



"Psychology Works" Fact Sheet: Behavioral and Psychological Symptoms of Neurocognitive Disorders in Seniors

What are Neurocognitive Disorders (NCD)?

Neurocognitive Disorders are characterised by a cognitive decline which affect one or more cognitive domains such as memory and learning, executive functions, perceptivomotor activities, attention, language and social cognition. The decline must be significant in comparison with the person's prior functioning, can be reported by the person or a family member, and objectified by a clinical assessment (e.g. neuropsychological evaluation). When cognitive decline does not affect the functional autonomy, about it is considered as a mild cognitive disorder. However, when deficits have more impact on functional autonomy, a diagnosis of major cognitive disorder can be made. Neurocognitive disorders have many etiologies such as Alzheimer disease, Vascular disease, Lewy Body disease, Frontotemporal Disorders, etc.

What are the behavioural and psychological symptoms of dementia (BPSD)?

People who suffer from a neurocognitive disorder, such as Alzheimer's disease, can have a number of difficulties related to:

- thinking (e.g., paranoid beliefs, delusions, , hallucinations);
- mood (e.g., anxiety, depression, apathy); and
- behaviour (e.g., aggressiveness, yelling, wandering, manipulating objects and inappropriate sexual conduct).

80 to 97% of older people with Alzheimer disorders may present BPSD during their disease (Gauthier S, Cummings J, Ballard C, Brodaty H, Grossberg G, Robert P, et al. Management of behavioral problems in Alzheimer's disease. *Int Psychogeriatr.* 2010;22(3):346-72.)

What causes BPSD?

BPSD can be caused by a number of factors. These include:

- brain changes associated with the neurocognitive disorder;
- environmental factors such as , excessive demands, sensory overstimulation (e.g. too much noise or agitation in the environment), the absence of visual cues to help the person remain oriented (e.g., the green tagged door is the kitchen, the door with the picture of trees is the person's bedroom), too few activities or pastimes;
- social factors such as challenging interpersonal or social relationships or situations (e.g., non adaptative communication);





- individual factors related to the person's physical or emotional state such as pain, fatigue, stress, fear, boredom, or other unmet basic needs.

What are the effects of BPSD?

The distressing nature of BPSD can affect the quality of life of the person. He/she can feel left aside, can be frustrated or angry, feel lonely or hurt. The presence of BPSD also increases the risk of physical and chemical contention. But BPSD also affect relationships with family and caregivers, as well as treatment. Family caregivers may see a decrease of their quality of life and feel more psychological distress as anxiety and depression symptoms, culpability, hopelessness as well as difficulties to cope with BPSD. This context may precipitate the decision by the family to place the patient in residential care. The staff of residential care center can also find it difficult to care for a person with BPSD (e.g. resistance and physical agitation can make hygiene care more challenging). They may report stress, anxiety, fear, helplessness, distress, burnout and they are more at risk of work-related accident.

What can psychologists do to help people with BPSD?

Studies have shown that psychological approaches are effective for reducing disruptive BPSD in individuals with neurocognitive disorder.

It is generally recommended that BPSD be treated first with nonpharmacological approaches, which are effective for many psychological and behavioral symptoms in individuals with neurocognitive disorders. However, when the situation is urgent or severe (i.e., there is a risk for the safety of the person or to others), pharmacological intervention might be added to non pharmacological approaches. Although some medications may help in treating BPSD, the risks and side-effects of the medication need to be carefully considered against their usefulness.

The implication of the psychologist in BPSD management is important. The psychologist's mandate is quite diverse, and he/she can play an important part both with the person with BPSD and with the caregivers (family and staff members).

ASSESSMENT

The psychologist does a thorough assessment of symptoms – what they are and what makes them better or worse. Some psychosocial models have been developed for BPSD. One of the most popular is the Cohen Mansfield unmet needs models (Cohen-Mansfield, 2000) who address BPSD as the result of unmet needs. Another interesting model is the Newcastle Model developed by James (2011). This model integrated elements of the experience of the person with neurocognitive disorder, the Cohen-Mansfield need model and cognitive behavioural model. With this model, clinicians work with caregivers to develop a hypothesis about the BPSD and take into account many contextual factors as personality traits, mental health, life story, social environment, etc. Second, the psychologist uses the findings from the assessment to develop a plan for intervention in collaboration with the caregiver and, in specific case, with the nursing team.





PSYCHOLOGICAL INTERVENTION

Psychological intervention as psychotherapy with patient with mild cognitive disorder may help decrease anxiety and depression symptoms (e.g. adaptation of CBT). The psychologist can also be involved to provide psychological support to the person and/or the family after a diagnosis of major neurocognitive disorder (e.g. understanding the illness, acceptance), or during life transitions associated with the illness (e.g. placement in a long-term care facility). Throughout the illness, psychological interventions can help reduce the person's distress (e.g. reminiscence therapy, validation techniques).

BEHAVIOURAL INTERVENTION

Behavioural interventions can help by structuring routines and the environment in order to eliminate the factors that trigger or maintain symptoms.

For example, some patients manifest aggressive behaviour during personal hygiene activities, such as bathing. In this situation, the discomfort associated with bathing may be the trigger and avoiding the activity is the reinforcer. Rather than reducing the time devoted to bathing, it may be more useful to divert the patient's attention away from the activity using conversation, music, etc. At the same time, it is necessary to reinforce appropriate behaviour that occurs during bathing. Similarly, lack of activity during the day may contribute to apathy and depressive symptoms. Scheduling pleasant activities may be a useful approach in this case.

Structuring activities in such a way to reduce stress is another approach. For example, a patient may present symptoms that are worse at a period of the day when he is very much involved in an activity. For this individual, it may be useful to provide rest and relaxation rather than activation during this specific time of day.

For another patient, symptoms may be worse during a period of the day when he is by himself and not doing anything. If the assessment reveals that symptoms are not usually present when the patient is engaged in activity, this might be the time to schedule visitors or arts and crafts.

Interventions such as sensory stimulation can also be of help. These include giving the patient fabric or a foam ball to handle, pictures in a book or magazine to look at, music to listen to, scents to smell, etc. Sometimes, if a particular person cannot be present to provide social interaction, listening to him or her on tape or watching him or her on video can be a good alternative.

It is not always necessary to stop patients from wandering. Organizing the environment to allow the patient to be physically active can be very helpful. For example, create specific areas in the residence where the patient can move about safely. Concealing outside doors and emergency exits can deter patients from exiting unsafely.

CAREGIVERS and NURSING TEAMS

Psychologists can have an important role to address distress and resistance of caregivers and nursing teams who work with people with BPSD. As a member (or partner) of the treating team, they can help





identify the team's difficulties, provide a space to vent their frustrations or express their concerns (debriefing), and help maintain motivation and well-being within the team. They can also help the team in reaching a better understanding of the illness and the BPSD and help implement nonpharmacological interventions through formal teaching or coaching, in order to increase the team's ability to manage BPSD.

At last, the psychologist can work with the family members in individual or group setting. The intervention could focus on increasing the caregiver's knowledge of neurocognitive disorders and BPSD or coaching the caregiver on BPSD management techniques. The psychologist **also** plays a key role in assessing and addressing caregivers' burnout and psychological distress. Psychotherapy can be necessary to address issues such as guilt and acceptance.

Where do I go for more information?

For more information visit the Alzheimer Society of Canada at <http://www.alzheimer.ca>.

<http://capsulescpd.ca/> (in French)

<https://www.baycrest.org/Baycrest/Education-Training/Educational-Resources/Responsive-Behaviours>

<https://www.msss.gouv.qc.ca/professionnels/maladies-chroniques/alzheimer-et-autres-troubles-neurocognitifs-majeurs/processus-cliniques-et-outils/> (in French)

You can consult with a registered psychologist to find out if psychological interventions might be of help to you. Provincial, territorial and some municipal associations of psychology often maintain referral services. For the names and coordinates of provincial and territorial associations of psychology, go to <https://cpa.ca/public/whatisapsychologist/ptassociations/>.

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Your opinion matters! Please contact us with any questions or comments about any of the *Psychology Works* Fact Sheets: factsheets@cpa.ca

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