



ACI

TRAINING & CONSULTANCY LTD

# Dementia Awareness

## Level 2

**Course Content:**

- What is dementia?
- Why does it happen?
- Types of Dementia
- Other Conditions Mistaken for Dementia
- Symptoms of Dementia
- Symptoms, diagnosis and treatment of Alzheimer's Disease, Vascular Dementia, Lewy Body Dementia and Fronto-Temporal Dementia
- Communication
- Aggressive Behaviour
- Handling Troubling Behaviour

## What is Dementia?

Dementia is an umbrella term used to describe a group of different conditions that affect a person's brain. These different conditions cause a person to experience a decline in certain abilities, including memory, thinking, reasoning and communication.

*Dementia is not a disease in itself - but a group of symptoms that may accompany conditions that affect your brain. Age UK*

The typical early signs of dementia are someone becoming forgetful and confused - forgetting people's names or how to get home. Later, people are likely to find everyday tasks - such as shopping or cooking - difficult. They may also find social situations hard to manage.

The symptoms of dementia grow worse over time. It is gradual, and everyone experiences the changes at different speeds. There is no cure but there are treatments that help slow it down or help people cope with certain symptoms.

Around 750,000 people in the UK have dementia. There are several types of dementia of which the most common is Alzheimer's disease. It mainly affects older people, both men and women. But it can be found in younger people. Being old doesn't automatically mean you will get dementia. It is just more common in the elderly. Around 80 percent of people aged over 80 are bright and alert, if occasionally forgetful.

## Why does it happen?

The brain is made up of millions of brain cells which send messages to each other. These messages tell us everything we need to know to cope with everyday life: such as how to move, what we are seeing, how to speak. They also store our memories and control our emotions - such as laughing and crying.

In someone with dementia, some of these brain cells become damaged and die (in most cases, it is not yet known exactly why). As a result, their brain doesn't work as well as it used to; simple messages do not get through. Hence they become forgetful and can become confused by their surroundings. They may not remember something that happened yesterday, or how to get dressed. They may not recognise their husband or their friends. Sometimes finding the right word might be difficult.

## Types of Dementia

### Alzheimer's disease

Alzheimer's disease is the most common type of dementia. It's found in more than half of people diagnosed with the illness. With Alzheimer's, individual brain cells become damaged. The numbers gradually increase over time so the brain starts to function less and less well. It starts slowly, and the decline can happen over a number of years. It usually affects short-term memory first. Gradually, other everyday tasks become more and more difficult.

### Vascular dementia

Vascular dementia is the second most common type of dementia. It also includes a type called multi-infarct dementia. In both cases, the blood supply to the brain is damaged or cut off. As a result, some brain cells die. This can happen either suddenly, following a stroke, or more gradually after a series of 'mini-strokes' or 'infarcts'. These mini-strokes can be so small that they go unnoticed to begin with. Then the person might have a sudden change but remain stable until the next 'mini-stroke'. With vascular dementia, people start to forget things and find day-to-day life harder to cope with.

### Lewy Body dementia

Lewy body dementia affects around 10 percent of people with dementia. It's caused by tiny, round deposits (Lewy bodies) that damage the brain tissue. This causes the brain to function less well in sending and receiving messages. The effects can be patchy and sporadic, so someone with this type of dementia can vary quite a lot day to day. As well as affecting memory, people can have hallucinations, physical stiffness, weaknesses in their arms and legs, and tremors. It is also related to Parkinson's disease, so some people with Parkinson's disease may develop this type of dementia, but people with Lewy body dementia don't necessarily get symptoms of Parkinson's.

### Fronto-temporal dementia

Fronto-temporal dementia (including Pick's disease) damages the front (which is responsible for your personality and behaviour) and side parts of the brain. This means people are likely to have behavioural and mood changes and may find it difficult to judge situations or plan ahead. They may do things at the wrong time or in the wrong place. Problems with memory are not as common, or occur later. Younger people, usually under 65, are more likely to be affected.

### Alcohol-related dementia

Alcohol-related dementia (including Korsakoff's syndrome) is caused by a lack of vitamin B1. Heavy drinkers may not be able to absorb the vitamin well, and may also have a poor diet. This type of dementia particularly affects the short-term memory. Stopping drinking halts the condition and, with the right treatment, may even reverse it.

## Other conditions

These are the main types of dementia. However, other illnesses or conditions can cause dementia, including:

- Huntingdon's disease
- Creutzfeldt–Jakob disease
- HIV or AIDS
- head injuries
- Down's syndrome

## Other Conditions Mistaken for Dementia

There are other conditions that mimic the symptoms of dementia such as depression, acute confusional state and age-related memory impairment. It is vital therefore that there is an accurate diagnosis.

### Depression

The symptoms of depression can be complex and vary widely between people. But as a general rule, if a person is depressed, they feel sad, hopeless and lose interest in things they used to enjoy.

#### Psychological symptoms include:

- Continuous low mood or sadness
- Feeling hopeless and helpless
- Having low self-esteem
- Feeling tearful
- Feeling guilt-ridden
- Feeling irritable and intolerant of others
- Having no motivation or interest in things
- Finding it difficult to make decisions
- Not getting any enjoyment out of life
- Feeling anxious or worried
- Having suicidal thoughts or thoughts of harming yourself

#### Physical symptoms include:

- Moving or speaking more slowly than usual
- Change in appetite or weight (usually decreased, but sometimes increased)
- Constipation
- Unexplained aches and pains

- Lack of energy or lack of interest in sex (loss of libido)
- Changes to your menstrual cycle
- Disturbed sleep (for example, finding it hard to fall asleep at night or waking up very early in the morning)

**Social symptoms include:**

- Not doing well at work
- Taking part in fewer social activities and avoiding contact with friends
- Neglecting your hobbies and interests
- Having difficulties in your home and family life

**Acute Confusional State**

Acute Confusional State is characterised by the sudden onset on confusion. This differs from dementia as the symptoms of dementia come on slowly.

Factors that can cause Acute Confusional State:

- An infection
- Electrolyte imbalance such as dehydration
- Medication
- Psychological Stress such as death of a spouse, change of house, going into hospital
- Disruption to normal routine
- Sleep deprivation
- Hearing or sight impairment
- Sensory overload such as a noisy or hectic environment
- Immobilisation
- Pain

**Age-related Memory Impairment**

The following types of memory lapses are normal among older adults and generally are not considered warning signs of dementia:

- Occasionally forgetting where you left things you use regularly, such as glasses or keys.
- Forgetting names of acquaintances or blocking one memory with a similar one, such as calling a grandson by your son's name.
- Occasionally forgetting an appointment.
- Having trouble remembering what you've just read, or the details of a conversation.
- Walking into a room and forgetting why you entered.

- Becoming easily distracted.
- Not quite being able to retrieve information you have “on the tip of your tongue.”

Remember getting older doesn't mean that a person will get dementia.

It is essential that these 3 conditions are not mistaken for dementia as they will require different treatment and management.

## Symptoms of Dementia

People experience dementia in different ways. Even people with a diagnosis of the same type of dementia are likely to have different symptoms and problems. Or they may have similar ones but they occur sooner or later. This means it isn't possible to say exactly what to expect or when.

As the dementia goes on, the symptoms and difficulties are likely to increase. Here are some of the general symptoms of dementia. Most people will only experience some of them and the changes happen very slowly:

- Have difficulty finding words or finishing thoughts
- Have difficulty remembering peoples' names or recent events
- Feel irritable and frustrated
- Lose things around the house
- Not recognise familiar people, places or everyday objects
- Forget appointments
- Find it difficult to follow directions or what people are saying
- Find decision-making difficult
- Find reading and writing difficult
- Have difficulty with practical tasks such as cooking or driving
- Have difficulty managing money
- Repeat questions many times
- Need help with basic activities such as washing, dressing and eating
- Be up and about at night
- Become angry or upset very quickly
- Have continence problems
- Have hallucinations (see or hear things that are not there)
- Having trouble remembering the day or date.
- Having problems controlling your mood, or controlling your emotions.

## Alzheimer's Disease

Alzheimer's disease is the most common cause of dementia. The word dementia describes a set of symptoms that can include memory loss and difficulties with thinking, problem-solving or language.

Alzheimer's disease, named after the doctor who first described it (Alois Alzheimer), is a physical disease that affects the brain. There are more than 520,000 people in the UK with Alzheimer's disease. During the course of the disease, proteins build up in the brain to form structures called 'plaques' and 'tangles'. This leads to the loss of connections between nerve cells, and eventually to the death of nerve cells and loss of brain tissue. People with Alzheimer's also have a shortage of some important chemicals in their brain. These chemical messengers help to transmit signals around the brain. When there is a shortage of them, the signals are not transmitted as effectively.

Alzheimer's is a progressive disease. This means that gradually, over time, more parts of the brain are damaged. As this happens, more symptoms develop. They also become more severe.

### Symptoms

The symptoms of Alzheimer's disease are generally mild to start with, but they get worse over time and start to interfere with daily life.

There are some common symptoms of Alzheimer's disease, but it is important to remember that everyone is unique. Two people with Alzheimer's are unlikely to experience the condition in exactly the same way.

For most people with Alzheimer's, the earliest symptoms are memory lapses. In particular, they may have difficulty recalling recent events and learning new information. These symptoms occur because the early damage in Alzheimer's is usually to a part of the brain called the hippocampus, which has a central role in day-to-day memory. Memory for life events that happened a long time ago is often unaffected in the early stages of the disease.

Memory loss due to Alzheimer's disease increasingly interferes with daily life as the condition progresses.

The person may:

- Lose items (e.g. keys, glasses) around the house
- Struggle to find the right word in a conversation or forget someone's name
- Forget about recent conversations or events
- Get lost in a familiar place or on a familiar journey
- Forget appointments or anniversaries.

Although memory difficulties are usually the earliest symptoms of Alzheimer's, someone with the disease will also have – or go on to develop – problems with other aspects of thinking, reasoning, perception or communication.

They might have difficulties with:

- Language – struggling to follow a conversation or repeating themselves
- Visuospatial skills – problems judging distance or seeing objects in three dimensions; navigating stairs or parking the car become much harder
- Concentrating, planning or organising – difficulties making decisions, solving problems or carrying out a sequence of tasks (e.g. cooking a meal)
- Orientation – becoming confused or losing track of the day or date.

A person in the earlier stages of Alzheimer's will often have changes in their mood. They may become anxious, irritable or depressed. Many people become withdrawn and lose interest in activities and hobbies.

### **Later stages**

As Alzheimer's progresses, problems with memory loss, communication, reasoning and orientation become more severe. The person will need more day-to-day support from those who care for them.

Some people start to believe things that are untrue (delusions) or – less often – see or hear things which are not really there (hallucinations). Many people with Alzheimer's also develop behaviours that seem unusual or out of character. These include agitation (e.g. restlessness or pacing), calling out, repeating the same question, disturbed sleep patterns or reacting aggressively. Such behaviours can be distressing or challenging for the person and their carer. They may require separate treatment and management to memory problems.

In the later stages of Alzheimer's disease someone may become much less aware of what is happening around them. They may have difficulties eating or walking without help, and become increasingly frail. Eventually, the person will need help with all their daily activities.

How quickly Alzheimer's disease progresses, and the life expectancy of someone with it, vary greatly. On average, people with Alzheimer's disease live for eight to ten years after the first symptoms.

### **Who gets Alzheimer's disease?**

Most people who develop Alzheimer's disease do so after the age of 65, but people under this age can also develop it. This is called early-onset Alzheimer's disease. In the UK there are over 40,000 people under the age of 65 with dementia. Developing Alzheimer's disease is linked to a combination of factors:

#### **Age**

Age is the greatest risk factor for Alzheimer's. The disease mainly affects people over 65. Above this age, a person's risk of developing Alzheimer's disease doubles approximately every five years. One in six people over 80 have dementia.

#### **Gender**

For reasons that are not clear, there are about twice as many women as men over 65 with Alzheimer's disease. This difference is not fully explained by the fact that women on average live longer than men. It may be that Alzheimer's in women is linked to a lack of the hormone oestrogen after the menopause.



## Genetic inheritance

Many people fear that the disease may be passed down to them from a parent or grandparent. Scientists are investigating the genetic background to Alzheimer's. There are a few families with a very clear inheritance of Alzheimer's from one generation to the next. In such families the dementia tends to develop well before age 65. However, Alzheimer's disease that is so strongly inherited is extremely rare.

## Health and lifestyle

Medical conditions such as diabetes, stroke and heart problems, as well as high blood pressure, high cholesterol and obesity in mid-life, are all known to increase the risk of both Alzheimer's disease and vascular dementia. Anyone can reduce their risk by keeping these under control. Depression is a probable risk factor for dementia; getting it treated early is important.

## Diagnosis

If someone does have dementia, an early diagnosis has many benefits: it provides an explanation for the person's symptoms; it gives access to treatment, advice and support; and it allows them to prepare for the future and plan ahead.

There is no single test for Alzheimer's disease. First there is a need to rule out conditions that can have similar symptoms, such as infections, vitamin and thyroid deficiencies (from a blood test), depression and side effects of medication.

A full medical history will be taken and how their symptoms are affecting their life. They will then be asked to complete some tests of mental abilities. A diagnosis of Alzheimer's might be made at this stage. If not, they will generally be referred to a specialist. This could be someone who specialises in the mental health of older people often based in a memory service. Or it might be a geriatrician, a neurologist or a general adult.

The specialist will assess the person's symptoms, and how they developed, in more detail. In Alzheimer's disease there will usually have been a gradual worsening of memory over several months. The person's memory, thinking and other mental abilities will also be assessed further with a pen-and-paper test. When someone with Alzheimer's is tested, they will often forget things quite quickly. They will often not be able to recall them a few minutes later even when prompted.

The person may undergo a brain scan, which can show whether certain changes have taken place in the brain. There are a number of different types of brain scan. The most widely used are CT (computerised tomography) and MRI (magnetic resonance imaging). A brain scan may rule out certain conditions such as stroke, tumour or a build-up of fluid inside the brain. These can have symptoms similar to those of Alzheimer's. It may also clarify the type of dementia. In a person with early Alzheimer's disease a brain scan may show that the hippocampus and surrounding brain tissue have shrunk.

## Treatment

There is currently no cure for Alzheimer's disease, but there is a lot that can be done to enable someone to live well with the condition. This will involve drug and non-drug care, support and activities.

The person should have a chance to talk to a professional about their diagnosis. This could be a psychiatrist or mental health nurse, a clinical psychologist, occupational therapist or GP.

There are drug treatments for Alzheimer's disease that can temporarily alleviate some symptoms or slow down their progression in some people. A person in the mild or moderate stages of Alzheimer's disease or mixed dementia will often be prescribed a drug such as donepezil (e.g. Aricept), rivastigmine (e.g. Exelon) or galantamine (e.g. Reminyl). The drug may help with memory problems, improve concentration and motivation, and help with aspects of daily living such as cooking, shopping or hobbies. A person in the moderate or severe stages of Alzheimer's disease or mixed dementia may be offered a different kind of drug: memantine (e.g. Ebixa). This may help with mental abilities and daily living, and ease distressing or challenging behaviours such as agitation and delusions.

If someone is depressed or anxious, talking therapies (such as cognitive behavioural therapy) or drug treatments (such as antidepressants) may also be tried. Counselling may help the person adjust to the diagnosis.

It is beneficial for a person with Alzheimer's to keep up with activities that they enjoy. Many people benefit from exercising their mind with reading or puzzles. There is evidence that attending sessions to keep mentally active helps (cognitive stimulation). Life story work, in which someone shares their life experiences and makes a personal record, may help with memory, mood and wellbeing. As the dementia worsens, many people enjoy more general reminiscence activities.

Over time, changes in the person's behaviour such as agitation or aggression become more likely. These behaviours are often a sign that the person is in distress. This could be from a medical condition such as pain; because they misunderstood something or someone; or perhaps because they are frustrated or under-stimulated. Individualised approaches should look for, and try to address, the underlying cause. General non-drug approaches often also help. These include social interaction, music, reminiscence, exercise or other activities that are meaningful for the person. They are generally tried before additional drugs are considered, particularly antipsychotics.

## Vascular Dementia

Vascular dementia is the second most common type of dementia (after Alzheimer's disease), affecting around 150,000 people in the UK. In vascular dementia, the symptoms occur when the brain is damaged because of problems with the supply of blood to the brain.

### Causes

Vascular dementia is caused by reduced blood supply to the brain due to diseased blood vessels. To be healthy and function properly, brain cells need a constant supply of blood to bring oxygen and nutrients. Blood is delivered to the brain through a network of vessels called the vascular system. If the vascular system within the brain becomes damaged - so that the blood vessels haemorrhage (leak) or become blocked - then blood cannot reach the brain cells and they will eventually die.

This death of brain cells can cause problems with memory, thinking or reasoning. Together these three elements are known as cognition. When these cognitive problems are bad enough to have a significant impact on daily life, this is known as vascular dementia.

## **Types of vascular dementia**

There are several different types of vascular dementia. They differ in the cause of the damage and the part of the brain that is affected. The different types of vascular dementia have some symptoms in common and some symptoms that differ. Their symptoms tend to progress in different ways.

### **Stroke-related dementia**

A stroke happens when the blood supply to a part of the brain is suddenly cut off. In most strokes, a blood vessel in the brain becomes narrowed and is blocked by a clot. The clot may have formed in the brain, or it may have formed in the heart (if someone has heart disease) and been carried to the brain. Strokes vary in how severe they are, depending on where the blocked vessel is and whether the interruption to the blood supply is permanent or temporary.

### **Post-stroke dementia**

A major stroke occurs when the blood flow in a large vessel in the brain is suddenly and permanently cut off. Most often this happens when the vessel is blocked by a clot. Much less often it is because the vessel bursts and bleeds into the brain. This sudden interruption in the blood supply starves the brain of oxygen and leads to the death of a large volume of brain tissue.

Not everyone who has a stroke will develop vascular dementia, but about 20 per cent of people who have a stroke do develop this post-stroke dementia within the following six months. A person who has a stroke is then at increased risk of having further strokes. If this happens, the risk of developing dementia is higher.

### **Single-infarct and multi-infarct dementia**

These types of vascular dementia are caused by one or more smaller strokes. These happen when a large or medium-sized blood vessel is blocked by a clot. The stroke may be so small that the person doesn't notice any symptoms. Alternatively, the symptoms may only be temporary - lasting perhaps a few minutes - because the blockage clears itself. (If symptoms last for less than 24 hours this is known as a 'mini-stroke' or transient ischaemic attack (TIA). A TIA may mistakenly be dismissed as a 'funny turn'.)

If the blood supply is interrupted for more than a few minutes, the stroke will lead to the death of a small area of tissue in the brain. This area is known as an infarct. Sometimes just one infarct forms in an important part of the brain and this causes dementia (known as single-infarct dementia). Much more often, a series of small strokes over a period of weeks or months lead to a number of infarcts spread around the brain. Dementia in this case (known as multi-infarct dementia) is caused by the total damage from all the infarcts together.

### **Subcortical dementia**

Subcortical vascular dementia is caused by diseases of the very small blood vessels that lie deep in the brain. These small vessels develop thick walls and become stiff and twisted; meaning that blood flow through them is reduced.

Small vessel disease often damages the bundles of nerve fibres that carry signals around the brain, known as white matter. It can also cause small infarcts near the base of the brain.

Small vessel disease develops much deeper in the brain than the damage caused by many strokes. This means many of the symptoms of subcortical vascular dementia are different from those of

stroke-related dementia. Subcortical dementia is thought to be the most common type of vascular dementia.

### **Mixed dementia (vascular dementia and Alzheimer's disease)**

At least 10 per cent of people with dementia are diagnosed with mixed dementia. This generally means that both Alzheimer's disease and vascular disease are thought to have caused the dementia. The symptoms of mixed dementia may be similar to those of either Alzheimer's disease or vascular dementia, or they may be a combination of the two.

### **Symptoms**

How vascular dementia affects people varies depending on the different underlying causes and more generally from person to person. Symptoms may develop suddenly, for example after a stroke, or more gradually, such as with small vessel disease.

Some symptoms may be similar to those of other types of dementia. Memory loss is common in the early stages of Alzheimer's, but is not usually the main early symptom of vascular dementia.

The most common cognitive symptoms in the early stages of vascular dementia are:

- Problems with planning or organising, making decisions or solving problems
- Difficulties following a series of steps (e.g. cooking a meal)
- Slower speed of thought
- Problems concentrating, including short periods of sudden confusion.

A person in the early stages of vascular dementia may also have difficulties with:

- Memory - problems recalling recent events (often mild)
- Language - e.g. speech may become less fluent
- Visuospatial skills - problems perceiving objects in three dimensions.

As well as these cognitive symptoms, it is common for someone with early vascular dementia to experience mood changes, such as apathy, depression or anxiety. Depression is common, partly because people with vascular dementia may be aware of the difficulties the condition is causing. A person with vascular dementia may also become generally more emotional. They may be prone to rapid mood swings and being unusually tearful or happy.

Other symptoms that someone with vascular dementia may experience vary between the different types. Post-stroke dementia will often be accompanied by the obvious physical symptoms of the stroke. Depending on which part of the brain is affected, someone might have paralysis or weakness of a limb. Or if a different part of the brain is damaged they may have problems with vision or speech. With rehabilitation, symptoms may get a little better or stabilise for a time, especially in the first six months after the stroke.

Symptoms of subcortical vascular dementia vary less. Early loss of bladder control is common. The person may also have mild weakness on one side of their body, or become less steady walking and more prone to falls. Other symptoms of subcortical vascular dementia may include clumsiness, lack of facial expression and problems pronouncing words.

### **Progression and later stages**

Vascular dementia will generally get worse, although the speed and pattern of this decline vary. Stroke-related dementia often progresses in a 'stepped' way, with long periods when symptoms are stable and periods when symptoms rapidly get worse. This is because each additional stroke causes further damage to the brain. Subcortical vascular dementia may occasionally follow this stepped progression, but more often symptoms get worse gradually, as the area of affected white matter slowly expands.

Over time a person with vascular dementia is likely to develop more severe confusion or disorientation, and further problems with reasoning and communication. Memory loss, for example for recent events or names, will also become worse. The person is likely to need more support with day-to-day activities such as cooking or cleaning.

As vascular dementia progresses, many people also develop behaviours that seem unusual or out of character. The most common include irritability, agitation, aggressive behaviour and a disturbed sleep pattern. Someone may also act in socially inappropriate ways.

Occasionally a person with vascular dementia will strongly believe things that are not true (delusions) or - less often - see things that are not really there (hallucinations). These behaviours can be distressing and a challenge for all involved.

In the later stages of vascular dementia someone may become much less aware of what is happening around them. They may have difficulties walking or eating without help, and become increasingly frail. Eventually, the person will need help with all their daily activities.

How long someone will live with vascular dementia varies greatly from person to person. On average it will be about five years after the symptoms started. The person is most likely to die from a stroke or heart attack.

### **Who gets vascular dementia?**

There are a number of things that can put someone at risk of developing vascular dementia. These are called risk factors. Most of these are things that contribute to underlying cardiovascular diseases. Some of these risk factors (e.g. lifestyle) can be controlled, but others (e.g. age and genes) cannot.

Age is the strongest risk factor for vascular dementia. A person's risk of developing the condition doubles approximately every five years over the age of 65. Vascular dementia under the age of 65 is uncommon and affects fewer than 8,000 people in the UK. Men are at slightly higher risk of developing vascular dementia than women.

A person who has had a stroke, or who has diabetes or heart disease, is approximately twice as likely to develop vascular dementia. Sleep apnoea, a condition where breathing stops for a few seconds or minutes during sleep, is also a possible risk factor. Someone can reduce their risk of dementia by keeping these conditions under control, through taking prescribed medicines (even if they feel well) and following professional advice about their lifestyle.

There is some evidence that a history of depression also increases the risk of vascular dementia. Anyone who thinks they may be depressed should seek their doctor's advice early.

Cardiovascular disease - and therefore vascular dementia - is linked to high blood pressure, high cholesterol and being overweight in mid-life. Someone can reduce their risk of developing these by having regular check-ups (over the age of 40), by not smoking, and by keeping physically active. It will also help to eat a healthy balanced diet and drink alcohol only in moderation.

Aside from these cardiovascular risk factors, there is good evidence that keeping mentally active throughout life reduces dementia risk. There is some evidence for the benefits of being socially active too.

Researchers think there are some genetic factors behind the common types of vascular dementia, and that these are linked to the underlying cardiovascular diseases. Someone with a family history of stroke, heart disease or diabetes has an increased risk of developing these conditions. Overall, however, the role of genes in the common types of vascular dementia is small.

People from certain ethnic groups are more likely to develop cardiovascular disease and vascular dementia than others. Those from an Indian, Bangladeshi, Pakistani or Sri Lankan background living in the UK have significantly higher rates of stroke, diabetes and heart disease than white Europeans. Among people of African-Caribbean descent, the risk of diabetes and stroke - but not heart disease - is also higher. These differences are thought to be partly inherited but mainly due to lifestyle factors such as diet, smoking and exercise.

### **Diagnosis**

Anyone who is concerned that they may have vascular dementia (or any other type of dementia) should seek help from their GP. If someone does have dementia, an early diagnosis has many benefits: it provides an explanation for the person's symptoms; it gives access to treatment, advice and support; and it allows them to prepare for the future and plan ahead. For vascular dementia, treatments and lifestyle changes may also slow down the progression of the underlying disease.

There is no single test for vascular dementia. The GP will first need to rule out conditions that can have similar symptoms, particularly depression. Symptoms could also be caused by infections, vitamin and thyroid deficiencies (diagnosed from a blood test) and side effects of medication.

The doctor will also talk to the person about their medical history (e.g. high blood pressure or diabetes). This will include questions about dementia or cardiovascular disease in close family members. The doctor will probably do a physical examination and will ask about how the person's symptoms are currently affecting their life.

The GP or a practice nurse may ask the person to do some tests of mental abilities. It is often helpful if a close friend or family member accompanies the person to medical appointments. They may be able to describe subtle changes that the person themselves has not noticed, such as starting to struggle with daily activities.

The GP may feel able to make a diagnosis of vascular dementia at this stage. If not, they will generally refer the person to a specialist. This might be an old-age psychiatrist (who specialises in the mental health of older people) based in a memory service, or a geriatrician (who specialises in the physical health of older people) in a hospital.

The specialist will assess the person's symptoms in more detail. The way that symptoms developed - in steps or more gradually - may suggest different underlying diseases. The person's thinking and

other mental abilities will also be assessed further with a wider range of tests. In someone with vascular dementia, the test might show slowness of thought and difficulties thinking things through, which are often more common than memory loss.

A person suspected of having vascular dementia will generally have a brain scan to look for any changes that have taken place in the brain. A scan such as CT (computerised tomography) or MRI (magnetic resonance imaging) may rule out a tumour or build-up of fluid inside the brain. These can have symptoms similar to those of vascular dementia. A CT scan may also show a stroke or an MRI scan may show changes such as infarcts or damage to the white matter. If this is the case, the brain scan will be very helpful in diagnosing the dementia type, rather than simply ruling out other causes.

If the person has dementia, and the circumstances mean it is best explained by vascular disease in the brain, a diagnosis of vascular dementia will be made. For example, the dementia may have developed within a few months of a stroke, or a brain scan may show a pattern of disease that explains the dementia symptoms.

The diagnosis should be communicated clearly to the person and usually also those closest to them, along with a discussion about the next steps.

### **Treatment and support**

There is currently no cure for vascular dementia: the brain damage that causes it cannot be reversed. However, there is a lot that can be done to enable someone to live well with the condition. This will involve drug and non-drug treatment, support and activities.

The person should have a chance to talk to a health or social care professional about their dementia diagnosis. This could be a psychiatrist or mental health nurse, a clinical psychologist, occupational therapist or GP. Information on what support is available and where to go for further advice is vital in helping someone to stay physically and mentally well.

### **Control of cardiovascular disease**

If the underlying cardiovascular diseases that have caused vascular dementia can be controlled, it may be possible to slow down the progression of the dementia. For example, after someone has had a stroke or TIA, treatment of high blood pressure can reduce the risk of further stroke and dementia. For stroke-related dementia in particular, with treatment there may be long periods when the symptoms don't get significantly worse.

In most cases, a person with vascular dementia will already be on medications to treat the underlying diseases. These include tablets to reduce blood pressure, prevent blood clots and lower cholesterol. If the person has a diagnosed heart condition or diabetes they will also be taking medicines for these. It is important that the person continues to take any medications and attends regular check-ups as recommended by a doctor.

Someone with vascular dementia will also be advised to adopt a healthy lifestyle, particularly to take regular physical exercise and, if they are a smoker, to quit. They should try to eat a diet with plenty of fruit, vegetables and oily fish but not too much fat or salt. Maintaining a healthy weight and keeping to recommended levels of alcohol will also help. The GP should be able to offer advice in all these areas.

## Other treatment and support

Supporting a person with vascular dementia to live well includes treatment for symptoms, support to cope with lost abilities, and help to keep up enjoyable activities. For someone who has had a stroke or has physical difficulties, treatment will also include rehabilitation.

The drugs that are routinely prescribed for Alzheimer's diseases do not have benefits for vascular dementia, and are not recommended for it. These drugs may, however, be prescribed to treat mixed dementia (Alzheimer's disease and vascular dementia).

If someone is depressed or anxious, talking therapies (such as cognitive behavioural therapy) or drug treatments may also be tried. Counselling may also help the person adjust to the diagnosis.

There are many ways to help someone remain independent and cope with the cognitive symptoms of vascular dementia. For example, breaking complex tasks down into smaller steps will make them easier. An environment which is not too busy or noisy will make it easier to concentrate. For someone with memory loss, a regular routine and appropriate technology, such as pill boxes or electronic devices, can help.

It is important that a person with any type of dementia stays active and continues to do things they enjoy. Keeping mentally active (cognitive stimulation) is known to help with memory and communication. Life story work, in which someone shares their life experiences and makes a personal record, may help with memory, mood and wellbeing. As the dementia worsens, many people enjoy more general reminiscence activities.

If the person has physical difficulties, for example after a stroke, they will usually benefit from rehabilitation. This could mean working with a physiotherapist (especially for help with weakness, coordination, movement and balance), occupational therapist (for everyday activities) or speech and language therapist (for all aspects of communication).

The details of the support that is available, and how people are generally referred, can vary around the country. The GP can give information about what is available in the local area.

Over time, changes in the person's behaviour - such as agitation or aggression - become more likely. These are often a sign that the person is in distress. There are many potential causes. For example, the person might be in pain, they may have misunderstood something or someone, or they may be frustrated or under-stimulated. Individualised approaches should try to address the cause. General non-drug approaches (e.g. social interaction) often help. They should generally be tried before additional drugs are considered, particularly in the case of antipsychotics.

Anyone caring for the person is likely to find these behaviours distressing. Support for carers is particularly important at such times.

## Dementia with Lewy bodies (DLB)

Dementia with Lewy bodies (DLB) is a type of dementia that shares symptoms with both Alzheimer's disease and Parkinson's disease. It may account for around 10 per cent of all cases of dementia. DLB tends to be mistakenly diagnosed as other conditions (that is, DLB is under-diagnosed).



DLB is sometimes referred to by other names, including Lewy body dementia, Lewy body variant of Alzheimer's disease, diffuse Lewy body disease, cortical Lewy body disease, and senile dementia of Lewy body type. All these terms essentially refer to the same disorder.

### **Lewy bodies**

Lewy bodies, named after the doctor who first identified them, are tiny deposits of protein in nerve cells. Researchers don't have a full understanding of why Lewy bodies appear in the brain, or exactly how they contribute to dementia. However, their presence is linked to low levels of important chemical messengers (mainly acetylcholine and dopamine) and to a loss of connections between nerve cells. Over time, there is progressive death of nerve cells and loss of brain tissue.

Lewy bodies are the underlying cause of several progressive diseases affecting the brain and nervous system, notably DLB and Parkinson's disease. Together, these are sometimes called Lewy body disorders.

The symptoms a person experiences will depend partly on where the Lewy bodies are in the brain. Lewy bodies at the base of the brain are closely linked to problems with movement (motor symptoms). These are the main feature of Parkinson's disease. Lewy bodies in the outer layers of the brain are linked to problems with mental abilities (cognitive symptoms), which are characteristic of DLB.

Movement problems and changes in mental abilities can occur together. About one third of people diagnosed with Parkinson's disease eventually develop dementia (Parkinson's disease dementia). Similarly, at least two thirds of people with DLB develop movement problems at some point. The symptoms of DLB and Parkinson's disease dementia become more similar as the conditions progress. Together they are referred to as Lewy body dementias.

### **Who is affected?**

DLB accounts for around 4 per cent of all recorded dementia, but there is good evidence that the condition is under-diagnosed. Based on studies of brain tissue after death, scientists think DLB may represent as much as 10 per cent of all dementia.

DLB appears to affect men and women about equally. As with Alzheimer's disease and vascular dementia, DLB becomes more common over the age of 65. However, in certain cases people under 65 develop DLB.

Other than age, there are few risk factors (medical, lifestyle or environmental) which are known to increase a person's chances of developing DLB. Most people who develop DLB have no clear family history of the disease. A few families do seem to have genetic mutations which are linked to inherited Lewy body disease, but these mutations are very rare.

### **Symptoms**

As with most types of dementia, the initial symptoms of DLB are often subtle, but gradually worsen to cause problems with daily living. Everyone is different, but a person with DLB will usually have some of the symptoms of Alzheimer's disease and some of the symptoms of Parkinson's disease. They will also have some symptoms which are unique to DLB.

Problems with attention and alertness are very common. It is a feature of DLB that these problems vary (fluctuate) widely over the course of the day, by the hour or even a few minutes. There may also be difficulties with judging distances and perceiving objects in three dimensions, and with

planning and organising. Some also experience depression. Day-to-day memory is often affected in people with DLB, but typically less in the early stages than in early Alzheimer's disease.

Visual hallucinations (seeing things that are not there) occur in most people with DLB, and can be distressing. These are often of people or animals, and are experienced as detailed and convincing. Auditory hallucinations (hearing sounds that are not real, such as knocking or footsteps) can happen but are less common.

Hallucinations and visual difficulties partly explain why many people with DLB have delusions (thinking things that are not true). Someone may believe they are being persecuted, that there are strangers living in the house, or that a spouse has been replaced by an identical imposter. Relatives and carers may find such delusions very distressing.

Up to two thirds of people with DLB have movement problems when the condition is diagnosed, and this proportion increases as it progresses. These symptoms are those of Parkinson's disease, and include slowness and rigidity of movement with a blank facial expression. Walking is often stooped and shuffling, with problems balancing. Trembling of the limbs is also sometimes seen.

Motor symptoms are one reason why a person with DLB is prone to falls. They may also faint or have unexplained episodes when they lose consciousness for a few minutes.

Sleep disorders are another common symptom of DLB. The person may fall asleep very easily by day, but have restless, disturbed nights. Common problems include confusion, hallucinations and violent movements as the person tries to act out nightmares. This night-time sleep pattern is called rapid eye movement sleep behaviour disorder. For bed partners it can be very distressing or even physically harmful.

### **Later stages**

DLB is a progressive disease. Symptoms become worse and tend to become more numerous with time, generally over a period of several years.

As the disease progresses, problems with day-to-day memory and other mental abilities come to resemble more closely those of middle- or later-stage Alzheimer's disease. People can also develop behaviours that challenge (e.g. agitation, restlessness, shouting out).

Worsening movement problems mean that walking gets slower and less steady. Falls become more common. In the later stages of DLB, many people have problems with speech and swallowing, leading to chest infections or risk of choking.

Eventually, someone with DLB is likely to need extensive nursing care. The rate of progression of the condition and the life expectancy of a person with DLB are very variable. On average someone might live for about eight years after the first symptoms. This is similar to Alzheimer's disease.

### **Diagnosis**

It is always important to get an accurate diagnosis of dementia, but a proper diagnosis is particularly important if DLB is suspected. This is mainly because people with DLB can benefit from some medications but also react very badly to others.

However, DLB can be difficult to diagnose, and diagnosis should ideally be made by a specialist with experience of the condition. People with DLB are often mistakenly diagnosed as having Alzheimer's disease or – less often – vascular dementia. Tests for conditions other than dementia that can cause similar symptoms, including infection or side effects of medication, will also need to be carried out.

The doctor will talk to the person, and someone who knows them well, about the person's medical history, when the symptoms started, and how these are affecting their life now. Tests of mental abilities are used but can be complicated by the fluctuating nature of DLB and its effect on visual and spatial abilities (e.g. drawing a shape). A neurological examination (looking at reflexes and balance, for example) should also be done.

A diagnosis of DLB is largely based on the symptoms – particularly fluctuating attention or alertness, persistent detailed visual hallucinations, and movement problems associated with Parkinson's disease. Brain scans help to clarify the diagnosis: computed tomography (CT) or magnetic resonance imaging (MRI) scans may rule out brain conditions (e.g. brain tumour, increased pressure) with overlapping symptoms. They may also help to distinguish DLB from vascular dementia. If there is still doubt, a more specialised brain scan might be carried out. This can confirm a diagnosis of DLB if it shows reduced density of a particular type of cells (dopamine nerve cells) at the base of the brain.

### **Treatment and support**

At present, there is no cure for DLB. However, with support it is possible to live well with DLB, and management of the condition aims to maximise the person's overall quality of life. Given the range of symptoms, input from a variety of professionals is needed at different times. When caring for someone with DLB, it is important to be as flexible as possible, bearing in mind that many of the symptoms will fluctuate.

Treatment of DLB with drugs is often problematic: everyone responds differently, there is only limited evidence about what works, and there are few approved treatments. Also, medication given to improve mental abilities or hallucinations can make movement problems worse. Similarly, drugs for movement problems may have a negative effect on mental abilities or make hallucinations worse. There are also serious issues with use of antipsychotic drugs for a person with DLB.

Management of the condition starts by focusing on the symptoms that the person and carer identify as the most troublesome. Non-drug approaches should be tried before drug treatments, where options are available.

### **Problems with mental abilities**

A person with DLB will benefit from individualised and meaningful occupation (e.g. tasks, hobbies), social interaction, reminiscence or life story work and strategies to cope with memory loss and visual hallucinations.

There is some evidence that the drugs galantamine, donepezil and especially rivastigmine (which are routinely prescribed for Alzheimer's disease) can help with DLB. They improve fluctuating cognition, alertness and daily functioning. None of these drugs are currently licensed for use in DLB, although one (rivastigmine) is licensed for Parkinson's disease dementia. For this reason, families may find that doctors are reluctant to prescribe one of these drugs for a person with DLB, though they may do so 'off label' (outside the terms of the licence).

There is mixed evidence of benefit from memantine, a drug which is often given to people in the later stages of Alzheimer's disease.

## Hallucinations and delusions

If someone is having hallucinations or delusions, in most cases it is unhelpful to try to convince them that there is nothing there, or that what they believe is untrue. What the person is experiencing is real to them at the time. Instead, carers can offer reassurance that they are there to support the person, and perhaps try distracting them.

It is a good idea to get any glasses or hearing aids checked. If faulty, these may increase any difficulty with perception. Misperceptions (different from true hallucinations) can also be triggered by things in the environment such as excess noise and reflective or patterned surfaces.

If hallucinations are distressing or likely to lead to physical harm, drug treatments may be offered. There is good evidence that galantamine, donepezil and rivastigmine reduce hallucinations and delusions in people with DLB. This treatment is recommended by the National Institute for Health and Care Excellence (NICE) and may be prescribed 'off label'.

The prescription of antipsychotic drugs for hallucinations or delusions in DLB is very problematic. These drugs do not work in everyone and are known to increase the risk of stroke and death in people with dementia.

There is an additional and much greater risk surrounding the use of antipsychotic drugs in people with DLB (in comparison with other types of dementia). In up to half of cases, these drugs cause a severe reaction, with rigidity, immobility, worsening confusion and an inability to perform tasks or communicate. They may even cause sudden death. If someone is admitted to hospital or sees a new doctor, the person or family should check that medical staff know that the person has DLB.

If a person with DLB must be prescribed an antipsychotic for distressing visual hallucinations or delusions, this should be done only by a specialist after all other approaches have failed. The drug should be given with the utmost care, under constant supervision and with regular monitoring.

## Behaviours that challenge

As in other dementias, behaviours that challenge (e.g. agitation, aggression) in a person with DLB should be viewed as a form of communication – a sign of an unmet need. Approaches tailored to the individual should try to identify and meet this need.

The underlying cause may be a medical condition such as pain or the side effects of drugs. Or the behaviour might reflect frustration, fear or boredom. To manage these, carers should look for specific triggers and make appropriate changes in the person's environment or care. Aromatherapy, massage or talking therapies may also help.

Behaviours that challenge can often be prevented by social interaction, structured activities (e.g. music or dance therapy, reminiscence and life story work) or physical exercise.

If behaviours persist and are severe or distressing, drug treatments may be offered. One of the three Alzheimer's drugs – galantamine, donepezil or rivastigmine – should be tried first. If this fails and an antipsychotic is finally offered to someone with DLB, then all of the risks of a severe reaction (and need for extreme caution) mentioned above apply.

## Sleep disorders

Steps can be taken to help a person with DLB have more restful nights. Increasing physical exercise and reducing daytime napping can be of benefit. It can also help to avoid alcohol, caffeine and nicotine late at night, and to keep the bedroom quiet and at a comfortable temperature.

Carers should talk to the GP about sleep problems. Drugs such as clonazepam or melatonin can be effective treatments for sleep disorders.

### **Movement problems**

A person with movement problems will often benefit from working with an occupational therapist or physiotherapist. These professionals can help the person maintain their independence and mobility, and advice on aids and adaptations in the home.

Support from a speech and language therapist is often helpful if the person develops problems with swallowing or speaking. The drug levodopa, routinely used to treat Parkinson's disease, is sometimes given to people with DLB and movement problems. Levodopa is, however, less effective in DLB than in Parkinson's disease. It improves movement problems and falls in only around one third of people with DLB, and can further increase confusion and reduce mental abilities (e.g. alertness) or make hallucinations worse.

With correct diagnosis and support from a team of professionals, it is possible to live well with DLB.

## **Fronto-Temporal Dementia**

Fronto-temporal dementia covers a range of specific conditions. It is sometimes called Pick's disease or frontal lobe dementia. The word fronto-temporal refers to the two lobes of the brain that are damaged in this form of dementia. The frontal lobes of the brain - situated behind the forehead - control behaviour and emotions, particularly on the right side of the brain. They also control language, usually on the left. The temporal lobes - on either side of the brain - have many roles. On the left side, these lobes control the understanding of words.

Fronto-temporal dementia is caused when nerve cells in the frontal and/or temporal lobes of the brain die and the pathways that connect them change. There is also some loss of important chemical messengers. Over time, the brain tissue in the frontal and temporal lobes shrinks.

This damage to the brain causes the typical symptoms of frontotemporal dementia, which include changes in personality and behaviour, and difficulties with language. As frontotemporal dementia is a less common form of dementia, many people (including some health professionals) may not have heard of it.

### **Symptoms**

A person with behavioural variant frontotemporal dementia may:

- **Lose their inhibitions** – behave in socially inappropriate ways and act in an impulsive or rash manner; this could include making tactless or inappropriate comments about someone's appearance
- **Lose interest in people and things** - lose motivation but (unlike someone with depression) they are not sad
- **Lose sympathy or empathy** - become less responsive to the needs of others and show less social interest or personal warmth; this can make the person appear selfish and unfeeling
- **Show repetitive, compulsive or ritualised behaviours** - this can include repeated use of phrases or gestures, hoarding and obsessions with timekeeping

- **Crave** sweet or fatty foods, lose table etiquette, or binge on 'junk' foods, alcohol or cigarettes.
- **Slow, hesitant speech** - speech may seem difficult to produce and a person may stutter before they can get the right word out, or may mispronounce it when they do
- **Errors in grammar** - a person may have 'telegraphic speech', leaving out small link words such as 'to', 'from' or 'the'
- **Impaired** understanding of complex sentences, but not single words.
- **Asking** the meaning of familiar words (e.g., 'What is knife?')
- **Trouble** finding the right word, leading to less precise descriptions instead (e.g. 'the thing for opening tins'), or use of generalised words such as 'animal' instead of 'cat'
- **Difficulty** recognising familiar people or common objects.

### Causes

The cause of frontotemporal dementia is not known. Experts assume that the disease reflects a mixture of genetic, medical and lifestyle factors. Unlike Alzheimer's disease or vascular dementia, it doesn't seem that frontotemporal dementia becomes much more common in older age.

Autopsy studies show that the death of nerve cells in the frontal and temporal lobes is linked to clumps of abnormal proteins inside the cells, including one called tau. The tau protein may take the form of Pick bodies, which gave frontotemporal dementia its original name of Pick's disease. Frontotemporal dementia runs in families much more often than in the more common forms of dementia. About one third of people with it have some family history of dementia.

### Diagnosis

Frontotemporal dementia can be hard to diagnose, because it is uncommon and does not initially cause memory problems. Doctors may also not suspect dementia in a middle-aged person.

Frontotemporal dementia may be misdiagnosed as atypical Alzheimer's disease (a form of Alzheimer's disease without early memory loss). Behavioural symptoms may be mistaken for depression, schizophrenia or obsessive-compulsive disorder. Problems with language or movement may be misdiagnosed as stroke. Blood tests and a thorough physical examination are important to rule out other possible causes of symptoms. A specialist may suspect a diagnosis of frontotemporal dementia after questioning the affected person and someone who knows them well. The specialist will take a detailed history of their symptoms and gather information to gain a wider picture of the person's behaviour and functioning in their daily life.

Standard cognitive tests, which tend to focus on memory loss, can be less helpful in the diagnosis of frontotemporal dementia. More specialised tests of social awareness or behaviour may be needed.

CT (computerised tomography) and MRI (magnetic resonance imaging) brain scans should be used to assess the pattern of damage to the brain. They can also rule out other possible causes of symptoms such as stroke or tumour. If further tests are needed, more specialised brain scans will be carried out such as PET (positron emission tomography) and SPECT (single photon emission computerised tomography) to measure brain activity. These scans are useful as they may detect reduced activity in the frontal and/or temporal lobes at an earlier stage than a CT or MRI scan might show structural changes.

Further tests may include a lumbar puncture, which involves collecting and analysing fluid from the spine and is carried out mainly in younger people. After a person dies, it is possible to make a pathological diagnosis of frontotemporal dementia as the changes to the brain can be directly seen at a post-mortem.

### Treatment and support

Researchers are working to find effective new treatments for frontotemporal dementia, but there is currently no cure and the progression of the disease cannot be slowed. Approaches to treatment look to ease symptoms or help people cope with them.

## Communication

Improving your communication skills will help make caring less stressful and will likely improve the quality of the care you give. Good communication skills will also enhance your ability to handle the difficult behaviour you may encounter as you care for a person with dementia.

1. **Set a positive mood for interaction.** Your attitude and body language communicate your feelings and thoughts stronger than your words. Set a positive mood by speaking to the person in a pleasant and respectful manner. Use facial expressions, tone of voice and physical touch to help convey your message.
2. **Get the person's attention.** Limit distractions and noise—turn off the radio or TV, close the curtains or shut the door, or move to quieter surroundings. Before speaking, make sure you have their attention; address them by name, identify yourself by name and relation, and use nonverbal cues and touch to help keep them focused. If they are seated, get down to their level and maintain eye contact.
3. **State your message clearly.** Use simple words and sentences. Speak slowly, distinctly and in a reassuring tone. Refrain from raising your voice higher or louder; instead, pitch your voice lower. If they do not understand the first time, use the same wording to repeat your message or question. If they still do not understand, wait a few minutes and rephrase the question. Use the names of people and places instead of pronouns or abbreviations.
4. **Ask simple, answerable questions.** Ask one question at a time; those with yes or no answers work best. Refrain from asking open-ended questions or giving too many choices. For example, ask, “*Would you like to wear your white shirt or your blue shirt?*” Better still, show her the choices—visual prompts and cues also help clarify your question and can guide her response.
5. **Listen with your ears, eyes and heart.** Be patient in waiting for the person's reply. If they are struggling for an answer, it's okay to suggest words. Watch for nonverbal cues and body language, and respond appropriately. *Always strive to listen for the meaning and feelings that underlie the words.*
6. **Break down activities into a series of steps.** This makes many tasks much more manageable. You can encourage the person to do what they can, gently remind them of steps they tend to forget, and assist with steps they are no longer able to accomplish on their own. Using visual cues, such as showing them with your hand where to place the dinner plate, can be very helpful.

7. **When the going gets tough, distract and redirect.** When the person becomes upset, try changing the subject or the environment. For example, ask them for help or suggest going for a walk. It is important to connect with the person on a feeling level, before you redirect. You might say, *“I see you’re feeling sad—I’m sorry you’re upset. Let’s go get something to eat.”*
8. **Respond with affection and reassurance.** People with dementia often feel confused, anxious and unsure of themselves. Further, they often get reality confused and may recall things that never really occurred. *Avoid trying to convince them they are wrong.* Stay focused on the feelings they are demonstrating (which are real) and respond with verbal and physical expressions of comfort, support and reassurance. Sometimes holding hands, touching, hugging and praise will get the person to respond when all else fails.
9. **Remember the good old days.** Remembering the past is often a soothing and affirming activity. Many people with dementia may not remember what happened 45 minutes ago, but they can clearly recall their lives 45 years earlier. Therefore, *avoid asking questions that rely on short-term memory*, such as asking the person what they had for lunch. Instead, try asking general questions about the person’s distant past—this information is more likely to be retained.
10. **Maintain your sense of humour.** *Use humour whenever possible, though not at the person’s expense.* People with dementia tend to retain their social skills and are usually delighted to laugh along with you.

## Aggressive Behaviour

### What is aggressive behaviour?

Aggressive behaviour is not unique to people with dementia. However, more than one third of people living with dementia have at times behaved aggressively, particularly in the moderate to severe stages of the condition.

Aggressive behaviour can be very stressful and upsetting for the person with dementia and their carers. It can also be a factor in the decision to move the person with dementia into a care home.

Aggressive behaviour may be:

- Verbal – e.g. swearing, screaming, shouting, making threats
- Physical – e.g. hitting, pinching, scratching, hair-pulling, biting.

Aggression may be linked to the person’s personality and behaviour before they developed dementia. However, people who have never been aggressive before may also develop this type of behaviour.

Aggression is one type of challenging behaviour that can result from dementia. Other behaviours that challenge include agitation, restlessness, walking about, and being sexually inappropriate. It can also be hard for carers to deal with restlessness, repeated questioning and being followed around.



## Causes of aggressive behaviour

People with dementia have the same needs as everyone else, including comfort, social interaction, stimulation, emotional wellbeing and being free from pain. However, people with dementia may be unable to recognise their needs, know how to meet them, or communicate what they need to others. This may cause them to act in ways that are seen as challenging, including aggression.

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The aggressive behaviour might be the person's way of meeting the need, an attempt to communicate it, or an outcome of the unmet need. For example, if a person with dementia is not getting enough stimulation they might become bored, and this may lead to them behaving in a way that is seen as challenging, such as walking about or following their carer.

Meeting the need by providing stimulation to the person may stop the behaviour as they will no longer be bored.

Understanding what is causing the person's behaviour can help carers to find a solution. Some possible explanations for aggression are listed below. The causes could be biological, social or psychological.

### Biological

- There may be pain, illness (including infections) or physical discomfort (including being constipated or thirsty, or from sitting for too long).
- Side effects and/or taking too many medications may mean that a person becomes more confused and drowsy. This means they may be less able to problem-solve their way out of distressing situations.
- The environment may not meet their needs or may be over-stimulating. It could be too hot or too cold, noisy or too bright.
- Poor eyesight or hearing can lead to misunderstandings and misperceptions.
- Hallucinations (where people see things that aren't there) and/or delusions (where people believe things that aren't true) can be confusing and frightening, leading the person with dementia to respond to them in an aggressive way.
- The physical effects of dementia may have affected the person's judgement and self-control. They may have lost their inhibitions or have a decreased awareness of what kind of behaviour is appropriate.

### Social

- Lack of social contact and loneliness.
- Boredom, inactivity and sensory deprivation.
- Different carers coming in with a different approach or changing the established routine.
- Not liking or trusting a particular carer.
- Trying to hide their condition from others.

## Psychological

- The person with dementia may have a perception that their rights are being infringed or that they are being ignored. This may be due to misperceptions, memory difficulties or problems processing information, but it may also be true.
- The person may become frustrated at not being able to complete tasks, e.g. making a cup of tea.
- There may be depression or other mental health problems.
- A carer's intentions may be misunderstood. For example, personal care may be seen as threatening or an invasion of personal space. Accepting help with intimate tasks such as washing, dressing or going to the toilet is understandably distressing and stressful.
- Others may assume that the person with dementia can no longer do things for themselves or leave them out of decisions that affect them. This can cause the person with dementia to become angry because they are not being listened to or are being ignored.
- The person may feel threatened by an environment that appears strange or unfamiliar. They may think that they are in the wrong place or that there are strangers in their home.
- People may have difficulties understanding and interpreting the world around them, and may experience a different sense of reality from others. For example, if the person believes that they need to collect their children from school, they may become aggressive if they are prevented from doing so.

## Reacting to Aggressive Behaviour

### At the time

- It is often necessary for you to make changes to how you approach the situation. It is important to adapt to the perspective and needs of the person with dementia. It can be frustrating but it is important to understand that reasoning or logical argument are unlikely to result in insight and change on the part of the person with dementia.
- Before you react, take a deep breath, step back to give the person space and take some time. You may need to leave the room until you have both calmed down.
- Try to stay calm and avoid any potential for confrontation. A heated response may make the situation worse.
- Try not to show any fear, alarm or anxiety, as this may increase the person's agitation – although if you feel threatened, this is easier said than done. If you do end up feeling threatened, call for help.
- Try not to shout or initiate physical contact – this could be misinterpreted as threatening behaviour. If the person's behaviour is physically violent, give them plenty of space and time. Unless it is absolutely necessary, avoid closing in or trying to restrain someone, as this can make things worse.
- Reassure the person and acknowledge their feelings.

- Try not to take the behaviour personally – the person is most likely trying to communicate a need, not attacking you on a personal level. If you find the cause of the behaviour, you may be able to prevent future incidents.
- Listen to what they are saying. This shows that you are not against them and that you want to help.
- Maintain eye contact and try to explain calmly why you are there. Encourage communication.
- Try to find out what is causing the behaviour.
- Try to distract their attention if they remain angry.
- Ask yourself if whatever you are trying to do for the person really needs to be done at that moment. If you are able to give them space, come back later and try again – you may be able to avoid a confrontation.

### **After the incident**

- Don't punish the person for their behaviour; try to carry on as normal and be as reassuring as possible.
- Focus on the person, not the behaviour that they displayed. They may still be upset and distressed after the incident.
- Take some time and talk through your feelings with others – for example, the GP, family, counsellor or dementia support worker.
- Bottling up your feelings may make it harder to care for the person with dementia and also mean that you find yourself focusing on the behaviour instead of the person.

### **Preventing and Managing Aggressive Behaviour**

Finding ways to prevent and manage the behaviour will improve the quality of life for both the person with dementia and the carer. It will also make the caring role easier. Working out what is causing the aggressive behaviour will make it easier to find a solution. It is important to consider the person's perceptions – whether accurate or not – when looking at ways to manage aggression. It can also help to tailor your communication with the person in ways that let them know that they are being listened to and respected.

To reduce or prevent aggressive behaviour, carers will need to look at the person as an individual and work out why they are behaving in a certain way. It is important to see what is happening from the perspective of the person with dementia and to identify the reason for the behaviour. The person with dementia is probably trying to communicate something and the challenge is to find out what it is and why. There is no 'one size fits all' solution, and carers will need to tailor their approach to each situation. They should use what they know about the person, including their personality, likes and dislikes.

## The Problem-Solving Approach

A problem-solving approach may help manage the aggressive behaviour.

The first step is to define the problem:

- Is it the behaviour of the person with dementia that is causing the problem?
- Is it the reaction or attitudes of other people?
- Is it the living situation?
- What are the other factors? Is the person in pain? Are they getting enough stimulation? Is the environment suitable?

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Next, you should consider the situation:

- Look at all the circumstances that might be contributing to the problem.
- When and where does the problem happen?
- Does the person always act in the same way in the same place?
- Does it always happen with the same person or in similar circumstances?
- Who are the other people involved? Visitors, a family member, a friend?
- Look for patterns in the behaviour. It may be helpful to make a diary of when aggressive behaviour occurs, noting down everything that was going on at that time that could have triggered the behaviour.

Assess the person in the situation. Are they:

- Unwell, in pain, uncomfortable?
- Overtired, overstimulated, bored, anxious or frustrated?
- Embarrassed, ignored, misunderstood, feeling patronised?
- Delusional, having hallucinations, depressed?
- Under-stimulated, lacking in social contact?
- In a suitable environment?

Use what you know about the person to think about whether they could be reacting to:

- An unpleasant incident or association
- Change
- A memory
- Provocation or a personality conflict.

Next, develop a strategy to manage the behaviour. Talk to the person with dementia and other people who they spend time with to come up with a plan. Start to make some changes and then assess whether or not they have made a difference to the person's behaviour. It might take some trial and error to find effective solutions. Look at making a range of changes, for example changing

the way that you talk to the person during care, as well as altering the environment. The person with dementia should always be at the centre of the solutions.

### **Possible solutions**

Make sure that the person has been checked for any physical problems that might be causing them to behave aggressively. Pain is common in people with dementia but it is often not recognised, even in formal care settings like care homes. Carers should look for signs that the person is in pain or discomfort, and look for things that could potentially cause the person pain.

Signs may include:

- Rubbing or pulling at a particular body part
- Facial expressions – looking scared or clenching their teeth
- Body language – are they huddled or rocking, for example?
- A change in appetite
- Being more restless
- New swellings or inflammations
- Having a temperature.

Causes may include:

- Infections including chest infections and urinary tract infections (UTIs)
- Existing injuries such as cuts or bruises
- Constipation
- Existing conditions such as arthritis
- Being in an uncomfortable position or being moved in an uncomfortable way
- Toenails or fingernails that need cutting
- Toothache, earache or problems with dentures.

The person should also have their hearing and eyesight tested, and get glasses or hearing aids if needed.

In the past, antipsychotic drugs were regularly prescribed for 'challenging' behaviours, including aggression. However, these can suppress the behaviour without addressing its cause, and may add to the person's confusion. There is now an effort to reduce prescriptions of these drugs so that they are only used when absolutely necessary. Non-drug approaches should be the first method for treating aggressive behaviour. Antipsychotics should only be used when there is evidence of psychosis (delusions or hallucinations) and the person with dementia is in severe distress, or immediate harm will be caused to them and/or anyone who cares for them. If these drugs are to be used, they should be regularly reviewed and monitored.

The following suggestions may help with aggressive behaviour, and should be tried before drug treatments.

**Communication** – One of the key ways to deal with aggressive behaviour is by using the information you have gained during the problem-solving approach to communicate and engage with the person in ways that are likely to manage the situation. The content, pacing and tone of words, along with good body language, are all important in helping the person feel they are being respected and listened to.

**Music** – Listening to the favourite music of the person with dementia may help to reduce aggressive behaviour. For example, if there is a certain time of day when the person tends to become aggressive, it may help to put on some music that you know they enjoy at that time. If a particular activity such as bathing can lead to the person behaving aggressively, put on some music before you begin.

**Social interaction and stimulation** – We all have a need to spend time with other people. Lack of social interaction can make someone feel bored, isolated and unhappy. Make sure that the person with dementia regularly receives some good one-to-one interaction. It could just be a chat or reading together, but it is important to have proper time for this, when the person with dementia can have your full attention. Planning new activities that you both enjoy, or adapting daily tasks so that the person can still take part in them, will help to keep the person stimulated. If you find something that works well, keep doing it.

**Reminiscence** – Reminiscence or life story activities involve recalling and talking about past experiences of the person with dementia. These should be positive and personally significant, such as a family event or favourite football match. They have been found to improve the mood of people with dementia, reducing the risk of aggressive behaviour. It is important to note that people may have negative memories as well as positive ones, and you should be prepared to support the person with both types of memories.

You could try making a memory box of photos and familiar items, which the person can go through with a friend or relative. Developing a life story book may also be an option. These help to keep the person with dementia at the centre of their care, as well as helping people see beyond the dementia.

What a person with dementia has to say about their life experiences is a great way of demonstrating their value as a person – both to them and you, and even when their memory storage system is inconsistent, to really engage with them while they remember happy times is therapeutic and valuable to you both. Old photographs are a great way to get going and since home and family (assuming it was relatively happy) is so central to all our lives, this may be a good place to start.

People with dementia can access a wealth of long-term memories although it works better if you can avoid direct questions. To help them, you can slip some facts into a comment while looking at (say) an old photograph, for example – "...oh look, there's your brother Peter – he looks nice in that jacket doesn't he, and there's Freddie the dog, he's looking very alert!"; now the person won't have the embarrassment of having forgotten the person's – or the dog's name, and the comment might lead to other memories.

**Changes to the environment** – Think about the person’s surroundings, as these will have an effect on their behaviour. It may be that you can make small changes to the home that will make it a better environment for the person with dementia. For example:

- Is there enough light?
- Is it too hot or too cold?
- Can the person with dementia find the toilet?

Making sure that the path to the toilet is free from obstacles and putting a sign on the toilet door with both pictures and words can help. It should also be clearly visible and in the person’s line of sight.

**Exercise** – Physical activity and exercise can help to reduce agitation, as well as improving sleep.

Other methods that may work include:

- Hand massage
- Aromatherapy
- Sensory stimulation such as nature sounds or familiar, repetitive actions such as folding clothes or sorting buttons
- Cognitive stimulation – this involves activities and exercises that are designed to improve memory and communication skills; they are based on day-to-day interests, reminiscence and information relating to the current time and place
- Light therapy or bright light therapy – this involves a person sitting in front of a light box that provides about 30 times more light than the average office light, for a set amount of time each day
- Animal-assisted therapy
- Doll or toy therapy
- Arts therapy (including dance, drama, drawing, painting).

## TRAINING & CONSULTANCY LTD

### Handling Troubling Behaviour

Some of the greatest challenges of caring for a person with dementia are the personality and behaviour changes that often occur. You can best meet these challenges by using creativity, flexibility, patience and compassion. It also helps to not take things personally and maintain your sense of humour.

To start, consider these ground rules:

**We cannot change the person.** The person you are caring for has a brain disorder that shapes who they have become. When you try to control or change their behaviour, you’ll most likely be unsuccessful or be met with resistance.

It's important to:

- *Try to accommodate the behaviour, not control the behaviour.* For example, if the person insists on sleeping on the floor, place a mattress on the floor to make them more comfortable.
- *Remember that we **can** change our behaviour or the physical environment.* Changing our own behaviour will often result in a change in the person's behaviour.

**Check with the doctor first.** Behavioural problems may have an underlying medical reason: perhaps the person is in pain or experiencing an adverse side effect from medications. In some cases, like incontinence or hallucinations, there may be some medication or treatment that can assist in managing the problem.

**Behaviour has a purpose.** People with dementia typically cannot tell us what they want or need. They might do something, like take all the clothes out of the closet on a daily basis, and we wonder why. It is very likely that the person is fulfilling a need to be busy and productive. *Always consider what need the person might be trying to meet with their behaviour—and, when possible, try to accommodate them.*

**Behaviour is triggered.** It is important to understand that all behaviour is triggered—it doesn't occur out of the blue. It might be something a person did or said that triggered behaviour or it could be a change in the physical environment. *The root to changing behaviour is disrupting the patterns that we create. Try a different approach, or try a different consequence.*

**What works today, may not tomorrow.** The multiple factors that influence troubling behaviours and the natural progression of the disease process means that solutions that are effective today may need to be modified tomorrow—or may no longer work at all. The key to managing difficult behaviours is being creative and flexible in your strategies to address a given issue.

### Wandering

People with dementia walk, seemingly aimlessly, for a variety of reasons. This could be because of boredom, medication side effects or to look for "something" or someone. They also may be trying to fulfil a physical need—thirst, hunger, a need to use the toilet or exercise. Discovering the triggers for wandering is not always easy, but they can provide insights to dealing with the behaviour.

- Make time for regular exercise to minimize restlessness.
- Consider installing new locks that require a key. Position locks high or low on the door; many people with dementia will not think to look beyond eye level. Keep in mind fire and safety concerns for all family members; the lock(s) must be accessible to others and not take more than a few seconds to open.
- Try a barrier like a curtain or coloured streamer to mask the door. A "stop" sign or "do not enter" sign also may help.
- Place a black mat or paint a black space on your front porch; this may appear to be an impassable hole to the person with dementia.
- Add "child-safe" plastic covers to doorknobs.
- Consider installing a home security system or monitoring system designed to keep watch over someone with dementia. Also available are new digital devices that can be worn like a



watch or clipped on a belt that use global positioning systems (GPS) or other technology to track a person's whereabouts or locate him if he wanders off..

- Put away essential items such as the confused person's coat, purse or glasses. Some individuals will not go out without certain articles.
- Have your relative wear an ID bracelet and sew ID labels in their clothes. Always have a current photo available should you need to report your loved one missing. Consider leaving a copy on file at the police department.
- Inform neighbours about the person's wandering behaviour and make sure they have your phone number.

## Agitation

Agitation refers to a range of behaviours associated with dementia, including irritability, sleeplessness, and verbal or physical aggression. Often these types of behaviour problems progress with the stages of dementia, from mild to more severe. Agitation may be triggered by a variety of things, including environmental factors, fear and fatigue. Most often, agitation is triggered when the person experiences "control" being taken from him.

- Reduce caffeine intake, sugar and junk food
- Reduce noise, clutter or the number of persons in the room.
- Maintain structure by keeping the same routines. Keep household objects and furniture in the same places. Familiar objects and photographs offer a sense of security and can suggest pleasant memories.
- Try gentle touch, soothing music, reading or walks to quell agitation. Speak in a reassuring voice. Do not try to restrain the person during a period of agitation.
- Keep dangerous objects out of reach.
- Allow the person to do as much for themselves as possible—support their independence and ability to care for themselves.
- Acknowledge the confused person's anger over the loss of control in their life. Tell them you understand their frustration.
- Distract the person with a snack or an activity. Allow them to forget the troubling incident. Confronting a confused person may increase anxiety.

## Repetitive Speech or Actions (Perseveration)

People with dementia will often repeat a word, statement, question or activity over and over. While this type of behaviour is usually harmless for the person with dementia, it can be annoying and stressful to carers. Sometimes the behaviour is triggered by anxiety, boredom, fear or environmental factors.

- Provide plenty of reassurance and comfort, both in words and in touch.
- Try distracting with a snack or activity.
- Avoid reminding them that they just asked the same question. Try ignoring the behaviour or question and distract the person into an activity.

- Don't discuss plans with a confused person until immediately prior to an event.
- You may want to try placing a sign on the kitchen table, such as, "Dinner is at 6:30" or "Lois comes home at 5:00" to remove anxiety and uncertainty about anticipated events.
- Learn to recognize certain behaviours. An agitated state or pulling at clothing, for example, could indicate a need to use the bathroom.

### Paranoia

Seeing a person suddenly become suspicious, jealous or accusatory is unsettling. Remember, what the person is experiencing is very real to them. It is best not to argue or disagree. These, too, is part of the dementia—try not to take it personally.

- If the confused person suspects money is "missing," allow her to keep small amounts of money in a pocket or handbag for easy inspection.
- Help them look for the object and then distract them into another activity. Try to learn where the confused person's favourite hiding places are for storing objects, which are frequently assumed to be "lost." Avoid arguing.
- Take time to explain to others that suspicious accusations are a part of the illness.
- Try nonverbal reassurances like a gentle touch. Respond to the feeling behind the accusation and then reassure the person. You might try saying, "I see this frightens you; stay with me, I won't let anything happen to you."

### Sleeplessness/Sundowning

Restlessness, agitation, disorientation and other troubling behaviour in people with dementia often get worse at the end of the day and sometimes continue throughout the night. Experts believe this behaviour, commonly called *sundowning*, is caused by a combination of factors, such as exhaustion from the day's events and changes in the person's biological clock that confuse day and night.

- Increase daytime activities, particularly physical exercise. Discourage inactivity and napping during the day.
- Watch out for dietary culprits, such as sugar, caffeine and some types of junk food. Eliminate or restrict these types of foods and beverages too early in the day. Plan smaller meals throughout the day, including a light meal, such as half a sandwich, before bedtime.
- Plan for the afternoon and evening hours to be quiet and calm; however, structured, quiet activity is important. Perhaps take a stroll outdoors, play a simple card game or listen to soothing music.
- Turning on lights well before sunset and closing the curtains at dusk will minimize shadows and may help diminish confusion. At minimum, keep a nightlight in the person's room, hallway and bathroom.
- Make sure the house is safe: block off stairs with gates, lock the kitchen door and/or put away dangerous items.
- As a last resort, consider talking to the doctor about medication to help the agitated person relax and sleep. Be aware that sleeping pills and tranquilizers may solve one problem and create another, such as sleeping at night but being more confused the next day.

## Bathing

People with dementia often have difficulty remembering “good” hygiene, such as brushing teeth, toileting, bathing and regularly changing their clothes. From childhood we are taught these are highly private and personal activities; to be undressed and cleaned by another can feel frightening, humiliating and embarrassing. As a result, bathing often causes distress for both the carers and the person.

- Find out what the person’s normal hygiene routine – did they prefer baths or showers? Mornings or nights? Did she have their hair washed at the salon or do it themselves? Was there a favourite scent, lotion or talcum powder they always used? Adopting—as much as possible—their past bathing routine may provide some comfort. Remember that it may not be necessary to bathe every day—sometimes twice a week is sufficient.
- If the person has always been modest, enhance that feeling by making sure doors and curtains are closed. Whether in the shower or the bath, keep a towel over their front, lifting to wash as needed. Have towels and a robe or clothes ready when they get out.
- Be mindful of the environment, such as the temperature of the room and water (older adults are more sensitive to heat and cold) and the adequacy of lighting. It’s a good idea to use safety features such as non-slip floor bath mats, grab-bars, and bath or shower seats. A hand-held shower might also be a good feature to install. Remember—people are often afraid of falling. Help them feel secure in the shower or tub.
- Never leave a person with dementia unattended in the bath or shower. Have all the bath things you need laid out beforehand. If giving a bath, draw the bath water first. Reassure the person that the water is warm—perhaps pour a cup of water over their hands before they steps in.
- If hair washing is a struggle, make it a separate activity. Or, use a dry shampoo.
- If bathing in the tub or shower is consistently traumatic, a towel bath provides a soothing alternative.

## Nutritional Needs

If someone has dementia, their eating and drinking habits should be carefully monitored no matter if they live in their own home or in an aged care home. This is because people with dementia may forget to eat and drink, and they may also find it difficult to chew and swallow. Here are a few tips to help you manage their eating and nutrition needs:

- Ask their doctor to check that there isn't a treatable cause of appetite loss, such as acute illness, depression or denture pain
- Offer snacks and meals regularly, perhaps trying 5-6 small meals a day
- Try an alarm or phone call to remind them about mealtimes
- Only serve one course at a time
- Serve foods that are familiar to them
- Avoid using plates with patterns

- Demonstrate chewing if this seems to be the problem, and eat with the person so that they can copy you
- If they're having difficulty with cutlery, perhaps serve them finger foods instead
- Consider nutrition supplements, particularly in later stages of dementia when people tend to lose a lot of weight. Ask a dietician or doctor about what supplements might be helpful
- Offer drinks regularly. This is particularly important in hot weather
- Encourage and find ways for them to participate in regular physical exercise.

### Continence Needs

When a person has dementia, their mental functions decline and this may result in incontinence (the term used to describe the loss of control of the bladder and/or bowel). This is because being in control of these functions depends on being aware of bodily sensations such as the feeling of having a full bladder and the memory of how, when and where to respond.

There are many ways to manage incontinence including respecting the person's privacy and dignity in what can be a humiliating situation. Here are a few tips to help you manage their continence needs:

- Observe patterns of when the person empties their bladder and/or bowel and use this pattern to remind them, at regular intervals, to go to the toilet
- Watch for non-verbal clues such as pulling on clothes and increased agitation, and when this happens, use short, simple words to suggest they go to the toilet
- Make sure the bathroom isn't too far away, the bed isn't too high to get in and out of, the toilet paper can be easily seen and the room the toilet is in is clearly marked
- Consider installing nightlights in the hallways and in the toilet to help them find their way to the toilet at night
- Install raised bars to help them get on and off the toilet
- Use clothing with elastic and Velcro waistbands so they can easily remove clothing and put it back on again
- Use continence aids and appliances such as pads if necessary
- Introduce regular low-caffeine drinks, a high fibre diet and a regular exercise routine.

### Additional Problem Areas

- Dressing is difficult for most people with dementia. Choose loose-fitting, comfortable clothes with easy zippers or snaps and minimal buttons. Reduce the person's choices by removing seldom-worn clothes from the closet. To facilitate dressing and support independence, lay out one article of clothing at a time, in the order it is to be worn. Remove soiled clothes from the room. Don't argue if the person insists on wearing the same thing again.
- Hallucinations (seeing or hearing things that others don't) and delusions (false beliefs, such as someone is trying to hurt or kill another) may occur as the dementia progresses. State simply and calmly your perception of the situation, but avoid arguing or trying to convince

the person their perceptions are wrong. Keep rooms well-lit to decrease shadows, and offer reassurance and a simple explanation if the curtains move from circulating air or a loud noise such as a plane or siren is heard. Distractions may help. Depending on the severity of symptoms, you might consider medication.

- Sexually inappropriate behaviour, such as masturbating or undressing in public, lewd remarks, unreasonable sexual demands, even sexually aggressive or violent behaviour, may occur during the course of the illness. Remember, this behaviour is caused by the disease. Talk to the doctor about possible treatment plans. Develop an action plan to follow before the behaviour occurs, i.e., what you will say and do if the behaviour happens around other adults or children. If you can, identify what triggers the behaviour.
- Verbal outbursts such as cursing, arguing and threatening often are expressions of anger or stress. React by staying calm and reassuring. Validate the person's feelings and then try to distract or redirect his attention to something else.
- "Shadowing" is when a person with dementia imitates and follows the carer, or constantly talks, asks questions and interrupts. Like sundowning, this behaviour often occurs late in the day and can be irritating for carers. Comfort the person with verbal and physical reassurance. Distraction or redirection might also help. Giving the person a job such as folding laundry might help to make them feel needed and useful.
- People with dementia may become uncooperative and resistant to daily activities such as bathing, dressing and eating. Often this is a response to feeling out of control, rushed, afraid or confused by what you are asking of them. Break each task into steps and, in a reassuring voice, explain each step before you do it. Allow plenty of time. Find ways to have them assist to their ability in the process, or follow with an activity that they can perform.

## References

Dementia Care

Age UK

Alzheimer's Society