

This document is provided for information purposes only and should not replace the use of other, more detailed definitions. The definitions below were drawn up in collaboration with Québec clinicians and experts. For further details or to access the tools for the deprescribing and appropriate use of antipsychotics, go to inesss.qc.ca.

Major neurocognitive disorders (NCDs), formerly known as *dementia*, are characterized by a marked cognitive decline from the previous level of functioning that compromises the individual's independence in daily life. The main subtypes of major NCDs are NCDs due to Alzheimer's disease, frontotemporal NCDs, Lewy body NCDs, vascular NCDs, and NCDs due to Parkinson's disease.

Beyond basic needs, persons with major NCDs and a low level of cognitive functioning sometimes have needs for social contact that they are not always able to express.

Adapted from: [American Psychiatric Association, 2013].

The behavioural and psychological symptoms of dementia (BPSD) encompass symptoms of disturbed perception, thought content, mood and behaviour that frequently occur in persons with major neurocognitive disorders. They include hallucinations, illusions, delusions, anxiety and depression or wandering, verbal and motor agitation, aggressive behaviours and resistance to care.

BPSD generally cause a strong sense of discomfort in those who experience them and are a source of misunderstanding and distress for the family and care providers. A person can have several BPSD (e.g., verbal agitation and insomnia), at the same time or at different times.

Adapted from: [Finkel and Burns, 1999].

The basic approach consists in adapting verbal and nonverbal communication strategies, the physical or social environment, and the pace of care to the needs and cognitive impairments of the individual with a major neurocognitive disorder (NCD). Specifically, this approach includes strategies and basic communication principles, such as validation, diversion, adapted active listening, the decisional strategy, touching, and refusal management.

The following explanations are aimed at providing a better understanding of the strategies in the basic approach:

- **Basic communication principles** adapted to the person's cognitive impairments are aimed at fostering cooperation and the establishment or maintenance of a harmonious relationship (e.g., get their attention before speaking to them, avoid startling them, ask them for permission, have a calm and cheerful attitude, slow down speech delivery, make a single request at a time, use short sentences and provide encouragement).
- **Environmental adaptation** is aimed at modifying (adding, moving or removing) something in the immediate environment in order to meet the individual's needs (e.g., lowering the sound on the television or adjusting the lighting).
- **Validation** consists in identifying the emotions expressed by the person during the occurrence of a behavioural and psychological symptom of dementia (BPSD), in acknowledging them and in allowing the individual to express them. This strategy is aimed at connecting with the person's reality and at reassuring them (e.g., someone who goes to the guard station repeatedly to say that they do not want to miss their train. You could say: *Don't worry. Your train is in 2 hours. We'll come to get you. We won't forget*).
- **Diversion** seeks to divert the person's attention from a situation that causes them discomfort or anxiety. This strategy redirects their attention to something positive in their personal history (e.g., pointing to a photo and saying: *I can really see from this photo how beautiful your daughter is*). Diversion relies on conversation or various actions. Using a tangible object generally increases the impact of diversion.
- **Adapted active listening** is aimed at fostering discussion by avoiding confrontation with the person and enables them to express themselves and to have a pleasant conversation. Adapted active listening focuses on the form of the conversation rather than its contents (e.g., whenever the person stops talking, to encourage them to continue expressing themselves, you could say: *Well, no kidding! or I can't argue with that!*).

- **The decisional strategy** consists in giving the person an opportunity to make choices that are within their ability (e.g., *Do you want to wear the blue dress or the green one?*).
- **Touching** may enable you to connect with the person and to establish a trusting relationship or comfort them when they are experiencing negative emotions or loneliness. It may be one of the only ways to communicate with certain individuals with severe cognitive impairment.
- **Refusal management** fosters a respectful resolution of situations where the person verbally or physically resists an intervention. Different strategies can be used to facilitate their acceptance of an intervention (e.g., changing the wording of the request, taking breaks, changing care providers). Managing a refusal often requires a group discussion before selecting an optimal solution.

The basic approach calls for the care providers, family and caregivers to adjust to the cognitive impairments and needs of the person with the major NCD. In their interactions with the individual, and to overcome a situation that could become problematic, they adjust their way of being and doing to stimulate the individual's openness, cooperation and all their personal resources. In their interactions and when providing care, the care providers take the person's values, preferences, beliefs, needs and abilities into consideration. In reality, the care providers and family members try to seize every opportunity for meaningful interaction.

Sources : www.capsulescpd.ca, www.oiiq.org, [Voyer *et al.*, 2009], [Bourque and Voyer, 2013], [Voyer *et al.*, 2013], [Voyer, 2017].

Reframing consists in analyzing a situation and looking at the behavioural and psychological symptom of dementia (BPSD) exhibited by the person from a fresh perspective by asking the following:

- In what way is the BPSD disruptive, *really*?
- What are its *actual* negative consequences?
- Who *actually* suffers the most from it (the individual or those around them)? and
- Is an intervention *really* necessary?

If the expression of BPSD can be reframed in such a manner as to no longer be perceived as a problem by the care providers, family, caregivers and other residents, no intervention will be necessary. If it cannot, consideration will be given to individualized nonpharmacological interventions to manage the BPSD.

Reframing requires the care providers, family and caregivers to change the way they view the BPSD (e.g., *In the end, we can tolerate his sticking out his tongue*).

This change in the way the BPSD is perceived may require those around the person to rethink their expectations, for example, with regard to respecting social conventions.

Sources : www.capsulescpd.ca, [Voyer *et al.*, 2009], [Bourque and Voyer, 2013], [Voyer, 2017].

Individualized nonpharmacological interventions are aimed at facilitating the management of behavioural and psychological symptoms of dementia (BPSD) when the basic approach and reframing are ineffective or insufficient. To be individualized, nonpharmacological interventions, such as music therapy and behavioural therapies, must take into account the person's biographical history, values, preferences and beliefs. Individualized nonpharmacological interventions also take into consideration the underlying causes, the person's unmet needs, their abilities, and the clinical objectives. The family and caregivers may be asked to help guide the choice of nonpharmacological interventions. These interventions may make communication, interaction with the individual, and understanding their reality easier. Lastly, they may target the person themselves, the staff, the family or the environment.

Individualized nonpharmacological interventions are established during interprofessional meetings and, if possible, in consultation with the family, caregivers or legal representative of the person with the BPSD. They need to be tailored according to the person, the causes of the BPSD and the objectives (reducing and preventing BPSD, improving or maintaining quality of life, keeping the individual in a comfort zone, etc.). Several such interventions may be necessary and carried out in tandem (e.g., music therapy and gardening). Some will have an immediate effect on the BPSD, while others may have a preventive effect against the recurrence of these symptoms.

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