Occupational Therapy Clinical Guideline for People with Dementia

Working Group on Psychogeriatrics
Coordinating Committee in Occupational Therapy
Hong Kong Hospital Authority

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Third Edition
April 2011
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First Edition: 1997
Third Edition: 2011

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OCCUPATIONAL THERAPY PROCESS FOR PEOPLE WITH DEMENTIA

1. **Occupational Therapy Referral**
   - **In referral, is patient demented?**
     - **Yes**
     - Collecting data base of patient and understanding patient’s dementia history
     - Page 1
     - Physical aspect: Vision, Hearing, Range of Motion, Muscle strength, Muscle Tone, Co-ordination, and contracture, deformity….
     - Cognitive Screening Assessments (Select one) Page 11
   - **No**
     - Occupational Therapy Depression Guideline for Older Adults

2. **In referral, is patient depressed?**
   - **Yes**
     - Occupational Therapy Depression Guideline for Older Adults
   - **No**
     - Collecting data base of patient and understanding patient’s dementia history
     - Page 1
     - Physical aspect: Vision, Hearing, Range of Motion, Muscle strength, Muscle Tone, Co-ordination, and contracture, deformity….
     - Cognitive Screening Assessments (Select one) Page 11

3. **Is patient’s mental state and vital sign satisfactory?**
   - **Yes**
     - Occupational Therapy evidence-based Treatment
     - Page 19
   - **No**
     - Waiting until condition stabilized

4. **Evaluate and modify the treatment**
   - **No**
     - Does patient’s condition / performance improve? (evaluated by previous assessments)
     - **Yes**
     - Pre-discharge assessment
     - Maintenance treatment / Discharge to community
   - **Yes**
     - Occupational Therapy evidence-based Treatment
     - Page 19

**Assessments on other clinical profile (Elective)**
- Cognitive Assessments (Page 12)
- Behavioral and Psychological Symptoms of Dementia (BPSD) (Page 14)
- Caregiver’s Burden (Page 15)
- Quality of Life (QOL) (Page 15)

**Practical Tips in Communication**
- Page 37
1. Background

1.1 Definition

Dementia is not a specific disease. Instead, it describes a group of symptoms affecting intellectual and social abilities severely enough to interfere with daily functioning. It is caused by conditions or changes in the brain. Memory loss generally occurs in dementia, but memory loss alone does not mean person has dementia. Dementia indicates problems with at least two brain functions, such as memory loss along with impaired judgment or language. (Mayo Foundation for Medical Education and Research, 2009) 
http://www.mayoclinic.com/health/dementia/DS01131

1.2 Prevalence

Ferri et al. (2005) report the consensus prevalence at aged 60 and above are 3.9%. In the other words, 24.3 million people have dementia in the world in 2001, with 4.6 million new cases of dementia every year (one new case every 7 seconds). The number of people affected shall double every 20 years to 81.1 million by 2040. Most people with dementia live in developing countries which is 60% in 2001 and rising to 71% by 2040. Rates of increase are not uniform. The numbers in developed countries are forecast to increase by 100% between 2001 and 2040, but by more than 300% in India, China, and their south Asian and western Pacific neighbors. According to Alzheimer's Association's 2009 Facts and Figures Report, women are more likely than men to have Alzheimer's disease and other dementias.

In Hong Kong, the Department of Health (2006) estimates a rate of 9.3% for dementia prevalence in those aged 70 and over, with 15.3% for female and 8.9% for male. And, 240,000 persons who are 70 years old and above will be afflicted in Hong Kong in 2036. The percentage of people for the age group 60 to 64 suffering from dementia is 1.2%. On the classification of dementia, 73.5% of the sufferers are suffering from Alzheimer's disease and 22.4% of them are vascular dementia. From the study of the Chinese University of Hong Kong, the overall prevalence of very mild dementia and mild dementia for persons aged 60 years or above is 5.8% and 5.4% respectively. Moreover, these prevalence for aged 70 years or above increases up to 8.5% and 8.9% respectively. Among subjects with clinical dementia, 84.6% has mild dementia. (Lam et al, 2007)
1.3 Types of dementia

1.3.1 Cortical Dementia

Alzheimer’s disease (AD) / Dementia in Alzheimer Type (DAT)
http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp
http://www.mayoclinic.com/health/alzheimers-disease/DS00161

Vascular dementia (VD) / Multi-infarct dementia (MID) / Vascular cognitive impairment (VCI)
http://www.mayoclinic.com/health/vascular-dementia/DS00934
http://www.nature.com/nrneurol/journal/v2/n10/full/ncpneuro0294.html

Mixed dementia

Dementia with Lewy Bodies (DLB)
http://www.mayoclinic.com/health/lewy-body-dementia/DS00795

Frontotemporal Dementia
http://www.mayoclinic.com/health/frontotemporal-dementia/DS00874

Alcoholic Dementia
http://www.alzbrain.org/pdf/handouts/6001.ALCOHOL%20INDUCED%20DEMENTIA.pdf

Binswanger’s Disease
http://alzheimers.about.com/od/diagnosisissues/a/binswanger.htm

Pick’s Disease / Semantic dementia / Progressive non-fluent aphasia
http://alzheimers.about.com/od/diagnosisissues/a/picks.htm

Creutzfeldt-Jakob Disease
http://alzheimers.about.com/od/diagnosisissues/a/cjd.htm

Dementia pugilistica
http://en.wikipedia.org/wiki/Dementia_pugilistica#cite_note-cantuCTE-12

Moyamoya disease
http://en.wikipedia.org/wiki/Moyamoya_disease#cite_note-Scott-0

Posterior cortical atrophy
http://jnnp.bmj.com/cgi/content/abstract/74/11/1521?ijkey=c324f6cb6032c6e43e57b25d351e40cd607348e&keytype2=tf_ipsecsha
http://en.wikipedia.org/wiki/Posterior_cortical_atrophy
1.3.2 Subcortical Dementia
Dementia causing by Parkinson's Disease
http://www.mayoclinic.com/health/parkinsons-disease/DS00295
http://alzheimers.about.com/od/typesofdementia/a/parkinsons_dem.htm
Dementia causing by Huntington Disease
http://www.mayoclinic.com/health/huntingtons-disease/DS00401
Dementia causing by depression (Major depressive episode with prominent cognitive symptoms)
Dementia causing by AIDS / AIDS dementia complex
http://alzheimers.about.com/od/typesofdementia/a/hiv_complex.htm
Dementia causing by Hypothyroidism
Dementia causing by Vitamin B1 deficiency
Dementia causing by Vitamin B12 deficiency
Dementia causing by Folate deficiency
Dementia causing by Syphilis
Dementia causing by Subdural hematoma
Dementia causing by Hypercalcaemia
Dementia causing by Hypoglycemia
Dementia causing by Coeliac disease
Substance-induced persisting dementia (related to psychoactive use and formerly Absinthism)
Dementia causing by multiple etiologies
Dementia causing by other general medical conditions

1.3.3 Remarks
Delirium
Dementia is easy confused with Delirium, which is characterized by reduced ability to maintain the attention, incoherent excitement, confused speech, restlessness and hallucination in a short period. The cognitive deficits tend to fluctuate, while those of dementia tend to be stable and progressive. Delirium can be cured (reversible), but Dementia is cureless (irreversible). (Refer to Appendix – The 4 “D”s)
Several instruments are available to assist with a diagnosis of delirium in the older adult (Schuermans, Deschamps, Markham, Shortridge-Baggett, and Duursma, 2003). Of these the most widely used is the Confusion Assessment Method (CAM) (Christine, 2004). For screening high-risk, elder hospitalized patients, the NEECHAM Confusion Scale (NCS) (Liesbeth and Marieke, 2007) and Delirium Observation Screening Scale (DOSS) (Neville et al, 2007) are recommended.
http://www.mayoclinic.com/health/delirium/DS01064
Mild cognitive impairment (MCI)

Mild cognitive impairment is a transition stage between the cognitive decline of normal aging and the more serious problems caused by Alzheimer's disease. MCI do not meet currently accepted criteria for clinically probable Alzheimer’s disease. The overall rate of conversion of mild cognitive impairment to dementia was 10% (Bruscoli and Lovestone, 2004).

The disorder can affect many areas of thought and action — such as language, attention, reasoning, judgment, reading and writing. However, the most common variety of mild cognitive impairment causes memory problems.

Several instruments are available to assess the cognitive function of MCI, such as Montreal Cognitive Assessment HK version (HK-MoCA), Chinese Abbreviation MCI (CAMCI), Clinical Dementia Rating by Washington University.

Subjective Cognitive Impairment (SCI)

Subjective cognitive impairment has been proposed as a clinical stage which may precede mild cognitive impairment in the clinical continuum of Alzheimer’s Disease (AD), and is characterized by the presence of subjective memory complaints in the absence of objective cognitive deficits. The Derwent Memory clinic in Essex, UK diagnoses SCI as: (1) self-perceived memory difficulties persistent and severe enough to seek advice from a healthcare practitioner and referral to our memory clinic; (2) performance within normal limits for age and educational level on a detailed battery of cognitive tests; (3) absence of any physical or psychiatric illness that may be responsible for the perceived memory deficit; (4) no impairment in activities of daily living; (5) absence of Mild Cognitive Impairment or dementia. (Rodda, Dannhauser, Cutinha, Shergill and Walker, 2009)

There is growing evidence to suggest that subjective memory complaints are associated with an increased risk of dementia and with the presence of biological correlates of early Alzheimer’s disease. Amnestic mild cognitive impairment is by no means a homogeneous clinical entity, but it is likely that individuals with SCI are an even more heterogeneous group. However, given the evidence available to date and the impetus to identify individuals with AD at the earliest possible stage, SCI warrants further investigation in order to clarify it as a clinical concept.

No specific cognitive assessment is available to identify SCI. Those with SCI just show the absence of cognitive deficits in detailed standardized cognitive assessments.
1.4 **Stages of dementia**

Stages of dementia can be classified by following common staging tools:

- **The Clinical Dementia Rating Scale (CDR)** (Hughes, Berg, Danziger, Coben, and Martin, 1982)
  
  [http://bjp.rcpsych.org/cgi/content/abstract/140/6/566](http://bjp.rcpsych.org/cgi/content/abstract/140/6/566)

- **The Global Deterioration Scale (GDS)** (Reisberg, Ferris, Leon, et al., 1982)
  

- **Functional Assessment Staging of Alzheimer's Disease (FAST)** Reisberg, B. (1988)
  

1.5 **Reference**

   


   


   http://bjp.rcpsych.org/cgi/content/abstract/140/6/566


  http://www.mayoclinic.com/health/dementia/DS01131
  http://www.mayoclinic.com/health/alzheimers-disease/DS00161
  http://www.mayoclinic.com/health/vascular-dementia/DS00934
  http://www.mayoclinic.com/health/lewy-body-dementia/DS00795
  http://www.mayoclinic.com/health/frontotemporal-dementia/DS00874
  http://www.mayoclinic.com/health/mild-cognitive-impairment/DS00553
  http://www.mayoclinic.com/health/huntingtons-disease/DS00401
  http://www.mayoclinic.com/health/parkinsons-disease/DS00295
  http://www.mayoclinic.com/health/delirium/DS01064

   http://jnnp.bmj.com/cgi/content/abstract/74/11/1521?ijkey=c324f6cfb6032c6e43e57b25d351e40cd607348e&keytype2=tf_ipsecsha

12. Neville et al. (2007). *Differentiating between delirium and dementia: New Zealand’s ageing population is increasing rapidly. Delirium and dementia are two common aged-related conditions. It is important nurses can differentiate between them.* Kai Tiaki: Nursing New Zealand.


http://www3.interscience.wiley.com/cgi-bin/fulltext/122232506/PDFSTART


http://en.wikipedia.org/wiki/Moyamoya_disease#cite_note-Scott-0

http://www.nature.com/ncpneurol/journal/v2/n10/full/ncpneuro0294.html

http://www.alzbrain.org/index.cgi 
http://www.alzbrain.org/pdf/handouts/6001.ALCOHOL%20INDUCED%20DEMENTIA.pdf 

http://alzheimers.about.com/od/diagnosisissues/a/binswanger.htm 
http://alzheimers.about.com/od/diagnosisissues/a/picks.htm 
http://alzheimers.about.com/od/diagnosisissues/a/cjd.htm 
http://alzheimers.about.com/od/typesofdementia/a/parkinsons_dem.htm 
http://alzheimers.about.com/od/typesofdementia/a/hiv_complex.htm
2. Interpretation of Evidence

Once all evidence statements relating to a particular clinical question were finalized and agreed by the members of the Working Group on Psychogeriatrics, Coordinating Committee in Occupational Therapy, of the Hong Kong Hospital Authority (WGPG), the associated recommendations were produced and graded (Eccles and Mason, 2001; Department of Health, 1996). Recommendations were graded A to C based on the level of associated evidence (refer to below table). It is important to clarify that these ratings represent the strength of the supporting research evidence to date.

### Hierarchy of evidence and recommendations grading scheme

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of evidence</th>
<th>Grade</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evidence obtained from a single randomized controlled trial or a meta-analysis of randomized controlled trials</td>
<td>A</td>
<td>At least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation</td>
</tr>
<tr>
<td>IIa</td>
<td>Evidence obtained from at least one well-designed controlled study without randomization</td>
<td>B</td>
<td>Well-conducted clinical studies but no randomized clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence</td>
</tr>
<tr>
<td>IIb</td>
<td>Evidence obtained from at least one other well-designed quasi-experimental study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities</td>
<td>C</td>
<td>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available</td>
</tr>
<tr>
<td></td>
<td>WGPG Recommended good practice based on the clinical experience of the Working Group on Psychogeriatrics, Coordinating Committee in Occupational Therapy, of the Hong Kong Hospital Authority (WGPG)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


3. Purpose and Scope

This Occupational Therapy Dementia Clinical Guideline is developed for assisting our local Occupational Therapists in screening and providing appropriate assessment and intervention to the people with dementia. In addition, the main focus of this guideline is on the evidence-based practice for providing comprehensive Occupational Therapy services to the people with dementia in the Hospital Authority settings by addressing their cognitive and functional performance and psychosocial functioning.

4. Guiding Principles - Assumptions

This Guideline had been developed by Dementia Working group of the Working group on Psychogeriatrics, Co-Ordinating Committee in Occupational Therapy, of the Hong Kong Hospital Authority and the expert authors for the Hospital Authority according to the state of clinical knowledge at the time of publication. It has been established that Occupational Therapist can act in accordance with a practice accepted as proper by a responsible body of clinical opinion even though others may adopt a different practice. As such, this guideline is for general guidance only; the management of individual cases must be the clinical judgment and decision of the therapist after considering all relevant circumstances, information and up-to-date clinical knowledge. In view of the general nature of this guideline and the changes in medical science, the Hospital Authority, the Co-Ordinating Committee in Occupational Therapy and the expert authors do not assume or accept any responsibility for this guideline.

It is the consensus of the members of the Working group on Psychogeriatrics, Co-Ordinating Committee in Occupational Therapy, the Hong Kong Hospital Authority that the following assumptions are critical starting points for Occupational Therapists working with people with dementia, and therefore were used as a framework for the development of this guideline.

4.1 Personal preferences, values and beliefs of our clients should be respected in case management. All our clients shall lead a meaningful life of their choice.
4.2 Occupational Therapists should empower our clients to return to their valued life roles at home, work and leisure by making the best use of their capabilities. Hence, the therapists should examine the clients’ life roles that are meaningful to them. Obstacles hindering individual client from fulfilling his/ her life roles should be identified. In addition, the therapist should provide opportunities for them in fulfilling their roles and gaining the sense of accomplishment.

4.3 Psychosocial background and lifestyle of clients are critical in their rehabilitation process and therefore should be addressed. Occupational Therapists should facilitate the clients in participating in balanced, meaningful and pleasant activities which can enhance their psychological well-being.

4.4 Occupational Therapists should consider the cognitive, motor and psychological factors relating to clients’ performance in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), and assist clients to attain optimal functioning within their home and community.

4.5 Occupational Therapists have an important role in planning safe discharge, providing ongoing care options and making referrals to appropriate agencies and services for our clients.

4.6 Best practice in Occupational Therapy should be identified based on research evidence.
5. Assessment

If the patient’s mental state and general physical condition are stable, he would be assessed on cognitive function, physical state, Activities of Daily Living performance and social aspect.

5.1 Cognitive Screening Assessments (Select at least one)

5.1.1 Cantonese version of Mini-mental status examination (CMMSE) (Chiu, Lee, Chung, and Kwong, 1994)

The CMMSE is a widely used screening measure of global cognitive function among older people. It is composed of five domains: orientation to time and place, registration and immediate recall, attention and calculation, language and visual construction.

5.1.2 Chinese Abbreviated Mild Cognitive Impairment Test (CAMCI) (Lam et al., 2008)

The CAMCI test is a relatively short cognitive test for screening of mild cognitive impairment in Chinese older adults. It is composed of shortened forms of the category verbal fluency test and delayed recall. It can be completed within 15 minutes and does not involve lengthy pen-and-paper tests.

5.1.3 The Mini-cog (Borson, Scanlan, Brush, Vitallano, and Dokmak, 2000)

It is a very simple and quick test carried out by a doctor or clinician. It takes about 3 minutes to administer and no special equipment is required. The test consists of a three item recall and a clock drawing test. The result will not be affected by level of education or language variations.

5.1.4 The clock drawing test (CDT) (Lam, Chiu, Ng, Chan, Chan, Li, and Wong, 1998)

The CDT has been regarded as a simple cognitive screening instrument in dementia. There are variations in the manner in which the test is administered and scored. The CDT by Lam et al. (1998) not only requires the patient to fill the numbers of the clock-face into a pre-drawn circle and place the hands at a given time, but also to read and set the time.
5.1.5 Chinese version of the Hierarchic Dementia Scale (CV-HDS) (Poon, Lam and Wong, 2008)

The CV-HDS measures the severity of dementia in elderly subjects. It covers nine major ability areas in six subtests: orientation, memory, observation, gnosis, praxis, language, concentration, cognition and motor function (prefrontal function). It contains 20 subscales, each hierarchically organized with 5 or 10 items of increasing levels of difficulty. It can be completed within 15 to 30 minutes.

5.1.6 Chinese version of Silver’s test (CVST) (Tsang and Man, 2006)

The CVST contains 19 items, assessing six areas of ability: memory, vocabulary, calculation, orientation, speech and practical abilities, and it takes 15-20 minutes to administer.

5.1.7 Cantonese version of Montreal Cognitive Assessment (MoCA) (Wong et al., 2009)

The HK-MoCA is a 10 min cognitive screening test that was designed to address some of the limitations of the MMSE. It evaluates a broad range of cognitive domains: visual/executive functions, naming, verbal memory and learning, attention, abstraction, 5-main delayed verbal memory, and orientation.

5.2 Cognitive Assessments (Elective)

5.2.1 Neurobehavioral Cognitive Status Examination (NCSE) (Chan, Fong, and Lee, 1999)

The NCSE consists of 10 subscales that assess the cognitive domains of orientation, attention, memory, language, calculation, constructional praxis and higher-level reasoning. It takes 10 to 30 minutes to administer.

5.2.2 Rivermead Behavioral Memory Test (RBMT) (Neuro-Rehabilitation Working Group, 1998)

The RBMT was constructed to identify and quantify persons’ memory deficits in daily living performance. It involves 11 items which require the examinees to either remember to carry out sampled everyday tasks or to retain various types of information essential for day-to-day functioning.

5.2.3 Chinese version of the Mattis Dementia Rating Scale (CDRS) (Chan, Choi, Chiu, and Lam, 2003; Chan and Siu, 2005)

The CDRS consists of 36 tasks that provides a global measure of dementia derived from subscales for five cognitive functions: attention, initiation/preservation, construction, conceptualization, and memory.
5.2.4 Alzheimer’s Disease Assessment Scale Cognitive Subscale (ADAS-Cog) (Chu, Chiu, Hui, Yu, Tsui, and Lee, 2000)

This is the cognitive subscale of the Alzheimer’s Disease Assessment Scale, which is a standardized assessment of cognitive function and non-cognitive features. The ADAS-Cog measures several cognitive domains, including language, memory and praxis.

5.2.5 Hong Kong List Learning Test (2nd Edition) (HKLLT) (Chan, 2006)

The HKLLT is a Chinese list-learning test that emphasizes the assessment of the process and organizational strategies involved in learning verbal information. The test consists of two 16-word lists; all of the words are two-character nouns. There are three immediate recall trails, two delayed recall trials and one recognition task.

5.3 Functional Assessments (Select at least one)

5.3.1 Barthel Index (BI) (Mahoney and Barthel, 1965); Chinese version of the Modified BI (Leung, Chan and Shah, 2007)

The BI is designed to evaluate a person’s functional ability on 10 ADL functions: bowel control, bladder control, grooming, toileting, feeding, transfer, mobility, dressing, stairs, bathing. The patient is scored by his or her independence in performance and the need for assistance from an attendant.

5.3.2 Instrumental activities of daily living scale (IADL) (Lawton and Brody, 1969); Chinese version of the Lawton IADL scale (Tong and Man, 2002)

The Lawton IADL scale comprises of shopping, meal preparation, housekeeping, external communication, external communication, laundry, use of public transportation, taking own medications and handling one’ own finances. It helps to identify whether the patient can return safely to independent living in the community.

5.3.3 Chinese version of the Disability Assessment for Dementia (CDAD) (Mok, Siu, Chan, Yeung, Pan and Li, 2005)

The CDAD is a 47-item informant-based instrument measuring the functional disability of individuals with dementia. During an interview, caregivers are asked to rate ADL and IADL performance of individual’s with dementia on a dichotomous scale. It is rated by a trained observer and takes 20 minutes to administer.
5.3.4 Chinese version of the Activities of Daily Living Questionnaire (ADLQ-CV) (Chu and Chung, 2008)

The ADLQ-CV is a caregiver-rated questionnaire. It consists of 28 items encompassing six domains of functional activity: self-care, household care, employment and recreation, shopping and money, travel and communication. The average time of completion is between 7 to 10 minutes.

5.3.5 Assessment of Motor and Process Skills (AMPS) (Fisher, 1995)

This is an observational assessment that evaluates motor and process skills simultaneously and their effect on the ability of performing IADL and personal activities of daily living. It is a functional assessment that adjusts ability measures for task simplicity and rater leniency. It is comprised of 16 motor and 20 process skills.

5.4 Behavioral and Psychological Symptoms of Dementia (BPSD) (Elective)

5.4.1 Chinese version of the Cohen-Mansfield Agitation Inventory (CMAI) (Choy, Lam, Chan, Li and Chiu, 2001)

The CMAI was developed for use in assessing different agitated behaviors in individuals with dementia in institutions or in the community. The agitated behaviors include wandering, aggression, inappropriate vocalization, sexual disinhibition and negativism. It takes 10-15 minutes to administer.

5.4.2 Chinese version of the Neuropsychiatry Inventory (CNPI) (Leung, Lam, Chiu, Cummings and Chen, 2001)

The CNPI is a brief interview assessing 10 domains: delusions, hallucinations, dysphoria, anxiety, agitation/aggression, euphoria, disinhibition, irritability/lability, apathy, and aberrant motor behavior. It may help distinguish between different causes of dementia, records severity and frequency separately, and takes 10 -15 minutes to administer.

5.4.3 Clifton Assessment Procedures of the Elderly (CAPE) (Pattie and Gillear, 1979)

The CAPE is used to evaluate the presence and severity of impairment in mental and behavioral functioning. It comprises of two components: the Cognitive Assessment Scale (CAS) and the Behavior Rating Scale (BRS). The CAS consists of 12 questions covering information/orientation subtest. The BRS covers physical disability, apathy, communication difficulties and social disturbance. Higher scores indicate a greater severity of behavior problems. It takes 15-30 minutes to administer.
5.5 Caregiver’s Burden (Elective)

5.5.1 Chinese version of the Zarit Burden Interview (ZBI) (Chan, Lam and Chiu, 2005)

The ZBI consists of 22 items covering caregiver’s health, psychological well being, finances, social life, and relationship between the caregiver and the impaired person.

5.5.2 Relative Stress Scale (RSS) (Greene, Smith, Gardiner and Timbury, 1982)

The RSS focuses on the assessment of the patient’s behavioral disturbances and the effect of this behavior on their relatives. It is rated by the patient’s relatives. To the best of our knowledge, the Chinese version has not been validated for Hong Kong Chinese people with dementia. Also, a Mainland China version is available, but a validation study of this tool cannot be found.

5.6 Quality of Life (QOL) (Elective)

5.6.1 Hong Kong Chinese version of World Health Organization Quality of Life – Brief Questionnaire (WHOQOL-BREF-HK) (Leung, Tay, Cheng and Lin, 1997)

The WHOQOL-BREF-HK is a 28-item scale measuring four domains of QOL: (1) physical health; (2) psychological health; (3) social relationships; (4) environment. Two items measuring overall quality of life and health are included to yield an overall QOL score.

5.6.2 Chinese version of the Quality of Life in Alzheimer’s Disease (CQOL-AD) Scale (Chan, Chu, Lee, Li, and Yu, 2011)

The CQOL-AD scale contains 13 items measuring aspects of physical and mental health, personal relationship, competence in performing daily chores and instrumental tasks, finance and overall life quality. There are two versions of the CQOL-AD scale: a patient version and a caregiver version. It takes an average of 10 minutes to administer.

5.7 Reference


6. Treatment

Upon completion of assessment, Occupational Therapist would plan treatment according to the needs and functioning of patients. Collaboration with members of health care team and patients’ caregivers are very essential.

6.1 Memory Coping Strategies

Memory coping strategies are a range of specific techniques that can be used to assist a person’s memory, and therefore compensate for their difficulties. Memory is a basic cognitive function that is pre-requisite to higher order cognitive functions. It is not a unitary construct but a collection of different components. The information-processing model of memory proposes that memory involves the processing of information in three distinct types of memory storage systems: Sensory-perceptual memory, Short-term memory, and Long-term memory. Each of the above stages involves Encoding, Storage, and Retrieval.

From these theories, therapist derives many techniques which are visual imagery, errorless learning, dyadic approaches, spaced retrieval techniques, encoding specificity with cognitive support at retrieval, external memory aids, and vanishing cues techniques (Grandmaison and Simard, 2003). Moreover, they can be classified as restorative strategies and compensatory techniques (Sitzer, Twamley, and Jeste, 2006). Restorative strategies are computerized visuospatial drills, memory drills emphasizing repetition, and general cognitive stimulation, such as prompting recall of remote memories, practicing conversation skills, problem-solving, reading, and engaging in creative activities. Compensatory techniques are visualization, procedural memory training, and external devices. Total 34 literatures were reviewed and evaluated (Grandmaison and Simard, 2003; Sitzer, Twamley, and Jeste, 2006). There were 19 randomized controlled trial programs. Although the effectiveness of the programs could be identified, the sample size and the number of published well-controlled studies were relatively small along 25 years. Multiple techniques increased the difficulty to evaluate the efficacy of a single strategy (Sitzer, Twamley, and Jeste, 2006).

The errorless learning, spaced retrieval, and vanishing cues techniques, together with the dyadic approach, seem to present the best memory training methods (Grandmaison and Simard, 2003). Sitzer et al (2006) also agreed that compensatory techniques appeared to be less effective than restorative approach.

Level I, Grade A
6.2  Cognitive Training

Cognitive training typically involves guided practice on a set of standard tasks designed to reflect particular cognitive functions, such as memory, attention, or problem-solving (Clare and Woods, 2003). The specific domains being trained are expected to be maintained or even improved through continuous practice and generalized beyond the immediate training context. Cognitive training can be offered by individual or group sessions, using paper and pencil tasks or computerized activities with graded levels of difficulty.

Benefits on some cognitive and functional measures are supported, especially those cognitive training involves restorative strategies and individual treatment modalities (Sitzer et al., 2006). Insufficient evidence is due to small sample size, lack of RCT study and sensitive standardized outcome measures to capture the changes. Apart from immediate treatment effect, long term effect is also the focus of further study.

Cognitive training demonstrates benefits on cognitive and functional measures in people with dementia. Computerized cognitive training program has become popular in clinical practice and research studies, in which some results support its effectiveness in delaying the continuous progression of cognitive impairment in people with Alzheimer’s Dementia (Galante, Venturini, and Fiaccadori, 2007).

Level I, Grade A
6.3 Cognitive Stimulation

There is an overlap between what is described as reality orientation and cognitive stimulation as both programs often describe similar features. According to Woods et al (2009), cognitive stimulation (a) targets cognitive and social function, (b) has a social element – usually in a group or with a family caregiver, (c) includes cognitive activities which do not primarily consist of practice on specific cognitive modalities and (d) may be described as reality orientation sessions. As a prototypical cognitive stimulation approach, reality orientation is a well-recognised intervention for confusion and disorientation in people with dementia.

Reality orientation aims to provide the person a greater understanding of their surroundings and systematic reviews have concluded that it had benefits on people with dementia on both cognitive function and behaviour (Spector, Orrell, Davies, and Woods, 2000). Apart from a group-based reality orientation activity, 24 hours reality orientation is also promoted by using environmental characteristic to assist orientation, e.g. orientation board and signage.

Cognitive stimulation shows benefits on generalized cognitive function of people with dementia, particularly on language, as well as quality of life (Spector, Orrell, and Woods, 2010). The NICE guideline (2007) also recommends cognitive stimulation program for the people with dementia.

Level I, Grade A
6.4 Management of Behavioral and Psychological Symptoms of Dementia (BPSD)

BPSD include a great variety of non-cognitive symptoms, which can be classified as “depressive type” and “psychotic type”. The former encompasses anxiety, apathy, emotive incontinence, wandering, alterations of the sleep and the appetite, whilst the latter encompasses hallucinations, delusion, psychomotor agitation, aggression, misidentifications, euphoria and disinhibition (Finkel, Coasta e Silva, Cohen, Miller, and Sartorius, 1996; Olin, Katz, Meyers, Schneider, and Lebowitz, 2002). It contributes significantly to caregiver burden (Coen, Swanwick, O'Boyle, and Coakley, 1997; Evers, Tomic, and Brouwers, 2002), decreased quality of life for persons with dementia (O'Donnell, Drachman, and Barned, 2004), and increased institutionalization of people with dementia (Benoit et.al, 2006; Yaffe et.al, 2002).

Various approaches in managing challenging behaviour include multisensory stimulation (Van Diepen, Baillon, Redman, Rooke, Spencer, and Prettyman, 2002; Staal, Sacks, Matheis, Collier, Calia, Hanif, and Kofman, 2007), music therapy (Raglio, Bellelli, Traficante, Gianotti, Ubezio, Villani, and Trabucchi, 2008; Guetin et al., 2009), cognitive stimulation therapy (Romero and Wenz, 2001; Spector et al., 2003), behaviour therapy (Beck et al., 2002; DeYoung, Just, and Harrison, 2002; Buchanan and Fisher, 2002; Moniz-Cook, Woods, and Richards, 2001), environmental interventions (Kittur, and Ruskin, 2001; Mayer and Darby, 1991), caregiver education (Huang, Shyu, Chen, Chen, and Lin, 2003; Teri et al., 2003; Hebert et al., 2003).

Behavioural management techniques, specific types of caregiver education and cognitive stimulation therapy appear to have lasting effectiveness for reducing challenging behaviours exhibited by people with dementia. (Livingston, Johnson, Katona, Paton, and Lyketsos, 2005)

| Level I, Grade A |
6.5 Activity of Daily Living Training

Activities of Daily Living (ADL) are one of the core concerns of Occupational Therapy in the treatment of dementia. Activities of daily living can basically consist of two hierarchical levels, namely, basic activities of daily living (BADL) and Instrumental activities of daily living (IADL). BADL included those self-care tasks such as eating, grooming, dressing, toileting, bathing. IADL included tasks in household and community living such as laundry, cleansing, prepare meals, shopping, traveling, money management and medication.

ADL and IADL would be affected in various degrees during different stages of dementia. Dementia is closely related to both subsequent and concurrent functional impairment in basic and complex self-care tasks. (Sauvaget, Yamada, Fujiwara, Sasake, and Mimori, 2002) By disease progression, functional levels of the people with dementia are expected to increase dependence due to the impaired executive function and cognitive function.

Clients with cognitive impairment were more than three times as likely to have subsequent functional decline than non-impaired individuals. (Mebta, Yaffe, and Covinsky, 2002). These functional declines cause a substantial burden for patients, their caregiver and the society as patients become more dependent on caregiver and paid professional support and finally leading to an increase of health care cost. (Carpenter, Hastie, Morris, Fries, and Ankri, 2006).

Patients with dementia gradually lose their cognitive competence and the ability to perform daily living tasks, functional training is proved to be effective in delaying disease progression and improve cognitive functions. ADL training is of great value in delaying the progress of disease and improving some cognitive functions and ADL. (Avila, Bottino, Carvalho, Santos, Seral, and Miotto, 2004)

Level IIb, Grade B
6.6 Environmental Adaptation

In treating dementia, it is important not only to evaluate the patient and his/her support system, but also the environment surrounding them. A supportive physical and social environment can enhance the quality of life of individuals, allowing them to make more comfortable and pleasant, and maintain their dignity and self-respect (Lawton, 1981). Frequency and severity of problem behaviors are reduced by matching environmental characteristics with individual capacities (Hiatt, 1987; Laura, Julie, and Laraine, 2003). Therapeutic interventions designed to reduce problem behaviors such as wandering, incontinence, agitation and restlessness (Coons, 1985)

Good design of environment is regarded as a therapeutic resource to promote well-being and functionality among people with dementia (Kristen, Daisy, and Cheryl, 2000). Uses of neutral design, soft color scheme, elimination of unnecessary stimulation and consistent daily routines have been proved to reduce behavioral disturbances (Bianchetti, Benvenuti, Ghisla, Frisoni, and Trabucchi, 1997; Cleary, Clamon, Price, and Shullaw, 1988). Multisensory environment (MSE) was also proved to reduce anxiety and agitation in people with dementia. (Riley-Doucet, 2009) Even, enough home safety measures can prevent the people with dementia, who cannot recognize a safety hazard, from trapping into threatening situation. (Ann, Mary, Kathy, and Rose, 2004)

Moreover, a study on a home environmental approach as a therapeutic modality based in a competence-environmental press framework and personal control theory was published on 2001. The finding suggested that an environmental approach has a positive impact on both the burden level of caregiver and the functionality of the person with dementia. However, the intervention effects were always examined at one time point immediately following completion of the intervention. Caregiver may need more time to practice the use environmental strategies before beneficial outcomes are measurable. (Laura, Mary, Laraine, Alice, and Walter, 2001)

A good design of environment following suggested principle is regarded as a therapeutic resource to promote well being and functionality among people of dementia and relieve the burden level of caregiver.

Level I, Grade A
6.7 Reminiscence Therapy

Reminiscence has been defined as the vocal or silent recall of events in person’s life, either alone or with another person or group of people (Woods, Portnoy, Head, and Jones, 1992). Life review refers to the process of reviewing, organizing and evaluating the overall picture of one’s life, in order that a person can come to see their life as an unique story (Gemma, Jones, Bère, and Miesen, 1992). Reminiscing tends to occur as a short, semi-random, spontaneous recall of the past while life review is a form of structured reminiscing that helps people to formulate their life story according to the hope and goals they have set.

Presentation of triggers in a reminiscence activity helps to promote memory recall. It can be any form of stimuli to access and facilitate a particular memory during the activities. Reminiscence performed most effectively with peers in groups while life review preferred to be done in a one-to-one basis.

Woods and colleagues (2005) identified the effectiveness of reminiscence therapy to improve cognition and mood for people with dementia, however, the reviewed literatures showed relatively small sample size and diversion on the form of reminiscence activities.

Reminiscence can be an effective means of treatment activities for people with memory impairment, focusing on their long term memory which often remains intact until later disease process. Some significant results on cognition and mood were indicated and also no negative effect on the outcome measures was reported (Wang, 2007; Chin, 2007).

Level I, Grade A
6.8 Remotivation Therapy

Remotivation Therapy is a non-threatening form of treatment, which induces in people of all ages with psychiatric or chronic medical conditions, the incentive and impulse to seek fulfillment of fundamental emotional needs in orders to survive as functioning human beings (Cater, Lahaie, Lippert, and Sharkey, 1994). Its characteristics are “unwounded”, “non-threatening”, “simple”, “group”, and “therapy”. Five basic steps are designed to help the individual’s return to reality which are “Climate of Acceptance”, “Bridge to Reality”, “the World We Live In”, “The Work of the World”, and “Climate of Appreciation”. This recognized group therapy aims to support individual’s return to reality, stimulate awareness, interaction, verbalization, interest, self-esteem and self-efficiency. Remotivation Therapy has been used successfully in hospitals, institutions, nursing homes and community settings for clients suffering from mental illness, dementia, withdrawal, depression, Huntington Disease and low functioning problems. People of all ages can benefit from this therapy. Certified Remotivation Therapist must attends 32-hour theory course and passes both examination and audit practicum session.

Remotivation Therapy is developed about 60 years since 1949. Research studies are relatively little. From Cochrane Review, two randomized controlled trial are identified. Its effectiveness is still investigated.

Remotivation Therapy and the activities group are effective early components of a graded treatment program to increase social interaction among withdrawn schizophrenia (Don Beal, Duckro, Elias, and Hecht, 1977). For Dementia, randomized controlled trial with unclear result is also found (Birkett and Boltuch, 1973).

Level IV, WGPG
6.9 Montessori-Based Dementia Programming

Montessori-Based Dementia Programming (MBDP) uses rehabilitation principles including guided repetition, task breakdown, progressing from simple to complex and careful matching of demands to levels of competence. Additionally, principles of dementia interventions such as external cue usage and reliance on implicit memory (procedural memory) are used. Montessori materials consist of "learning games" suited to a person's abilities and interests, such as memory games, household utensils, books and so on.

Research has provided clear evidence of increased levels of engagement and participation in activities when MBDP approaches are implemented. Three non-randomized and two randomized studies were located for review by R. Padilla (2010). The three non-randomized studies used within-subject designs so that participants could serve as their own controls. The average amount of time constructively engaged was significantly higher and the average time engaged in negative occupations was significantly lower. Pleasure scores were significantly higher and anxiety scores lower during Montessori programming in contrast with regular unit activities, but these gains declined after subjects became familiar with the activities. Gains were made in attention, object permanence, and memory. No apparent benefit in vocabulary, spatial attention, spatial reasoning, and abstract reasoning were recorded. Further, no improvement in activities of daily living (ADL) measures was observed. The researchers in all these studies concluded that due to the small sample size and multiple subjective outcome measures, results should be considered with caution (Orsulic-Jeras, Judge and Camp, 2000; Vance and Johns, 2002; Jarrott, Gozali, and Gigliotti, 2008; Lee, Camp and Malone, 2007).

Lin, Yang, Kao, Wu, Tang, and Lin (2009) randomized institutionalized residents with dementia into three treatment sequences that included Montessori, acupressure, and presence (attention on intrapersonal processes) in various orders. The acupressure and Montessori-based-activities groups saw a significant decrease in agitated, aggressive, and physically nonaggressive behaviors than the presence group. Sample size, non-heterogeneous controls and inability to exclude effect from extraneous factors presented significant limitations for this study, and negative effects were not investigated.

Level I, Grade A
6.10  Sensory Stimulation

Sensory stimulation, or Snoezelen, aims at providing sensory stimuli to stimulate primary sense of sight, hearing, touch, taste, smell and movements, without the need for intellectual activity. The essence is to allow individual’s time, space and opportunity to enjoy the environment at their own pace.

Sensory deprivation or surplus of stimulation is common in people with dementia when they are interacting with an unstructured environment, which results in mood disturbance, disorientation and mal-adaptive behaviour. Sensory stimulation activities are commonly used in managing challenging behaviour, enhancing mood and communication for people with dementia (Baker et al., 2001; Staal, Sacks, Matheis, Collier, Calia, Hanif, and Kofman, 2007). However, no conclusive evidence on long-term effects can be drawn from the studies and thus better quality trials were indicated for robust conclusions (Chung and Lai, 2002).

Sensory stimulation involves individual or small group activities for the cognitively impaired elderly who have difficulty in relating and responding to their surroundings. The stimuli are presented systematically to allow participants to explore, enjoy and make appropriate responses. Duration should depend on their reaction and it should be terminated with sign of boredom.

Sensory stimulation is an appropriate treatment modality for people with dementia. As it does not focus on cognitive skill, it is more suitable for individuals with lower cognitive function. Either session-based multi-sensory activities or 24-hours integrated Snoezelen care is recommended for immediate effect on behaviour and mood for people with moderate to severe dementia (Staal et al., 2007; Chung and Lai, 2002).

Level I, Grade A
6.11 Aromatherapy

Aromatherapy is the use of pure essential oils extracted from fragrant plants to help reliving health problems and improving quality of life (Holt, Birks, Thorgrimsen, Spector, Wiles, and Orell, 2009). The healing properties of aromatherapy are claimed to promote relaxation and sleep, relieve pain as well as reduce depressive symptoms. Therefore, it is an alternative therapy for dementia which received great interest in recent decade, particularly in reducing the “Behavioural and Psychological Symptoms of Dementia” (BPSD)

Nevertheless, disparate findings on its efficacy in treatment for people with dementia were shown, in which Holt et al., (2009) revealed that only one small-scaled RCT showed favorable results. Further evidence for the effectiveness of aromatherapy is indicated with the consideration on different essential oils, different types and severity of dementia.

Ballard and colleagues (2002) revealed a significant treatment effects on the outcome measures of agitation and neuropsychiatric symptoms with the use of aromatherapy (Mellissa essential oil). Although aromatherapy appeared to be more acceptable and tolerable compared with pharmacological interventions (Douglas, James, and Ballard, 2004), further conclusions from more representative RCT studies were yielded to ensure safe and effective clinical practice.

Level IIa, Grade B
6.12 Reference


   http://psitri.stakes.fi/EN/Custom/PsiTriSearchTrial.htm?TrialId=cs3996


39. Leung, K.F. (2009). *Promoting Quality of Life in Rehabilitation and Social Services (course notes) SE 28-065-18-01(81)*. Hong Kong Hospital Authority: School of Professional and Continuing Education.


7. Practical Tips in Communication

Communication with individual with dementia required use of conversational strategies from health care providers. The strategies promote more successful comprehension and compliance, offset mood disorder and create ease in the way that health information may be accepted by the patient. (Randy, 2010)

A system view of communication strategies for people with dementia revealed that positive result in improving quality of care might achieved when communication strategies are embedded in daily care activities or interventions. (Vasse, Vernooij-Dassen, Soijker, Rikkert, and Koopmans, 2010)

The following suggestions are generated from clinical point of view and experience of occupational therapist. It served as a reminder for staff or caregiver when communicating with clients with dementia of different stages.

7.1 Characteristics on Communication Problems in Different Stage of Dementia

7.1.1 Early Stage

In early stage, clients may still able to carry on a complete conversation with limited problems. They may experience frustration and anger as they have difficulty in verbalizing, remembering and words findings. Some of the clients may speak less and slow while some of them may make up stories or words so as to hide their impairment.

To facilitate communication at this stage, speak slowly, simply and clearly but allow more time for client to respond. Assistance should be given in finding names or words during conversation and listen for words that my give us clue to understand or client.

7.1.2 Middle Stage

In this stage, communication problems are obvious that clients have more difficult in verbalizing ideas as vocabulary shrinks and have increasing difficulty in interpretation. They may speaks non-sense and illogically. Clients may not experience the same frustration and anger as before as they may not notice the problems.

In this stage, caregiver must rely on simple verbal communication and increase on non-verbal communication techniques.
7.1.3 Late Stage

In this stage, clients lost most of the verbal ability. Their verbal ability may limit to only a few words. Caregivers must pay close attention to sounds and be able to interpret the subtle forms of non-verbal communication. Communication at this stage often signals of discomfort or basic need such as thirsty, hungry or pain. Caregivers are advised to talk to the client and touch them as though they are capable of understanding.

7.2 Basic Strategies for Communicating with Dementia

7.2.1 Verbal Communication

Slowly

Speak slowly and clearly. Avoid confusion and distress made to cognitively impaired person, it is important to present any information slowly and allow more time to response as the need longer time to process information.

Simply

Simplify message. Get to the point and avoid lengthy explanations. “Yes” or “No” type question, limited choices in questioning are always better than open end question.

Repeatedly

Repeat several times allowing sufficient time for them to response in between repetition. If this is not work, then try to rephrasing the idea with different but simple words. If possible, use same words that the client use, this will help him to key in portion of idea that is still retrievable even other portion had been lost.

Concretely

Talk in calm, gentle and matter-of-fact approach but yet concrete and observable event by real objects demonstration can facilitate understanding. Abstract questions, complex argument and confronting must be avoided.

7.2.2 Non-verbal Communication

Tone of Voice

Tone of voice is often more revealing than words. Clients with dementia are sensitive to the tone deliver despite of their loss of ability in understanding words. In addition, the tone of voices from a person with dementia may probably reveal the intended message than their words. A low pitch of voice is recommended.
Facial Expression

Facial expression represents a wide range of emotions such as fear, anger, disgust, surprise, happiness, etc. Keep eye contact with the person. Be sensitive enough to clients’ facial expression and our facial expression when communicate with cognitively impaired person.

Touch

Appropriate body touch implied warmth and caring. Holding hands, touching arm or shoulders, patting back, stoking hair are good ways to offering reassurance. Using touch to convey message, it is an effective way in getting attention and increase readiness of clients.

Gesture

Gesture assisted to clarify our meaning. We use gesture to complement words and tone of voice when communicate additional information to the dementia person.

Supportive and Positive Attitude

A supportive atmosphere is essential to facilitate communication of the people with dementia as they experience frustration, embarrassing and frightening failure. When clients had difficulty in tasks, try to break task into simple steps and praise sincerely for success. Using positive approach to talk with the people with dementia can guide the behaviour and outcome as it encourage a meaningful communication.

7.3 Validation Therapy

Validation Therapy is a method of communicating with elderly people having diagnosis of Alzheimer’s disease and related dementia (Neal and Briggs, 2000). It was developed by Noami Feil between 1963 and 1980 and is built on the general principle of the affirmance of patient’s feelings, expressed thanks by the empathetic and non-judgmental attitude of the Validation practitioners (Feil, 1993). Originally called as fantasy therapy, it is based on the fact that some of the features associated with dementia were active strategies on the part of the patient to struggle in resolving unfinished life issues before death. Their behaviour is age-specific. Their movements reflect human needs and he/she retreats into inner reality (fantasy).

The method uses specific techniques (individual and group, verbal and non-verbal) according to four stages of Feil’s classification of cognitive impairment: Malorientation (Expressing past conflicts in disguised forms), Time confusion (No longer holding onto reality; retreating inward), Repetitive motion/ Perpetual motion (Movements replace words
and are used to work through unresolved conflicts. Persons in perpetual motion need empathy), Vegetation (Shuts out world completely and gives up trying to resolve living. Vegetation people still need touch, recognition and nurturing from another human being) (Jones and Miesen, 1993).

Feil believes that there are four realms reside in everyone, but the energy is concentrated on different realms at different times. Understanding these realms (Universal feelings, Personal repressed feelings, Sensory feelings, Rational thinking) of feeling and thinking explains the motivation of the disoriented (Jones and Miesen, 1993).

Validation therapy has been used on both individual or group basis for elderly with Alzheimer’s disease or other disease resulting in cognitive impairments or BPSD. Literature review indicated that there were inconsistent results on research studies of Validation therapy (Caltagirone, Bianchetti, Di Luca, Mecocci, Padovvani, Pirfo, Scapicchio, Snin, Trabucchi, and Musicco, 2005; Livingston et al., 2005; Robb, Stegman and Wolanin, 1986; Toseland, Diehl, Freeman, Manzanares, Naleppa, and McCallion, 1997). Based on clinical experience, there was a certain level of benefits in change of behaviour and emotion of patients with dementia.

7.4 Reference


2. Feil, N. (1993) Validation therapy with late-onset dementia populations. in Care-giving in dementia; research and applications (Eds. Gamma & Miesan), New York: Tavis/Routledge, pp. 199-218


Appendix

The four ‘D’s – dementia, delirium, depression and drugs

The differential diagnosis should include the four ‘D’s of geriatric practice – dementia, delirium, depression and drugs. Remember that the patient’s age, level of education, cultural background and co-morbid illnesses may affect their assessment.

A comparison of the clinical features of delirium, dementia and depression

<table>
<thead>
<tr>
<th>Feature</th>
<th>Delirium</th>
<th>Dementia</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Acute/sub-acute depends on cause, often twilight</td>
<td>Chronic, generally insidious, depends on cause</td>
<td>Coincides with life changes, often abrupt</td>
</tr>
<tr>
<td>Course</td>
<td>Short, diurnal fluctuations in symptoms; worse at night in the dark and on awakening</td>
<td>Long, no diurnal effects, symptoms progressive yet relatively stable over time</td>
<td>Diurnal effects, typically worse in the morning; situational fluctuations but less than acute confusion</td>
</tr>
<tr>
<td>Progression</td>
<td>Abrupt</td>
<td>Slow but even</td>
<td>Variable, rapid slow but uneven</td>
</tr>
<tr>
<td>Duration</td>
<td>Hours to less than 1 month, seldom longer</td>
<td>Months to years</td>
<td>At least 2 weeks, but can be several months to years</td>
</tr>
<tr>
<td>Awareness</td>
<td>Reduced</td>
<td>Clear</td>
<td>Clear</td>
</tr>
<tr>
<td>Alertness</td>
<td>Fluctuates; lethargic or hypervigilant</td>
<td>Generally normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Attention</td>
<td>Impaired, fluctuates</td>
<td>Generally normal</td>
<td>Minimal impairment but is distractible</td>
</tr>
<tr>
<td>Orientation</td>
<td>Fluctuates in severity, generally impaired</td>
<td>May be impaired</td>
<td>Selective disorientation</td>
</tr>
<tr>
<td>Memory</td>
<td>Recent and immediate impaired</td>
<td>Recent and remote impaired</td>
<td>Selective or patchy impairment ‘islands’ of intact memory</td>
</tr>
<tr>
<td>Thinking</td>
<td>Disorganised, distorted, fragmented, slow or accelerated incoherent</td>
<td>Difficulty with abstraction, thoughts impoverished, marked poor judgement, words difficult to find</td>
<td>Intact but with themes of hopelessness, helplessness or self-deprecation</td>
</tr>
<tr>
<td>Perception</td>
<td>Distorted; illusions, delusions and hallucinations, difficulty distinguishing between reality and misperceptions</td>
<td>Misperceptions often absent</td>
<td>Intact; delusions and hallucinations absent except in severe cases</td>
</tr>
<tr>
<td>Stability</td>
<td>Variable hour to hour</td>
<td>Fairly stable</td>
<td>Some variability</td>
</tr>
<tr>
<td>Emotions</td>
<td>Irritable, aggressive, fearful</td>
<td>Apathetic, labile, irritable</td>
<td>Flat, unresponsive or sad. May be irritable</td>
</tr>
<tr>
<td>Sleep</td>
<td>Nocturnal confusion</td>
<td>Often disturbed. Nocturnal wandering and confusion</td>
<td>Early morning awakening</td>
</tr>
<tr>
<td>Other features</td>
<td>Other physical disease may not be obvious</td>
<td></td>
<td>Past history of mood disorder</td>
</tr>
</tbody>
</table>
(Adapted from NZ Guideline 6:22 and LoGiudice 1999)
