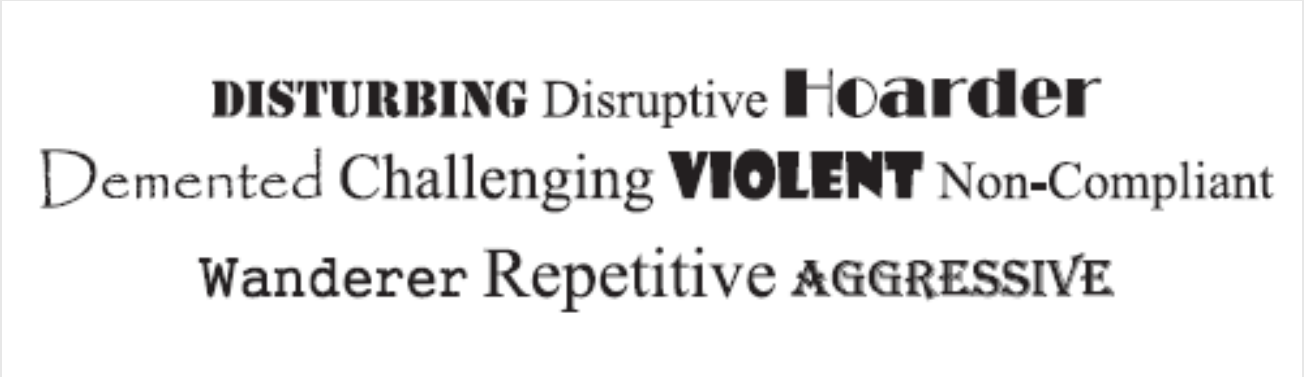
Perseveration on bathroom activities

Wandering

Aggression during daily care

Attention seeking behaviors

Problematic Behaviour Vs Responsive Behaviour



Problematic Behaviour Vs Responsive Behaviour

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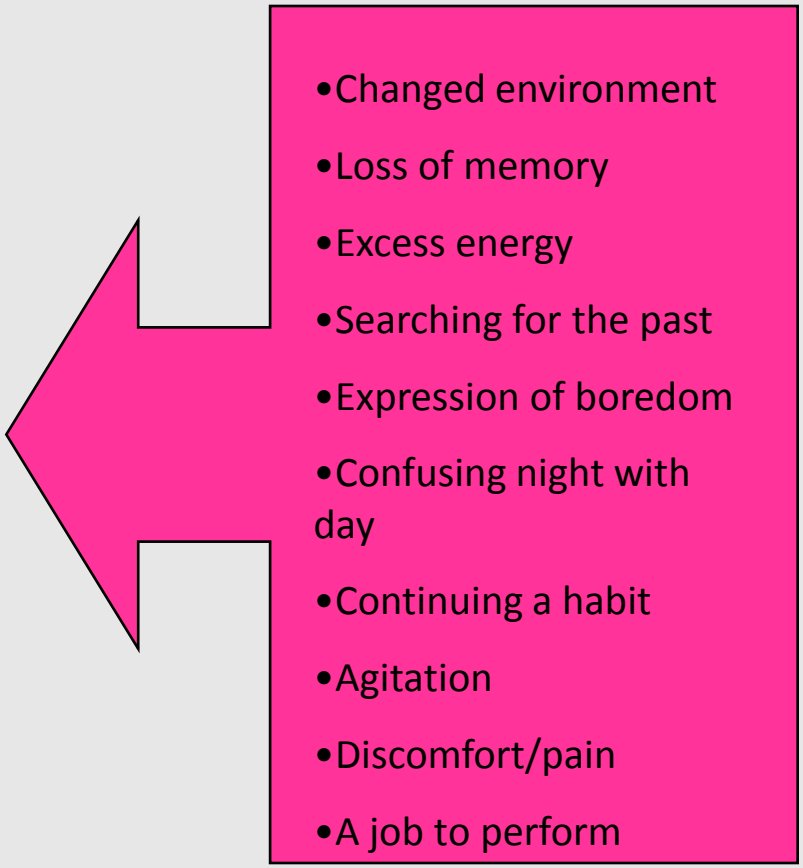

Problematic Behaviour Vs Responsive Behaviour

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Pathologizing behavior: Meanings of behaviors in dementia care

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ABSTRACT

Deficit and problem-based approaches to behavior stigmatize persons with dementia and cause great unnecessary suffering. In order to reduce the harm caused to persons misunderstood, it is important to understand the process by which staff attach meaning to behaviors and how those meanings ultimately influence how staff respond to behaviors. To this end, this research sought to examine the perceptions and meanings that staff attach to behaviors, how staff experience these behaviors, and the role that meanings and experiences have in staff actions and responses to specific behaviors. This paper focuses on one sensitizing concept that emerged from our study – *pathologizing behavior* – that reflects how behaviors become pathologized and problematized in the long-term care context. Conducted as part of a larger interpretive grounded theory study, active interviews were conducted with 48 staff members working in a range of positions in long-term care homes in Ontario, Canada. All staff interpreted and placed residents' behaviors in context through a complex process that started with the process of *filtering behavior through the lens of pathology*, and guided how staff then *assigned meaning to the behaviors*, how they *characterized behaviors as "challenging"*, and ultimately *reacted through crisis management*. The findings demonstrate the impact biomedical discourses have on meanings attached to behaviors and responses to behaviors and point to the need for alternative discourses that emphasize *understanding meanings of actions* using multidimensional lenses.

Staff Attitudes

Frequency distributions of responses to ADQ items

Approaches to dementia questionnaire items	Agree/ strongly agree (%)
Person-centered attitude items	
Spending time with people with dementia can be very enjoyable	809 (46.9)
There are a lot of things that people with dementia can do	945 (54)

More than half of the staff believed that "Not enjoyable" & "Not much things can do"

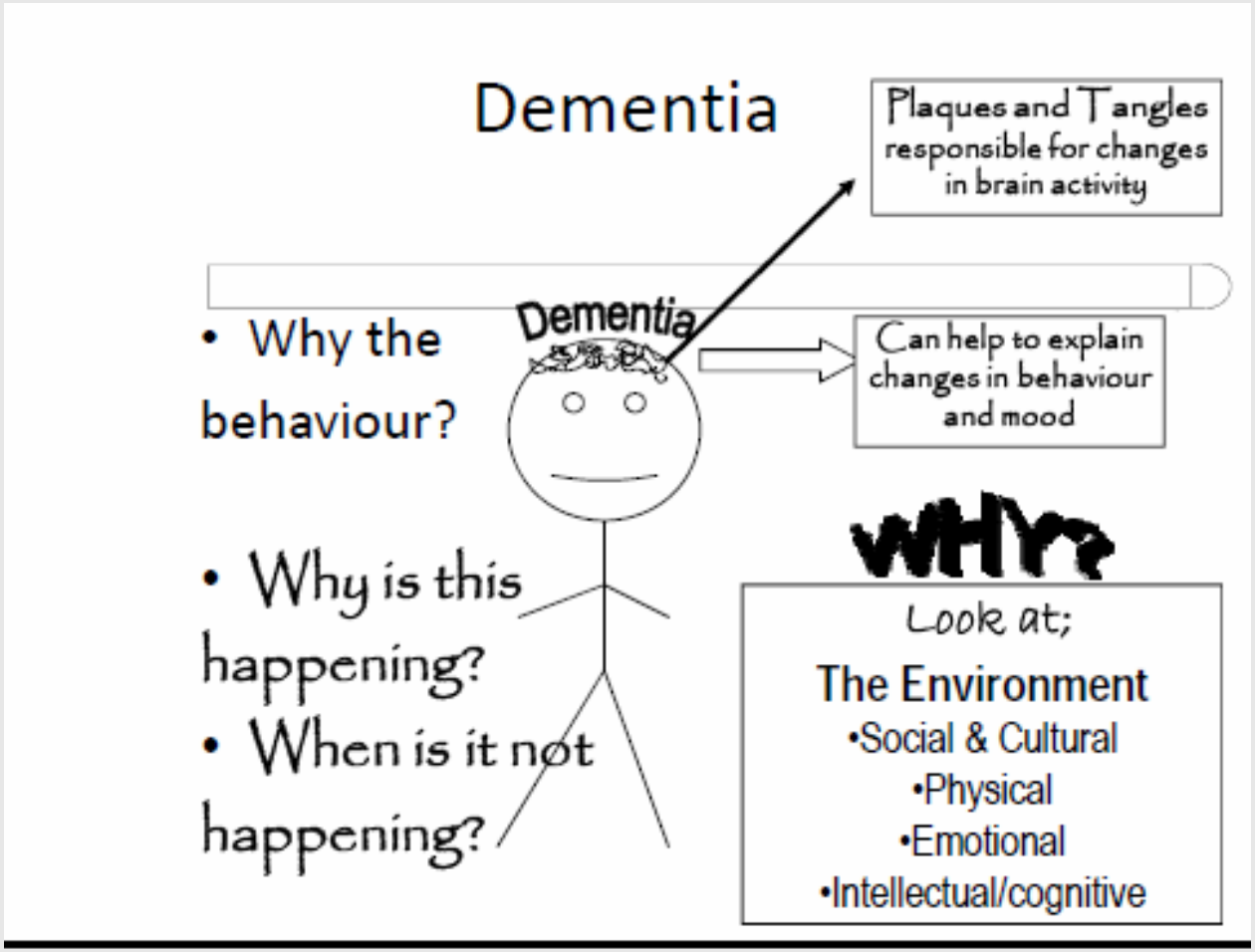
Responsive Behaviour

A **responsive behavior** discourse views all actions as meaningful and moves us away from judging behaviors to understanding meaning in actions and responses.

It means moving from a focus on dysfunction, deficit and decline, to recognizing, valuing and believing in the continued abilities of persons with dementia to express their experiences and act in purposeful, meaningful and even intentional ways.

It places the reasons or triggers for behaviours outside of the individual rather than within, recognizing that problems in the environment can be **addressed** and **changed**

Problematic Behaviour Vs Responsive Behaviour



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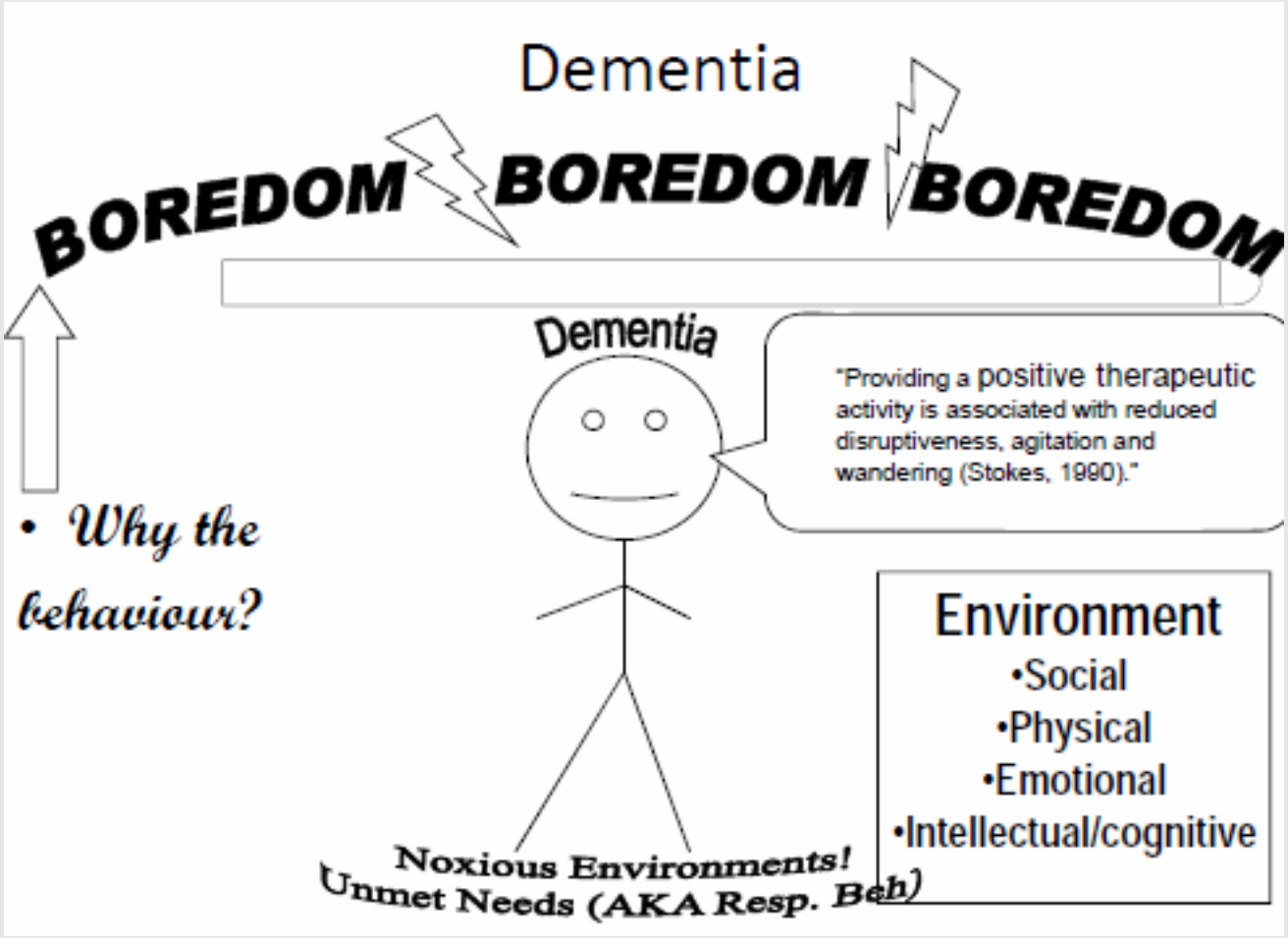

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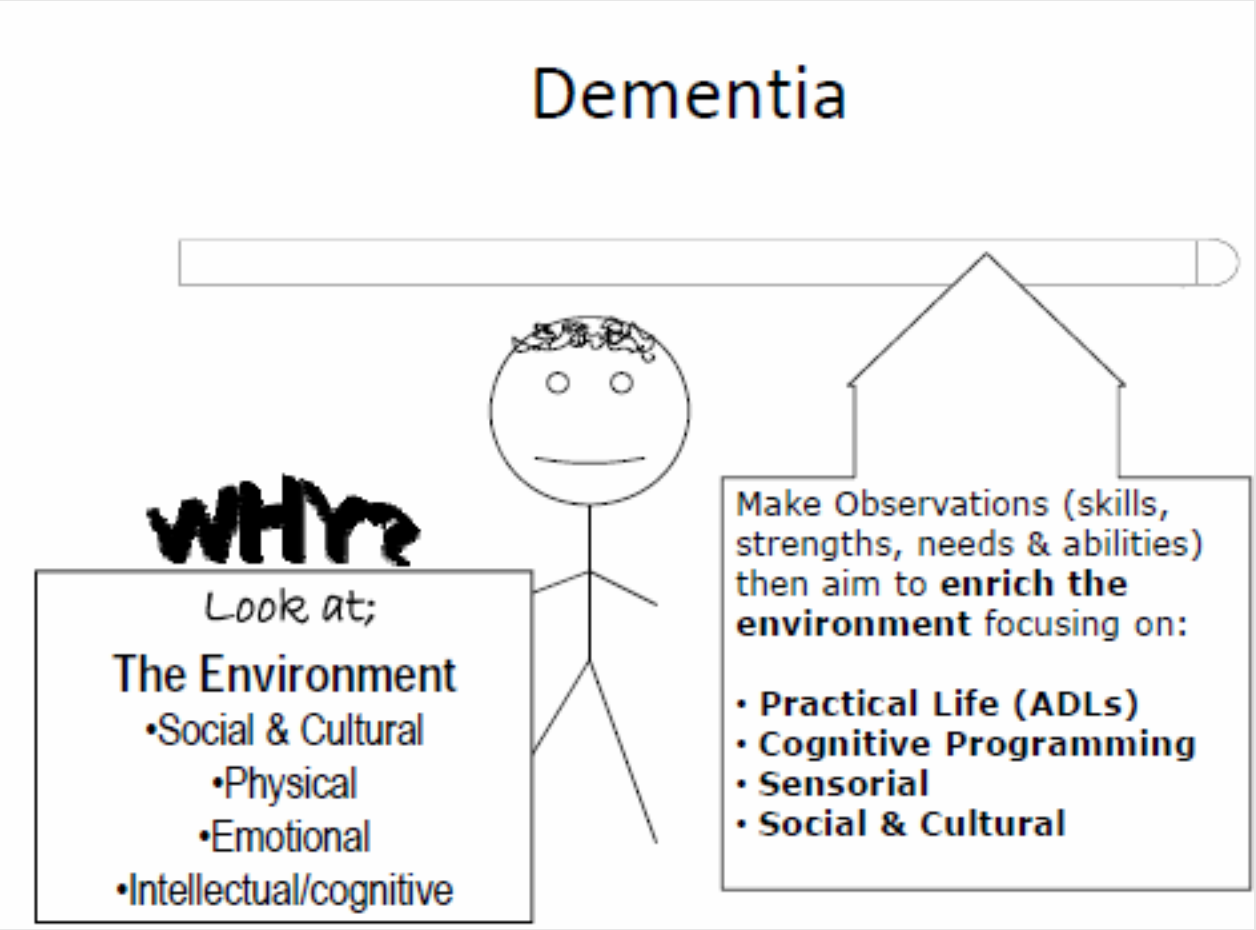

Non-pharmacological Intervention in mange of responsive behaviors

Non-pharmacological Intervention

Department of Veterans Affairs
Health Services Research & Development Service

Evidence-based Synthesis Program

HSR&D

A Systematic Evidence Review of Non-pharmacological Interventions for Behavioral Symptoms of Dementia

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http://www.hsrd.research.va.gov/publications/esp/Dementia-Nopharm.pdf

Non-pharmacological Intervention

1.Cognitive/emotion-oriented interventions

Reminiscence Therapy; Validation Therapy; Simulated Presence Therapy (SPT)

2. Sensory stimulation interventions

Snoezelen Multisensory; Stimulation Therapy; Music Therapy; Acupuncture; Aromatherapy; Light Therapy; Massage and Touch

3. Behavior management techniques

Include a wide variety of behavioral interventions such as functional analysis of specific behaviors, token economies, habit training, progressive muscle relaxation, communication training, behavioral or cognitive-behavioral therapy.

Non-pharmacological Intervention

Key Question #1. How do non-pharmacological treatments of behavioral symptoms compare in effectiveness with each other, with pharmacological approaches, and with no treatment?

Reminiscence Therapy, Validation Therapy, Sensory Stimulation Interventions, Aromatherapy,,

- showed a benefit on mood
- evidence is insufficient and does not support as the treatment of behavioral symptoms of dementia.

Snoezelen Multisensory Stimulation Therapy

Preliminary findings of short-term benefits and the reported pleasantness of the treatment of MSS, however, suggest that future research may be warranted.

Non-pharmacological Intervention

Behavior Management Techniques

- provide some support for behavior management techniques as effective interventions for behavioral symptoms of dementia

- showed a benefit on mood
- the evidence is insufficient and does not support the as the treatment of behavioral symptoms of dementia.

Reality Orientation

•Reality Orientation (RO) intervention represents the first significant attempt at rehabilitation programming for the disoriented, institutionalized elderly

•Originally developed by Dr. James Cannon Folsom(1958) for the hospitalized elderly under his care in the Veteran‘s Administration Hospitals in the United States

Reality Orientation

- RO operated through the presentation and repetition of orientation information (Interpersonal-interactional component) → understanding to surroundings, resulting in an improved sense of control and self-esteem.

- The ability of an individual to take part in daily activities is directly related to his / her familiarity with the surrounding materials and environment (Prosthetic environmental component).

Reminiscence Therapy

Reminiscence therapy involves the discussion of past activities, events, and experiences with another person or a group of people

Resurgence of unresolved conflicts and for reintegration of whole life experience (Unruh,1989, Burnside, 1987)

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President & CEO, ILC-USA

Reminiscence Therapy

Outcome:
1.Baines,1987~Moderate to severe (N=15); 5 days per week (30 mins per session)x 4 weeks→improved in behavioural outcome

2. Morgan, 2000~Mild to moderate (N=17); 12 sessions →improved in mood

Validation Therapy

Validation Therapy was developed by Naomi Feil between 1963~ 1980

A method for communicating with empathy to the very old person.

Worker tunes into the world of the clients.

Intended to give the individual an opportunity to resolve unfinished conflicts by encouraging and validating expressions of feeling.

Helped old-old people regain dignity, reduce anxiety and enhance happiness.

Multisensory Stimulation Therapy (Snoezelen)

Developed in Netherlands in the 1960s

A combination of 2 Dutch words roughly translate as to “sniff & doze”

Snoezelen is recognized as a room specifically designed to stimulate all the senses

Based on the premise that neuropsychiatric symptoms may result from periods of sensory deprivation.

Combines the therapeutic use of light, tactile surfaces, music, and aroma.

Multisensory Stimulation Therapy (Snoezelen)

Outcome:

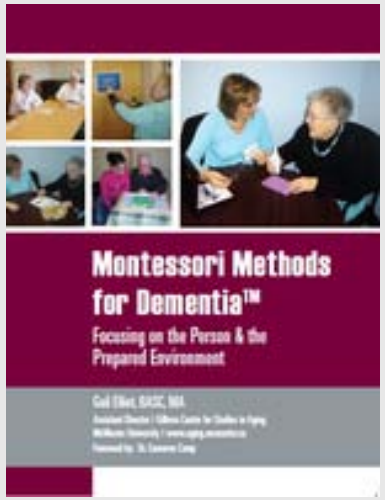
- Julia, 2004-12 psychogeriatric wards in six Dutch nursing homes in the Netherlands; (N=125); Implementation of *snoezelen x* 18 months
- A positive influence on the deterioration of behaviour and the improvement of mood and happiness of the residents.
- Change to a more person-centered approach
- Positive effects on the quality or working life of nurses in psychogeriatric care.

Montessori-based method for Dementia

- Developed by Dr. Cameron Camp in 1995.

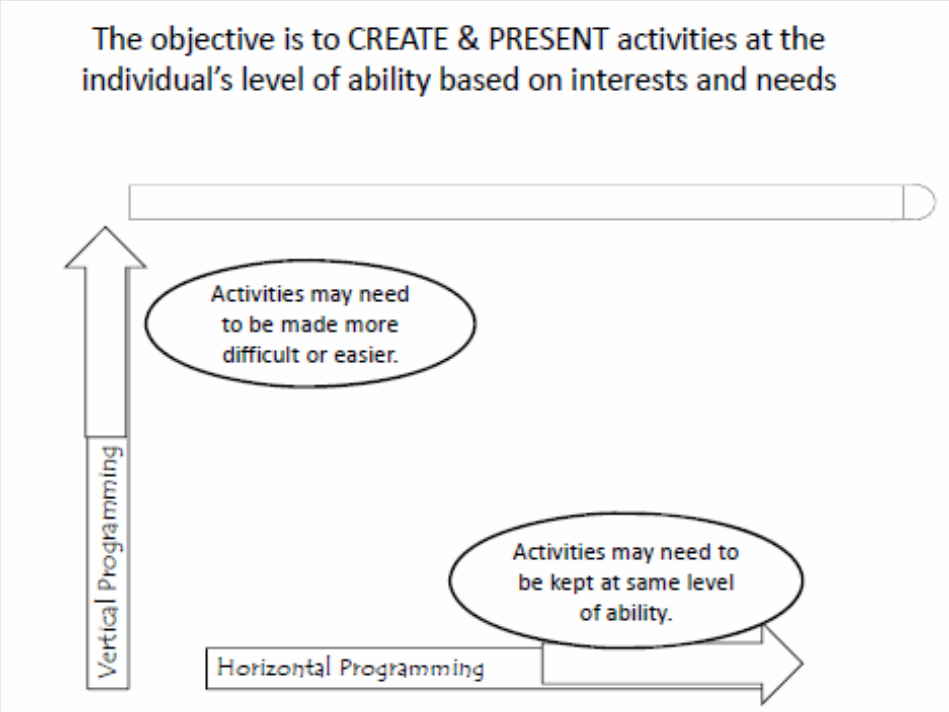
- Method of ***CREATING*** and ***PRESENTING*** activities based upon models of **learning** and **rehabilitation**

- Combats invasive memory loss by focusing on spared capacity through **procedural memory** and environmental cues that build on existing abilities



Montessori-based method for Dementia

- Resident is engaged in more meaningful activity which is matched with **interests** and **needs** and **skills** & **abilities**.



Conclusion

• Limited benefits and potential harms associated with psychotropic medications, non-pharmacological interventions for BPSD may be an attractive alternative to pharmacological treatment.

•Staff attach meaning to behaviors and ultimately influence how staff respond to it.

•Effective staff education to reduce pathologized and problematized attitudes toward the responsive behaviours of the residents in the long-term care settings will be benefit to enhance the overall quality of care for the demented elderly.

Thank You!