

Special Article - Psychopathology in Older Adults

Diseases Related to Alzheimer's Disease and Alzheimer's Special Care Units (Scu): Mixed Results

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***Corresponding author:** Deboves P, Department of Psychology, University of Nice Sophia-Antipolis, France**Received:** June 15, 2015; **Accepted:** July 30, 2015;**Published:** August 05, 2015**Abstract**

Alzheimer's disease is, nowadays, the most common dementia as it would be at the origin of seven to eight dementias on ten. But it is not the only one we met in nursing homes: gathered today under the term "Alzheimer's disease and related disorders", other pathologies-frontotemporal degeneration, dementia with Lewy bodies, vascular dementia for more frequent-with the same type of symptoms but having a mechanism and different events, affect many patients and require careful thought for their support.

Dementia is usually accompanied by "Behavioral and Psychological Symptoms of Dementia (BPSD)", which may have detrimental effects on residents not suffering from this condition and worsen in environments over-stimulated by too crowded or noise. To support them, different units gradually emerge. Among them, the Alzheimer's special care units, small units, separate and distinct from the rest of the nursing home, provide a distinctive architectural environment, a program and a special caregiver for residents with a diagnosis of Alzheimer's disease or related disorders.

The present article proposes a reflection as for the care of the behavior disorders bound to the related diseases of the Alzheimer's disease in Alzheimer's special care units. Four clinical situations will put forward the deadlock and the indecision which can arise in the support of these residents in nursing homes.

Keywords: Dementia; Disorders related to Alzheimer's disease; Behavioral and psychological symptoms of dementia; Alzheimer's special care units

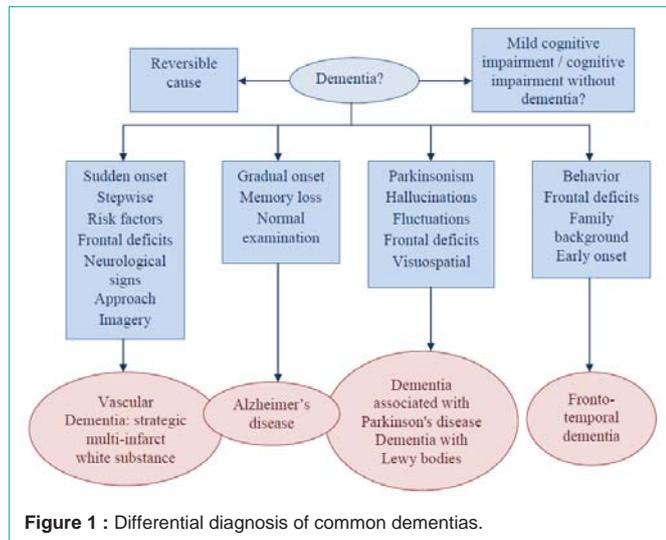
Introduction

The definition of dementia, clearly evolved since the Diagnostic and Statistical Manual of Mental Disorders IV (DSMIV) published by the American Psychiatric Association [1]. Indeed, in DSM 5 [2], the memory problems are no longer essential to get to this diagnosis. Also appears the notion of Neurocognitive Disorder (NCD), with a distinction made between "mild neurocognitive disorder" (more severe than the normal forgetfulness due to aging) and "major cognitive disorder" (the latter embodying dementia). In both cases, cognitive decline is significant in one or more cognitive domains, compared to a previous level of functioning. This decline must be suspected by the patient, a third party, or clinician. The criterion A of the "major neurocognitive disorder" indicates substantial impairment of cognitive performance that must be demonstrated by a standardized neuropsychological evaluation or other quantitative clinical evaluation, while infringement is modest as regards the "minor neurocognitive disorder". Things also differ as to the criterion B: if the cognitive deficits appearing during a major NCD prevent the subject from realizing alone daily activities, the cognitive deficits of minor NCD have meanwhile no significant consequence on the functioning of the subject. The criterion C is common to both levels of NCD and indicates that cognitive deficits do not occur exclusively during delirium. Finally, criterion D is also valid for both, announces that cognitive deficits are not better explained by another mental disorder (major depression, schizophrenia, etcetera). NCD can be owed to Alzheimer's disease, Parkinson's disease, Huntington's

disease, traumatic brain damage, prion disease (Creutzfeldt-Jakob disease), infection with HIV, or another medical condition and multiple causes; others can be led by a substance or a drug; others else can be frontotemporal, with Lewy bodies, vascular; Finally, others still remain unspecified.

Dementias are numerous; Alzheimer's disease is, nowadays, the most common dementia as it would be at the origin of seven to eight dementias on ten [3]. It is a neurodegenerative disease characterized by the progressive and insidious loss of multiple cognitive functions. But it is not the only one we met in nursing homes: gathered today under the term "Alzheimer's disease and related disorders" [4], other pathologies - frontotemporal degeneration, dementia with Lewy bodies, vascular dementia for more frequent [5] - with the same type of symptoms but having a mechanism and different events, affect many patients and require careful thought for their support (Figure 1). This last expression proposed, but also before it that of "Alzheimer-type dementia", quickly become a junk category, source of confusions: all dementias become Alzheimer's disease (AD). Nevertheless, related diseases does not mean similar. Furthermore, mixed pathologies are much more common than "pure" diseases, in particular Alzheimer's disease associated with vascular disease or dementia with Lewy bodies [5,6].

Dementia comes along generally with "Behavioral and Psychological Symptoms of Dementia (BPSD)", that the High Authority of Health defines as a set of "behaviors, attitudes or expressions disturbing, disruptive or harmful for the person or for



others, which can be observed in Alzheimer's disease and related diseases most [4]. It is essentially a question of:

- Opposition (verbal or nonverbal);
- Stirring (motor or verbal);
- Aggressiveness (physical or verbal);
- Aberrant motor behavior (wanderings, ceaseless gestures, gripping attitudes...);
- Disinhibition (unrefined remarks, improper sexual attitudes...);
- Shouts;
- Delirious ideas (persecution, abandonment, jealousy...);
- Hallucinations (visual, auditory, taste...);
- Arrhythmias stay up / sleep.

In order to establish the most adapted care for these "behavioral disorders", more and more numerous structures appear, including Alzheimer special care units, or the Reinforced Host Units (RHU), or still the Activities Poles and Adapted Care (APAC), etc.

The present article proposes a reflection as for the care of the behavior disorders bound to the related diseases of the Alzheimer's disease in Alzheimer's special care units. After a brief history of Alzheimer's special care units, four clinical situations will put forward the deadlock and the indecision which can arise in the support of these residents in nursing homes.

Alzheimer's special care units in nursing homes: history, characteristics, issues.

An Alzheimer's special care unit (still called "secure Alzheimer Unit") is a separate and different unit from the rest of nursing homes that separates and provides a special architectural environment, special program and trained caregivers for residents having a diagnosis of Alzheimer's disease or related.

In France, 23% of nursing homes had a specific unit Alzheimer in 2003, 25% in 2006 and 39% in 2011 [7].

The idea of Alzheimer's special care units emerged for the first time in the 60's in the United States. It is one of the most important innovations in nursing homes [8-10]. They knew a real development in the years 80-90 and continue to proliferate: after having tripled in number during the first ten years following their appearance [11], they are now reaching about 20% of establishments [12]. The first units operated as services of psychiatric hospitalization. They then developed according to the postulate that an adapted environment would lead to a decrease in the loss of functional autonomy and a better quality of life for residents [13]. In addition, some researchers advancing adverse consequences of the cohabitation between subjects with dementia and "healthy" subjects, mostly when behavioral problems were involved. These results moved forward dissatisfaction, anxiety [14] or mood disorders for "healthy" subjects [15].

At their appearance in the 80's, these smaller units, which focused on activities, addressed only subjects with dementia at a moderate stage [16]. Gradually, work was conducted around their therapeutic indications: limitation of physical restraint and use of psychotropic drugs, family involvement, and the accent was put on residents with Alzheimer's disease who presented behavior disorders [17]. Although no consensus has yet developed regarding the specifics of these units [17], things seem to be changing as some specific characteristics emerge concerning their operation:

1. Are invited to join Alzheimer's special care units the subjects affected by Alzheimer's disease or related diseases complicated with psycho-behavioral symptoms called productive, "annoying" or disruptive [18,19];
2. Is supported and recruited in sufficient number a nursing staff trained in neurodegenerative diseases, qualified, voluntary [18,19];
3. Are highlighted care project and personal project [18,19];
4. Is set up an aid program to the family caregivers in order to support and involve up to families [17,19-22];
5. Is privileged and reflected an environment physically modified, architecturally adapted and independent besides from the rest of the nursing home [18,19];

Studies agree to demonstrate a better physical health of residents in Alzheimer's special care units [23-25] and a lower risk of being hospitalized compared to residents outside these units [26,27]. Paradoxically, it is also observed an increased use of psychotropic drugs in these units compared to outside [17,28,29], results questioned by other authors (i.e. [25]) who observe a decrease of prescribing antipsychotics in the UCS.

If researchers admit a particularly high cost of Alzheimer special care units [17], it is nevertheless beneficial results that are identified: improved NPI scores [17], decrease in physical restraints [17,25], decline in the number of depressive episodes [17], better care with fewer pressure ulcers, less hospitalization, weight loss than in other units [30]. But longitudinal studies are scarce and it still lacks solid evidence to prove irrevocably these results [17] still controversial [31].

In addition, Alzheimer's special care units remain extremely heterogeneous; the criteria vary according to countries and within countries. For example, in the US in 2001, Gerdner et al. [32] study

twenty-four UCS and note that 24.9% have a suitable architecture, 63% offer activities, 41% have a defined care plan, 39% have a program “quality assurance”, 26% have a training program for staff and finally 25% offer support groups for family. Another example, in Spain with a study conducted in 11 establishments which explains that there is no difference between the care provided by Alzheimer’s special care units and out, and that the quality of life would be poorer in these units, according to the staff. The main difference between these units and out will be the clinical variable concerning orientation in Alzheimer’s special care units (severe cognitive and functional disorders, aggressive behavior). These results must take into account the absence of a clearly stated regulation on the special care units regulation in Spain [33].

If a work seems to be particularly made on the criteria of admission in the SCU, other authors also wondered about possible criteria of not admission in these units. Thus, Lebert et al. [34] proposes to exclude residents with psychiatric disease, other dementias as Alzheimer’s disease or a high level of dependence. Other research considering behavioral, nutritional, functional and ethical issues of subject with dementia to a severe stage as being the same regardless of the causal pathology, that is to say, whatever the type of dementia, and therefore, the answers to bring in terms of supporting people would be similar [19].

The clinical elements that follow will allow us to reflect specifically on the criteria for inclusion or exclusion of diseases related to Alzheimer’s disease in these units.

Clinical

Our establishment has an “Alzheimer unity secure life” being able to welcome nineteen subjects, mainly with Alzheimer disease or related diseases, with important behavioral disorders. It has a living area and a large dining room. It is particularly fitting for light therapy as well as a big screen with sound amplifier for broadcast documentaries in order to appease behavioral disorders.

Residents we will discuss below are mostly diagnosed in their medical record “Alzheimer-type dementia” or “Alzheimer’s disease and related disorders”. What reminds us a related disease to Alzheimer’s disease rather than a pure Alzheimer’s disease is the fact that memory problems are not the first in the clinical picture.

Mrs. O enters into nursing homes in January 2012 in a context of Dementia with Lewy bodies (DLB) (diagnosis by two neurologists).

The « major or mild neurocognitive disorder with Lewy bodies » is a condition associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, Lewy bodies, affect the brain, which can generate alterations in thinking, movement, behavior, or mood. Two modalities exist: the “probable mild neurocognitive disorder or major with Lewy bodies”, in which the subject has two core features, or one suggestive feature with one or more core features; or the “possible major or mild neurocognitive disorder with Lewy bodies”, in which the subject has only one core feature, or one or more suggested features. The core diagnostic features correspond to: (i) fluctuating cognition with pronounced variations in alertness and attention, (ii) recurrent visual hallucinations, well formed and detailed, (iii) spontaneous demonstrations of Parkinsonism

subsequently occurring decline cognitive. The suggestive diagnostic features are (i) a response to the sleep disorder rapid eye movement criteria and (ii) a severe sensitivity to antipsychotics [2].

The « major or mild neurocognitive disorder with Lewy bodies » may either occur by itself or with Alzheimer’s disease or Parkinson’s disease.

No details appear in Mrs. O file concerning the nature of the DBL.

Upon her arrival, Mrs. O presents a state of great confusion and intense anxiety. She trembles, teeth chatter, cries, says to be terrified without knowing why, that someone is going to hit her, etcetera. First granted in Alzheimer special care unit, the frame stabilizes her, calms her, even if she complains of shouts and wandering of residents overnight. She is also very aggressive toward residents and caregivers. A few weeks later, Mrs. O is really better: disappearance of confusion, less anxiety, but, however, major difficulties for her to live in this unit: she explains that shouts and blows of residents reactivate in her the same fears she experienced in the past (Mrs. O has experienced several injuries she obviously still had trouble developing).

Thus, at the end of a year, caregivers decided to bring her down in the open unit, with the risk that the symptoms reappear since the context is that of dementia with Lewy bodies and therefore the symptoms are very fluctuating [35].

For about two years, Mrs. O is undeniably better, actively participates in various workshops, often goes out with her daughter for shopping ... She remains hyper vigilant and fearful with residents suffering from dementia, but once reassured and surrounded, she is soothed.

A flip-flop occurs late 2014 when her daughter could no longer come to see her: Mrs. O is again in a state of confusion and intense anxiety (as with early, shaking, teeth chattering, crying, diarrhea, and insomnia). A slight lack of the word is to be noted, especially in moments of anguish. Mrs. O suffers because she is conscious of being in excess.

Since January 2015, Mrs. O’s condition deteriorated further. She is aggressive (verbally and sometimes physically) with residents suffering from dementia, including those without behavioral disorders. Their incoherent speech terrifies her (it happened, for example, that Mrs. O strikes a resident or she puts him / her with power in the elevator “out of [her] view”).

Delusions and hallucinations (visual) have become daily, with a focus on the evening meal: from early morning, she worries about not having his evening meal and catch everyone (staff and residents) she meets, who obviously generally avoids, gets upset against (the worst to do), or sends to the psychologist. The kitchen staff wants to get off, they are so tired of Mrs. O who tracks them (arrival, setting the table, etc.) and persecutes them (she tell them they are evil, they will not feed her, they are not doing their job, they will hit her, etc.) For many weeks the psychologist accompanies the resident on the crenel 5-6:30 p.m. since it is one of the most distressing for her. Small outings away from home still make her good. Caregivers are exceeded, repeating daily, “it is necessary to make something we cannot it any more”. A reminder concerning the pathology of Mrs. O is performed on every transmission.

In March 2015, things intensify again. Mrs. O no longer supports a caregiver tells him he cannot take care of her right now, she becomes aggressive. Even the presence of someone, is from now on not enough to appease anxious moments.

Since October, the antidepressant treatment was changed several times, but no change (the Seroplex® seems to have worked some time and more effects; bad reaction to Effexor®, Cymbalta® no effect); no neuroleptics because they are contraindicated in the case of DCL [35], but an anxiolytic treatment (Seresta® and Valium®). Mrs. O also takes the Ebixa®.

Mrs. O is now refusing to participate in any therapeutic activity which nevertheless formerly contained.

Redirect Mrs. O in Alzheimer special care unit is unthinkable when we see that only the fact of meeting residents suffering from dementia in open unit terrorizes and makes her aggressive.

At present, Mrs. O is temporarily in a neuro-psycho-geriatric ward at the failure of its management in nursing homes.

Mr. R is 88 years old and came into a nursing home in February, 2014 for "Alzheimer's disease and other dementias." He suffers, among others, from a severe renal disease. Mr. R knows "quiet" periods, that is to say without conduct disorder, and other more turbulent during which the agitation, aggressiveness (physical and verbal), and falls are very pronounced.

Mr. R stays about one year in the open unit. Everything goes well, except for a few periods of confusion which mainly occur in the late afternoon. One year later, confusion episodes multiply, like the agitation periods (diurnal and nocturnal wandering, pat the hands and thus awakes and frightens other residents, falls into the rooms..), of logorrhea, care refusal and falls that occur in substantial number. Risperdal® was administered without great effect.

Caregivers then decide to try a stay at the Alzheimer special care unit in order to appease behavioral disorders. Much to our surprise, Mr. R quickly becomes very coherent, respite to enter the residents' rooms, but ... However, he is very angry at "being locked in crazy", not to be able to walk into the nursing home as he pleases, and does not support the proximity of residents no longer able to feed themselves. He ceaselessly claims not to be like them. These situations generate physical aggression (he tries to strangle a resident of the unit that roams and enters the rooms) and verbal (insults caregivers and other residents).

Caregivers then find that Mr. R condition is worse in this unit and so propose to make him recovering his bedroom in open unit, because even if behavior disorders change, aggressiveness and violence have emerged and endanger other residents. For many months, Mr. R raises no more behavior problem. These then returns in the same way, with strong agitation, including a wandering which generates other falls. In front of the failure in Alzheimer's care unit, restraint was required because the falls, too numerous, became dangerous, but it only increased in number and intensity Mr. R's aggressiveness. When we offered him an accompanying time and so we could remove the restraints, he became calmer.

Mr. A is 81 years old. His wife referred to a nursing home because home support had become too complicated, Mr. A sleeping very

little and being very agitated. The diagnosis is that of "dementia". Upon entry, hallucinations and delusional elements punctuate his speech. First installed in the open unit, Mr. A is rapidly becoming the "terror" of the floor, as he wanders night and day, he enters the room residents day and night, he defecates and urinates sometimes ... A neuroleptic (Zyprexa®) is then tried but Mr. A reacts very poorly (increased confusion, restlessness). Alzheimer's special unit care is then proposed and accepted by the family, although fearful. Very quickly, the "aberrant motor behavior" (wandering, intrusion into the rooms) disappears; Mr. A even manages once again to go to the toilets alone. Hallucinations, particularly visual, persist. The narrative, she makes of it are very rich, the speech remains elaborate. Except these hallucinatory phases, Mr. A maintains a coherent speech. He often asks caregivers what it does "in crazy" and says he "knows he will die completely crazy, but it's like that." Mr. A, full of care for others, like taking care of the most dependent residents. The family has more trouble getting used to the unit because it is afraid of other residents (that's why she locks herself in the bedroom of Mr. A). But the richly elaborated discourse quickly gives way to a speech punctuated by low lexicology, what many questioned the family who establishes a link between the entry into Alzheimer's special care unit and the rapid deterioration of speech.

Mrs. U is 86 and is in a nursing home for about six months. She was admitted following several episodes of confusion / disorientation, whose hallucinations, which have sometimes caused to endanger (found alone in the bus several kilometers from home, etc.). Mrs. U claims not to remember these episodes confusions. His children indicate that it was very difficult for them to realize that their mother was wrong because, apart from these episodes, Mrs. U had a speech entirely constructed and coherent. She does not understand why his children oriented her in a nursing home, although some people have told him her hallucinatory episodes but she would like to know more details. In recent years, Ms U was quoted addicted to advertising (checks or large objects to win).

Mrs. U only stayed fifteen days in the open unit. Her growing behavior disorders (day and night wandering, insomnia, physical and verbal aggression) and the many falls have led caregivers to accompany Mrs. U in Alzheimer's special care unit. Within weeks, behavioral problems have almost disappeared, the nights are better (it still happens a few sleepless nights during which Mrs. U wanders a good part of the night) but falls are still very frequent.

Mrs. U is benevolent with other residents, she sometimes expressed incomprehension about their speech, think they are "crazy" but agrees to listen to them "because they need someone."

But once again, these changes seem to have operated in favor of a progressive loss of speech elaboration. Her current treatment includes, among other antidepressants (Venlafaxine®), an atypical antipsychotic (Xeroquel®) and a hypnotic (Zopiclone®).

Alzheimer's Special Care Units and Diseases Related to Alzheimer's Disease: Between Rebellion and Resignation

The four clinical situations have several similarities

On the one hand, it would that the frame of Alzheimer's special care unit influences the reduction even the disappearance of several

present symptoms for numerous weeks in the open units: wandering, intrusion in rooms, urinate and defecate outside toilets. The smaller units would reduce the risk of over-stimulation caused by too much noise due to too many residents and thus allow to lower agitation than the rest of the nursing home [36]. The numerous signaling systems, including pictograms symbolizing places, clearly seem to work. Moreover, not insignificantly, the number of caregivers is most important enabling better supervision for better support. In terms of wandering, research shows that multisensory treatment methods clearly influence the reduction of behavioral disorders: thus, light therapy [37] or music [4] (very present in the unit) may have soothing effects on anxiety related to the environment and thus reduce wandering.

On the other hand, our four residents alternate phases of confusion, hallucinations, which they tell not to remember once recovered consciousness; and other phases where the speech is coherent, built, where they sometimes evoke the awareness that “something is wrong”, that “the ideas are not clear.” These phases of realization are often (not to say always) extremely difficult for the subject who is aware that “sometimes [he] loses his head.” We have seen that Mrs. O and Mr. R, they generated a lot of aggressiveness. Why?

Be aware of symptoms without being able to avoid them, and live with people who suffer from it at a later stage, falls unheard of violence, because the subject is seen brutally in their place. This is unbearable.

Moreover, the real of dementia of other residents brutally comes to end an illusion on which each of us draws to live: the illusion of our immortality, of the infinitude of our ego.

The ego of the subject (here namely Mrs. O and Mr. R) then sees its part of finiteness while it previously deluded its infinitude. The residents suffering from dementia return them to a part of themselves, they see them ill, affected by decay. This argument directs us to Messy who spoke of “ego- hideousness” [38]. This “ego- hideousness” would come from the stage of the broken mirror, itself triggered by an aggressive tension during the early imaginary encounter of the own old age. Thus a death wish appears toward the other that alienates us (our best example is Mr. R strangling a resident). The ego of Mrs. O and Mr. R is threatened by the reality of dementia, which ends infinity and illusions of omnipotence of the ego. That is why they will defend themselves. Thus, following this, they are invaded by an irrational fear of dying.

The proximity of the physical and mental decline sounds like the materialization of the reality of death. Thus, the subject in need who requires help, embodies the addiction, disease, death coming, respite horror for both our residents who see them through the demented residents.

Dementia is therefore a painful reality testing that underscores the inevitability of finiteness and its premise, which is physical decline and / or cognitive.

In *Pulsions et destins des pulsions* [39], Freud brings the concept of “impulse” by defining it as “a conceptual boundary between the psychic and the somatic, psychic as representing excitations, from inside the body and reaching the psyche.” The more the excitement

increases, the more the feeling of displeasure increases; conversely, the more it decreases and the more the sensation of pleasure can be felt. This feeling of pleasure or displeasure comes to characterize the relationship between the ego and the object (provided that the purely narcissistic stage has been exceeded). What particularly interests us here is his explanation of a relationship Ego / object causing some displeasure, since we can associate the relationship between Mrs. O / Mr. R and other residents. That’s what Freud said: “When the object is a source of displeasure sensations, a trend tries hard to increase the distance between it and ego, to repeat its native attempted escape in front of the outside world, transmitter excitation. We feel the “abhorrence” of the object and we hate it; this hatred can then go to a propensity to aggression against the object, to an intention to annihilate it.”

Kristeva goes further on this notion of “abhorrence” and introduced the concept of “abjection”. The objection seems to be specific to each subject in front of a danger or something inconceivable for the ego. Kristeva says: “There is, in abjection, one of these violent and obscure uprisings of being against what threatens it and seems to come from outrageous outside or inside, thrown next to the possible, to the bearable, to the thinkable. It is there, very close, but unassimilable. It solicits, worries, fascinates the desire which does not let itself be seduced. Frightened, it turns away. Sickened, it rejects. An absolute protects it from opprobrium, it is proud of, it sticks to. But at the same time, though, this momentum, this spasm, this jump is attracted to another place as tempting as doomed. Tirelessly, as indomitable boomerang, a call and abhorrence pole puts the one who is literally by it lived out of him [40].” The author speaks of an “abhorrence, [a] retch which digresses and turns away from the sully, the cloaca, the unclean. [...] Fascinated spurt which leads me and separates me from it [40].” The feeling of abjection can be divided into two phases within indisputable conflict ambivalence: abhorrence and fascination. The ego is thus cleaved: in an attempt to control anxiety, two simultaneous and opposite reactions occur. One considers the frustrating reality, the other looks for satisfaction. Abhorrence is a violent impulse. The object of abjection is then felt as a threat against which it is necessary to protect itself by rejecting it. This is of dementia and its manifestations. This observation of Kristeva can be linked to what Freud said by evoking displeasure: “The largest part of the displeasure we experience is indeed displeasure caused by perceptions. It can be the perception of the push of unsatisfied impulses or of an external perception, that could be painful in itself or that it awakens in the psyche unpleasant expectations and be recognized by it as “danger” [40].”

The fascination phase is due to its well: when Psychoanalysis speaks of object it refers to object of desire. Thus the object of abjection is not so abject than that, it asks, and our deeper nature, although “disgusted”, sublimate the image.

Faced with Alzheimer’s disease or related diseases, the stage of the fascination is very rarely achieved. Blocked at this image of decline and at the call of death, it causes, Mrs. O and Mr. R, overwhelmed by anxiety, will set up various defense mechanisms to protect their ego from the “danger” that they feel. It is not so much the symptoms manifested by dementia that threatens but rather the threat of their identity which is at stake.

Violence, aggressiveness, and indifference so allow to reject this painful and disturbing certainty of finiteness of the ego, suddenly propelled by the real of the dementia process. The frustrating image of decline invading Mrs. O and Mr. R puts back them immediately in what Kristeva calls the first phase of abjection: abhorrence. Horror and disgust so seize them who, strongly worried, try to defend themselves of this image by all means, and, at the same time, of demented subject in its entirety. Thus he will be rejected, denied, and even abused because he refers to something terrifying and unbearable for their ego. This aggressiveness made impossible the preservation of these two residents in the Alzheimer's special care unit.

As far as Mr. A and Mrs. U are concerned, consciousness phases does not rhyme with aggressiveness. Resigned or fascinated (as Kristeva suggested second step of abjection?), they both seem to find appeasement in the assistance provided to other residents. Is it the same help they would have if indeed they became "crazy" too? The important point to note, Mr. A and Mrs. U showed a striking alteration in speech.

As we have said, Alzheimer's special care unit is thought to house residents with Alzheimer's disease at an advanced stage, with behavioral disorders. Therefore, the proposed activities are less pronounced on cognitive demands, but rather on daily activities reminiscent those of the home (kitchen aid, access to a garden, help for single household activities like sweeping the floor) which would help, in combination with appropriate care, to a decrease in negative feelings, a lesser decline in functional capacity, and increased interest in the environment [13]. Weekly activities related to music are by far the most frequently organized. Then come some simple activities for cognitive rehabilitation and physical mobilization activities (e.g., ball games). When residents do not participate in collective activities, an individualized program is then implemented according to the resident or his past habits, or according to their current interests, or both. Finally, for residents with advanced disease, an accompaniment based on nonverbal communication is proposed [41]. In this case, well-being activities (reflexology, touch-massage, manicure ...) are often suggested. We see then that for residents suffering from diseases related to Alzheimer's disease, whose cognition fluctuate, but sometimes, still in good condition, the proposed activities are insufficient to do even a maintenance of cognitive abilities. In addition, other residents of the unit are usually at an advanced stage of their disease, many of them suffer from aphasia or significant alterations of speech. Therefore, it is difficult for our residents to have a built conversation.

Furthermore, assist a resident who suffers from a condition that Mr. A and Mrs. U would likely have perhaps could be a way to deny it, because in a helping relationship, there is always a caregiver and a dependent. Taking the place of the caregiver allow to close eyes to the dependence that is gradually settling.

Conclusion

To conclude, the criterion of inclusion of diseases related to Alzheimer's disease in the Alzheimer's special care unit is extremely tricky, because if the reassuring, mothering and protective framework reduces some behavioral problems, it seems to be at the origin of the occurrence of other disorders (Mrs. O and Mr. R). In addition, the income earned on the disappearance of some symptoms turns into

a disadvantage when we think of the fast and increasing speech alterations following the entry into USA (Mr. A and Mrs. U). Personal project and remaining capacity of the subject must be clearly and precisely defined to best adapt the care and the proposed daily activities. Thus, as Lebert et al. [34], we would rather think it is better to avoid directing these subjects in Alzheimer's special care unit. Perhaps it would be wise for institutions with multiple Alzheimer's special care units, to differentiate the clinical situations and so to distribute the residents according to their pathology (i.e., one unit for Alzheimer's disease, another one for diseases related; or the different units depending on the progress of cognitive impairment).

These related diseases can also be a deadlock when we think about, for example, Mrs O and Mr R who were unable to find their place either in open unit or Alzheimer's special care unit.

The relevance of Alzheimer's special care unit in the care of related diseases to Alzheimer's disease remains debatable.

Just like the relevance to maintain subjects at the end of life in these units...

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