CASE REPORT

Creative solutions for severe dementia with BPSD: a case of art therapy used in an inpatient and residential care setting

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ABSTRACT

Behavioral and psychological symptoms of dementia (BPSD) are common, distressing and compromise care. Their diverse etiology necessitates targeted, individualized treatment. We present a case of an 82-year-old with severe dementia and BPSD, and with limited response to a range of pharmacological and non-pharmacological treatments. Individualized art therapy was developed in an inpatient setting using felt material cut into shapes and coloring with stencils and pre-drawn line drawings utilizing preserved skills of coloring, while supporting frontal-executive and language deficits. The activity was replicable and carried over to the residential care setting and supported by family and professional carers.

Introduction

Behavioral and psychological symptoms of dementia (BPSD) are common, distressing and compromise care. Their diverse etiology necessitates targeted and individualized treatment, which usually involves a combination of pharmacological and non-pharmacological approaches. BPSD are difficult to treat irrespective of approach, and concerns about efficacy and safety of pharmacological approaches have led to concerted efforts to identify psychosocial treatments that confer demonstrable benefits, are acceptable to carers and patients alike and can be implemented in diverse care environments (O’Connor et al., 2009).

In severe dementia, the focus is on alleviating suffering and distress, often manifest as BPSD (Treloar, et al., 2010), the goal being to identify the cause of distress in order to target interventions. Paradigms for understanding the causes of BPSD include the Ummet Needs and Stress Threshold models which can be useful for selecting psychosocial treatments (O’Connor et al., 2009), and might underlie efficacy of some of the creative and sensory therapies for BPSD due to non-specific benefits of personal engagement, connectedness and respite from over-stimulation or boredom (O’Connor et al., 2009). Art therapy, which potentially addresses similar needs, has not been explored as an intervention for BPSD. We present a case of severe dementia in which art therapy was developed during inpatient care and carried through to residential care. The subject’s decision-making proxy gave written, informed consent to the publication of this case history.

Case study

Mrs D. was an 82-year-old nursing home resident with severe dementia with prominent frontal deficits and expressive dysphasia (Mini-Mental State Examination Score = 0). She had multiple admissions for BPSD manifesting as aggression, intrusive behavior, wandering and purposeless activity (e.g. stuffing objects down the toilet, breaking the cistern, ripping fixtures from walls). BPSD monitoring indicated no pattern in relation to timing, precipitant or relief. Pharmacological agents trialed with limited success included atypical antipsychotics, serotonin reuptake inhibitors, acetylcholinesterase inhibitors, memantine and anticonvulsants. She was currently on olanzapine and rivastigmine. Reversible infections and sources of discomfort were identified and treated. Non-pharmacological strategies trialed included doll therapy, distraction and scheduled activities such as walking and towel folding. She was so agitated that she often required the supervision of a nurse “special” (i.e. a nurse dedicated to a patient on a one-to-one basis over a whole nursing shift).
Assessment

After a period of assessment to monitor BPSD and identify strengths and deficits, a targeted, individualized art intervention was developed. It was hypothesized that the purposeless activity suggested a state of boredom, and the acts of aggression linked to feelings of isolation, alienation and frustration. Strengths were evident in visuospatial perception with an ability to recognize color and shapes and identify the location of objects in space. There was a higher than average artistic sensitivity when coloring in shapes, and dexterity in the manipulation of both pencils and paints, despite a lack of history of any premorbid interest or talent in artistic pursuits, apart from enjoying coloring-in activities with her children and grandchildren.

Intervention

Art therapy required no special environment, other than it being free from interruption. It was provided in the ward one to two days per week, individually and/or in group activities over five or six sessions for a minimum of one hour to a maximum of two hours, either by the art therapist or by the nurse “special” who was able to replicate some of the activities initially recommended by the art therapist.

To support her visuospatial function and pattern-making she was presented with felt material cut into a variety of shapes and colors, these being thicker and easier than paper to pick up for older hands, and a soft texture providing a self-soothing effect (Green Stewart, 2004). Stencils and pre-drawn lines provided her with structure and cuing to compensate for frontal-executive deficits and gave her scope to use her superior shading skills. It also stimulated self identity as a mother coloring with her children. Both activities provided cues for verbal interaction as well as exercising manual dexterity and eye–hand coordination (Galbraith et al., 2008).

The deficit in language ability required art materials to be identified and cues provided using body language and frequent eye contact, while deficits in executive function necessitated a demonstration of tasks in single steps with objects laid out sequentially.

She was easily engaged by the art therapist (GL), who observed Mrs D.’s motivation for the activity and Mrs D.’s recognition of her from activity to activity, possibly due to preserved visual memory and/or recall of a positive emotional experience, suggesting a capacity for a therapeutic relationship even within the context of severe dementia (Innes and Hatfield, 2001).

During her art making, Mrs D. was calm and focused. Once started, she was able to continue on her own until the limit of her attention span. She signaled when she was finished and showed gratitude, sometimes with a kiss on the cheek and a broad smile. Relationship resonated during contact time with the therapist who praised her achievements liberally.

While we did not formally measure the effects of the intervention on her BPSD between therapy sessions, we noted her calmness during the activity, and her positive states of emotion openly exhibited at the end of each session. On one occasion, she had spent two hours in the morning happily employed with art, then after lunch she became restless and wanted to pace. The special was able to lead her to the table (after some persuasion) and provide a drawing for her to color, once again distracting and calming her.

Clearly, the activity was replicable and able to be carried out by nursing staff in the absence of the art therapist, as well as being supported by the family who were eager to try psychosocial treatments.

The handover

Handover upon discharge to the nursing home ensured continuity of the individualized and targeted art therapy formulized for Mrs D. and to assist residential care staff in understanding her preferences and abilities. Staff responded with appreciation and the handover assisted in the settling in process. In the first week she was reported as co-operative and immediately interested in participating in the art making activity with a group of seven other residents. Once again her skills in color selection and precision were noted.

Discussion

There are several reasons why art therapy might be an appealing activity for those with dementia. First, the capacity for creativity continues even in those severely disabled by dementia (Cummings et al., 2008). Importantly, the progressive loss of visuospatial skills and less realistic depiction of subject matter does not necessarily mean that artistic quality is lost. Furthermore, depending on the particular pattern of deficits, spared cognitive functions can “release” creative areas leading to bursts of visual creativity. Some patients may still be able to retrieve internal imagery, while others who have lost the ability to create or copy images can still produce art by using remaining strengths in color or composition (Miller and Hou, 2004; Cummings et al., 2008). The practical import is that therapy should be tailored to patients’ strengths, yet clearly there will be patients who are too agitated or too dyspraxic to participate in art therapy. Certainly,
ensuring optimal engagement with such therapy would involve setting up the task and modeling the behavior (Cohen Mansfield et al., 2010).

Secondly, art therapy may provide a means of facilitating communication with those whose language deficits render them isolated and otherwise inaccessible to carers. Importantly, creative activities may foster selfhood and person-centered care (Innes and Hatfield, 2001) by creating images based on life stories that might not otherwise be accessed verbally. The creation of an artifact in an encouraging environment can promote positive social interactions and provide a sense of community, important in maintaining social function and promoting resilience (Galbraith et al., 2008).

Finally, art therapy may be a practically feasible and implementable intervention in diverse care environments. O’Connor et al. (2009) have recommended the testing of “simple affordable psychosocial interventions in community and residential settings”. That the benefits might be short-lived should not detract from their use, as the benefits of even those psychosocial interventions with an evidence base are similarly short-lived and often restricted to the duration of the activity (O’Connor et al., 2009). If we can provide relief from distress even for a short period, it is worthwhile.

Clearly, empirical investigation of the effect of art therapy on BPSD is needed; the best practice to meet quality standards is a randomly controlled trial using direct behavioral observation. However, the first step is to define a testable intervention. It is likely that our intervention had its success in the ability of the art therapist to discover and respond to a natural interest, and to design the task to suit the patient’s interest, manual dexterity and attention span – as well as giving positive reinforcement through human contact – rather than the activity per se. Thus, future work should be directed first to the development of empirical investigation for this process of individualized assessment and prescription of activity for such patients. We have initiated the first step of identifying a simple intervention that has appeal to both family and professional caregivers.

**Conflict of interest**

None.

**Description of authors’ roles**

Carmelle Peisah and Sharon Reutens were treating clinicians and contributed to the writing of the paper. Gabriel Lawrence provided the art therapy and contributed to the writing of the paper.

**References**


