Wandering: A Significant Problem Among Community-Residing Individuals With Alzheimer’s Disease

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This study evaluated the frequency, predictors, and effects of wandering in a population-based sample of 193 individuals with Alzheimer’s disease (AD). Although wandering occurred in subjects at all levels of cognitive impairment, analysis of variance indicated that for the group as a whole, greater frequency of wandering was associated with significantly more impairment in cognition, day-to-day functioning, and behavior. Caregiver distress also increased significantly with increased frequency of wandering. Logistic regression modeling identified functional impairment and disruptive behavior problems as the strongest independent predictors of wandering occurring within the past week. Cluster analysis revealed four characteristic groups of wanderers that represented a continuum of wandering frequency, each having a unique pattern of other behavioral disturbances. Based on this analysis, we recommend further evaluation and the development of possible treatment strategies that address the individual differences found among AD patients who wander.

COGNITIVELY impaired individuals who wander pose a danger to themselves and are of considerable concern to their care providers and family members (Baker, Kokmen, Chandra, & Schoenberg, 1991; Buchner & Larson, 1987; Cooper, Mungas, & Weiler, 1990). The fear that a person with dementia will wander away from home and become lost has led many caregivers to search for systems to enable them to monitor the individual, including latches and alarms on doors, barricading or disguising exits, and constant personal supervision. In addition, concern about wandering in other settings, such as in shopping centers or on outings into the community, may lead caregivers to restrict both their own activities and the activities of their care recipient. The situation is complicated by the variability of wandering both between and within individuals. For example, prior research with dementia patients in nursing homes indicates that at times and in some individuals, wandering may be related to exit-seeking (attempts to leave an undesired living situation); in others, wandering may be triggered by a desire for social interaction; and in others it may be best understood as a type of "exercise behavior" triggered by restlessness or lack of activity (Algase, 1992a; Monsour & Robb, 1982; Rader, Doan, & Schwab, 1985; Thomas, 1997).

Concern about wandering in community-residing individuals with AD has led to the establishment of a nationwide network, the Safe Return program, run by the National Alzheimer’s Association (Mills, 1995; Silverstein & Flaherty, 1996). Despite these precautions, news reports regularly describe instances where individuals with dementia wander away, become lost, and are injured or even die as a result of injuries or exposure. For all these reasons, wandering has been identified as a major reason for institutionalization of individuals with AD (Corey-Bloom & Gasasko, 1995; Rockwood, Stolee, & Brahim, 1991).

In the past, in institutional care settings, residents who wandered or left the facility were physically restrained or medicated to control wandering. However, research has demonstrated that such strategies may place the patient at increased risk of injury and may actually increase, rather than decrease, restlessness, agitation, and wandering (Maas, 1988; Raskind, 1989; Wragg &Jeste, 1988). Wandering has been managed in facilities by modifying the physical environment (e.g., disguising exits, providing circular wandering paths within the unit, or providing pictures on hallway walls to attract the attention of wandering residents) (Coltharp, Richie, & Kaas, 1996; Namazi, Rosner, & Calkins, 1989), by placing wanderers in special residential units and providing activity programs designed for individuals with AD (Maas, 1988), and by using electronic alarm systems to monitor the resident’s movements on the unit (Musallam, Cirelli, & Cascio, 1995).

Most research on wandering has focused on nursing home or dementia clinic-based samples. In these samples, wandering occurs in up to 65% of patients at some point in the disease process. Wandering is related to both severity of cognitive impairment and rate of cognitive decline (Algase, 1992b; Cooper & Mungas, 1993; Cooper et al., 1990; Miller, Tinklenberg, Brooks, Penn, & Yesavage, 1993; Walsh, Welch, & Larson, 1990). No information on wandering is available, however, on individuals with dementia, living at home in the community, who are not seeking dementia-specific clinical care. Nor is empirical information available to help identify which community-residing patients are at risk for wandering prior to the behavior’s occurrence, or to determine at what point caregivers need to take precautionary measures to prevent dangerous wandering.

The purposes of this study were to evaluate frequency of wandering behavior in a community sample of individuals diagnosed with Alzheimer’s disease, to examine demo-
graphic, cognitive, functional, and behavioral differences between wanderers and nonwanderers, and to identify predictors that will help determine which individuals are most likely to wander. In addition, the current investigation evaluates caregivers’ reports of how stressful they found their patients’ wandering behavior, and provides data to assist in the development of possible approaches to behavioral management of wandering in community-residing individuals.

**METHOD**

Subjects were individuals diagnosed with probable or possible Alzheimer’s disease, who were enrolled in the Alzheimer’s Disease Patient Registry, a registry of enrollees of a large health maintenance organization (HMO) in the greater Seattle area (Larson et al., 1990). The primary goal of the registry is to enroll all patients detected by their primary care physicians or other providers to have new dementia symptoms or complaints (e.g., memory loss, confusion, wandering). On identification, these patients were given a complete, standardized physical, neurological, and neuropsychological examination, after which a diagnosis based on criteria recommended by the National Institute of Neurological and Communicative Disorders and Stroke-Alzheimer’s Disease and Related Disorders Association (NINCDS-ADRDA; McKhann, Drachman, Folstein, Katzman, Price, & Stadlan, 1984) and the Diagnostic and Statistical Manual of Mental Disorders (DSM3R and DSM4; American Psychiatric Association, 1987) was given in a consensus conference. Since 1987, 1,028 individuals have been enrolled in the patient registry, 366 of whom have been diagnosed with probable AD (Larson et al., 1990). Of these, 193 subjects had a caregiver available who saw the subject at least once a week and completed a checklist assessing the frequency of behavior problems during the prior week. These subject-caregiver pairs constitute the current sample.

The mean age of subjects was 76.8 years (SD = 6.9; range 53–93), and 51% were men. Twenty-five percent had less than a high school education and 44% had additional education after high school. Eighty-nine percent of subjects were Caucasian, 7% were African American, and 3% were Asian/Pacific Islanders. Seventy-five percent lived with a spouse, who was the informant for the current investigation. Fourteen percent lived alone, and 6% lived with an adult child; for both these groups, an adult child was the informant. The remaining 5% of subjects shared a home with another person, such as a friend or sibling, who acted as the informant. The mean age of informants was 68.1 years (range 34–94), 34% were men, and 66% were women.

**Measures**

The *Mini Mental State Exam* (MMSE; Folstein, Folstein, & McHugh, 1975) is one of the most widely used screening instruments for cognitive impairment. It provides a total score, ranging from 0 to 30, with lower scores indicative of greater cognitive impairment, and was used to provide an overall assessment of cognitive functioning. In this sample, the mean MMSE score was 17.4 (SD = 7.1; range 0–29).

The *Blessed Dementia Rating Scale* (BDRS; Blessed, Tomlinson, & Roth, 1968), a measure of cognitive and functional impairment, was used to evaluate daily functioning. It includes 11 items that assess patients’ abilities to perform household chores, find their way around familiar streets, make change, and dress themselves. Scores can range from 0 to 17, with higher scores indicating greater impairment. Scores of 2 or higher are indicative of clinically significant functional impairment. The mean BDRS score of subjects in this sample was 4.7 (SD = 3.1; range 0–15).

The *Revised Memory and Behavior Problem Checklist* (RMBPC; Teri et al., 1992) was used to provide an overall assessment of behavior problems, as well as an assessment of specific areas of problems, including memory, depression, and disruption. It consists of 24 items, and is completed by the caregiver about the patient. Caregivers rated the frequency of each behavior problem during the past week on a scale of 0 (never occurred), 1 (occurred infrequently), 2 (occurred 1–2 times in the past week), 3 (occurred 3–6 times in the past week), and 4 (occurred daily or more often). Scores for memory, depression, and disruption were calculated separately by summing the items on each subscale, and then dividing by the number of responses on the subscale. Subscale scores can range from 0 to 4, with higher scores indicating greater frequency.

Wandering was assessed in the same manner described for behaviors on the RMBPC. Caregivers were given a list of potential behavior problems, one of which was “wandering or getting lost,” and were asked to rate the frequency of the problem during the past week on a scale of 0 (never occurred), 1 (occurred infrequently), 2 (occurred 1–2 times in the past week), 3 (occurred 3–6 times in the past week), and 4 (occurred daily or more often). Caregivers also rated their own reactions to their patient’s wandering by indicating how much the behavior “bothered or upset” them when it happened, on a scale of 0 (no distress) to 4 (severe distress).

In this sample, 124 subjects had never wandered, 46 subjects had wandered at least once but not within the past week, 10 subjects had wandered 1–2 times during the past week, 3 subjects had wandered 3–6 times during the past week, and 10 subjects had wandered daily or more often during the past week. Because of the small number of subjects in each of the last three categories, these subjects were combined into a single group. The characteristics of subjects in the three combined categories were similar (demographics, MMSE, BDRS, and RMBPC were not significantly different), and caregivers of these subjects expressed comparable levels of distress about wandering (mean distress ratings were 2.5 for subjects who had wandered 1–2 times, 2.7 for subjects who had wandered 3–6 times, and 2.9 for subjects who had wandered daily or more often; these scores were not significantly different, and indicated “very much” distress in each group). Thus, for the analysis, subjects were classified as nonwanderers, infrequent wanderers, and frequent wanderers.

**Statistical Analysis**

First, demographic, cognitive and behavioral differences among nonwanderers, infrequent wanderers, and frequent wanderers were evaluated using ANOVA, and post hoc pairwise comparisons were conducted (with the Bonferroni correction for multiple comparisons) to clarify the results of
the omnibus ANOVA tests. Second, to evaluate caregiver distress about wandering, Kendall’s tau b correlation coefficient was used to measure the association between frequency of wandering and caregiver reaction ratings. Third, logistic regression modeling (Hosmer & Lemeshow, 1989) identified demographic, behavioral, functional, or cognitive characteristics that independently predicted the occurrence of wandering at least once a week. Finally, an exploratory cluster analysis was conducted to examine behavioral profiles of individuals who wandered, to identify possible causes and treatments of wandering. The Lance-Williams flexible beta method was used for this analysis (Lance & Williams, 1967). In this method, beta is a parameter that can be varied to control the degree to which subjects form new groups, rather than join existing groups. For this analysis we used beta = -0.25, because taxonomy was sought and outliers were not an issue.

**Results**

In the current population-based sample, three categories of wanderers were identified: 124 (64%) subjects had never wandered (nonwanderers), 46 (24%) subjects had wandered at least once but not within the past week (infrequent wanderers), and 23 (12%) subjects had wandered within the past week (frequent wanderers). Table 1 describes the cognitive, functional, and behavioral characteristics of the three groups. Significant differences in cognition, function, and behavior were found among the three groups. Wandering was associated with lower MMSE scores \(F(2,186) = 12.31, p < .01\), greater functional impairment on the BDRS \(F(2,188) = 26.08, p < .0001\), and higher levels of behavioral disturbance on all three subscales of the RMBPC: Memory \(F(2,190) = 17.85, p < .0001\), Disruption \(F(2,190) = 12.31, p < .0001\), and Depression \(F(2,190) = 6.56, p < .01\). Post hoc comparisons indicated that nonwanderers were significantly less demented and less depressed than frequent wanderers; functional impairment was significantly different for all three levels of wandering (with greater impairment among more frequent wanderers); memory-related behavioral problems were significantly greater for both infrequent and frequent wanderers than for nonwanderers; and disruptive behavior problems were significantly greater for frequent wanderers than for infrequent or nonwanderers. There were no significant demographic differences in age, education, gender, living situation, marital status, or informant relationship. In addition, subjects who wandered were no more likely to have fallen since the onset of dementia symptoms than subjects who did not wander. Twenty-seven percent of subjects in the sample had reportedly fallen since the onset of their dementia symptoms, regardless of frequency of wandering.

To evaluate how stressful wandering was for the caregivers of these patients, informant reaction ratings for patients who had wandered at some time \(N = 69\) were examined. Results of this analysis are shown in Table 2. As can be seen, over half of these caregivers reported experiencing at least moderate levels of distress about wandering, and the level of distress increased significantly as the frequency of wandering increased (Kendall’s tau b correlation = 0.40, \(p < .001\)).

To identify potential variables that could predict which subjects were at highest risk of wandering, a stepwise multiple logistic regression analysis was conducted. Potential predictor variables included demographic characteristics (age, greater than high school education, living with spouse, gender, and married), and cognitive, functional and behavioral status (MMSE, BDRS, and RMBPC subscale scores). Outliers were examined, but none had a strong influence on the model. In this analysis, the strongest predictor of wandering within the past week was the BDRS score, with an odds ratio of 1.4 (95% CI = 1.2 to 1.6) for a one point change in the BDRS. The RMBPC disruption subscale was the only other variable that added significantly to the model, with an odds ratio of 2.9 (95% CI = 1.4 to 6.0).

The BDRS includes two items that intuitively appear to be related to wandering, and on statistical examination had a small but significant correlation with the frequency of wandering: finding one’s way about indoors (Spearman \(r = .26\) and finding one’s way about familiar streets (Spearman \(r = .21\)). It appeared plausible that those two items alone might account for the relationship between the BDRS and wandering status. However, when the two items were omitted from the BDRS, a score based on the remaining items was a significant predictor of wandering in the past week. Thus, it appears that adjusting the BDRS score is unnecessary, and the best predictors of wandering in this sample were overall level of functional impairment along with the frequency of other disruptive behaviors.

Finally, the relationship between wandering and other behavioral disturbances was evaluated in more detail with a cluster analysis. This analysis was designed to identify whether subjects who had wandered would constitute sub-

### Table 1. Means (SD) for Cognitive and Behavior Scores by Frequency of Wandering

<table>
<thead>
<tr>
<th>Scale</th>
<th>Never (n = 124)</th>
<th>Infrequent (n = 46)</th>
<th>Frequent (n = 23)</th>
<th>Significant Post Hoc Comparisons*</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE</td>
<td>18.6 (6.7)</td>
<td>16.0 (7.1)</td>
<td>13.5 (7.6)**</td>
<td>N-F</td>
</tr>
<tr>
<td>BDRS</td>
<td>3.7 (2.6)</td>
<td>5.7 (3.2)</td>
<td>7.9 (2.8)**</td>
<td>N-I; N-F; I-F</td>
</tr>
<tr>
<td>RMBPC</td>
<td>Memory</td>
<td>2.1 (1.0)</td>
<td>2.7 (0.9)</td>
<td>3.2 (0.6)**</td>
</tr>
<tr>
<td></td>
<td>Disruption</td>
<td>0.4 (0.5)</td>
<td>0.5 (0.6)</td>
<td>1.0 (0.7)**</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>0.6 (0.7)</td>
<td>0.8 (0.8)</td>
<td>1.2 (0.8)*</td>
</tr>
</tbody>
</table>

* = Never, I = Infrequent, F = Frequent.

*p < .01; **p < .001.

### Table 2. Caregiver Reaction Ratings by Wandering Frequency*

<table>
<thead>
<tr>
<th>Reaction Rating</th>
<th>Infrequent (n = 43)**</th>
<th>Frequent (n = 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>13 (30%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>A little</td>
<td>12 (28%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Moderately</td>
<td>9 (21%)</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>Very much</td>
<td>6 (14%)</td>
<td>6 (26%)</td>
</tr>
<tr>
<td>Extremely</td>
<td>3 (7%)</td>
<td>8 (35%)</td>
</tr>
</tbody>
</table>

*Kendall’s tau b correlation = 0.41, p < 0.001.

**Three caregivers did not provide a reaction rating.
groups, or clusters, representing different constellations of behavioral disturbances. The identification of such subgroups might provide a basis for the development of recommendations for intervention depending on the level and type of behavioral disturbance. Three depressive behaviors (crying, appearing sad or depressed, and sitting alone for long periods of time) and three disruptive, agitated behaviors (waking family members at night, being constantly restless, and appearing anxious or worried), were selected for this analysis. These behaviors were selected because: a) they represent behaviors commonly seen in AD patients; b) they were measured by direct caregiver observation and were not dependent on patient language ability, thus they could be assessed in even the most severely demented subjects; c) they were identified in the literature as being rejects with a mean MMSE of 19, who had reportedly wandered infrequently (mean wandering score = 1.3), and exhibited relatively few other behavior problems. Cluster 2 included 18 subjects with a mean MMSE of 13, who also wandered infrequently (mean wandering score = 1.5) and had relatively low levels of other behavior problems, but who had a much higher frequency of sitting alone for long periods of time and were more functionally impaired on the BDRS. Cluster 3 consisted of 13 subjects with a mean MMSE of 12, most of whom had wandered at least once in the past week (mean wandering score = 1.9). These subjects exhibited higher levels of anxiety and depression than those in Clusters 1 and 2. Finally, Cluster 4 consisted of 12 subjects also with a mean MMSE of 12, who exhibited the highest levels of wandering (mean score = 2.5), the greatest functional impairment, and the highest levels of behavioral disturbance on all three subscales of the RMBPC.

**DISCUSSION**

This article provides new information about the frequency and predictors of wandering in a community residing, population-based sample of individuals with Alzheimer’s disease. In contrast to earlier studies, the subjects in this study had not come to a clinic for cognitive or behavior problems, nor had family members explicitly sought medical assistance in caring for them. Thirty-six percent of these subjects had wandered or gotten lost at some time since memory problems had been identified, and 12% had wandered in the past week. There were no differences in the frequency of wandering among male and female subjects, nor among ethnic groups, age groups, or individuals in different community living situations. What did differentiate nonwanderers, infrequent wanderers, and frequent wanderers was the overall level of cognitive, functional, and behavioral disturbance, with wanderers exhibiting greater impairment in all areas.

Although this study found that wandering is more common among individuals with greater cognitive impairment, results also indicated that wandering does not occur in isolation from other behavioral disturbances and is not caused simply by cognitive decline. Indeed, considerable variability in wandering existed among individuals at all levels of cognitive impairment. Many subjects (53%) with severe cognitive impairment (MMSE ≤ 10) had never wandered and a number of individuals (20%) with relatively mild cognitive impairment (MMSE ≥ 24) had wandered. Assessments of day-to-day functioning (the BDRS) and of disruptive behavior (the RMBPC Disruptive Subscale) were better predictors of wandering than the MMSE.

Further, this article provides preliminary information

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**Table 3.** Spearman Correlations Between Wandering and Other Behavioral Disturbance

<table>
<thead>
<tr>
<th>Specific Behaviors Used in Cluster Analysis</th>
<th>Wandering</th>
<th>Spearman r</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waking others</td>
<td>.39</td>
<td>&lt;.0001</td>
<td></td>
</tr>
<tr>
<td>Constantly restless</td>
<td>.22</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>Anxious and worried</td>
<td>.20</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>Crying</td>
<td>.22</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>Sad or depressed</td>
<td>.15</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>Sitting alone</td>
<td>.23</td>
<td>&lt;.01</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Frequency of other behavioral disturbances in four clusters of subjects who had wandered at least once.

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**Table 4.** Means (SD) for Cognitive and Behavior Scores by Cluster

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cluster 1 (n = 23)</th>
<th>Cluster 2 (n = 18)</th>
<th>Cluster 3 (n = 13)</th>
<th>Cluster 4 (n = 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE</td>
<td>18.65 (5.5)</td>
<td>13.39 (6.8)</td>
<td>12.09 (7.7)</td>
<td>11.83 (7.4)</td>
</tr>
<tr>
<td>BDRS</td>
<td>4.86 (2.9)</td>
<td>7.61 (3.8)</td>
<td>6.35 (2.6)</td>
<td>8.42 (2.4)</td>
</tr>
<tr>
<td>RMBPC Memory</td>
<td>2.60 (0.9)</td>
<td>2.84 (0.6)</td>
<td>3.09 (0.7)</td>
<td>3.62 (0.4)</td>
</tr>
<tr>
<td>RMBPC Disruption</td>
<td>0.21 (0.2)</td>
<td>0.72 (0.6)</td>
<td>0.62 (0.5)</td>
<td>1.40 (0.8)</td>
</tr>
<tr>
<td>RMBPC Depression</td>
<td>0.48 (0.5)</td>
<td>0.64 (0.6)</td>
<td>1.49 (0.6)</td>
<td>1.86 (0.8)</td>
</tr>
</tbody>
</table>
about the effects of wandering on the family members who provide care for these individuals. Caregiver distress about wandering was related to frequency of wandering, with almost half of the caregivers of subjects who had wandered infrequently reporting moderate to severe levels of distress, and over three fourths of caregivers of patients who had wandered within the past week reporting moderate or higher distress about this behavior. However, the only assessment of caregiver distress in the current investigation was the caregiver’s rating of how much the wandering behavior “bothered or upset” him or her when it happened, so it is not possible based on these data to draw conclusions about the effects of wandering on overall level of caregiver burden, stress, or depression. Results of the current study indicate that future investigations of wandering in community-residing subjects should include a more detailed assessment of overall caregiver distress.

This study also illustrates the variability among wanderers and provides a basis for more detailed future research about the phenomenology and possible treatment of wandering. For example, individuals who had the lowest frequency of wandering were less cognitively impaired and behaviorally disturbed than the others. For such individuals, an identification bracelet, registration in the Alzheimer’s Association Safe Return program, and visual reminders (such as a note or sign on exit doors) may be sufficient to ensure their safety.

A second category of wanderers was more cognitively impaired but had few disruptive or depressive behaviors other than a high frequency of sitting alone. This group may represent a subset of individuals whose environments lack stimulation, for whom wandering represents an adaptive attempt to find and engage in some type of activity. This group may be similar to those nursing home residents whose wandering has been identified as “agenda behavior,” which they perform in an attempt to alleviate feelings of loneliness or isolation (Rader et al., 1985). A logical approach to treatment of individuals in this situation might include provision of appropriate activities, either with a companion in the home or in an adult day center. Educating caregivers that these individuals are likely to have difficulty initiating activity on their own and may need considerable direction to keep them occupied may also help in their treatment.

A third category of wanderers was characterized by a higher level of anxiety and depressive symptoms. Individuals with these characteristics would benefit from a thorough evaluation for anxiety and/or depression coexisting with their dementia. Both behavioral interventions and medication have successfully reduced depression in AD patients (Reifler et al., 1989; Teri, Logsdon, Uomoto, & McCurry, 1997), and appropriate treatment for depression and anxiety might also reduce their wandering behavior.

Finally, a category of subjects was identified that wandered frequently, had the lowest level of cognitive functioning and had the highest levels of behavioral disturbance. These individuals are at highest risk for institutional placement, based on prior research that found behavioral disturbance and wandering to be the most common causes of nursing home placement (Morris, Rovner, & German, 1996; Rockwood et al., 1991). Individuals with this behavioral profile warrant further evaluation to determine whether treatable problems are responsible for increasing their levels of wandering and other behavioral disturbances. Patients in this category require constant close supervision and monitoring to ensure their safety and may benefit from environmental, behavioral, and pharmacological treatments.

In summary, these findings provide objective data about the frequency of wandering in a population-based sample of individuals with AD, an analysis of the cognitive, behavioral, and functional factors related to wandering, and an assessment of caregiver distress about wandering. Results indicate similarities between community-residing individuals with dementia and those who reside in institutional settings. Lack of activity, greater cognitive impairment, and greater impairment in ADL functioning appear to be related to wandering in both settings (e.g., Algase, 1992b; Thomas, 1995). In addition, the current study suggests that depression and anxiety may contribute to wandering in a subset of community-residing individuals. Future investigations of wandering should examine specific episodes of wandering, including their antecedents and consequences, in more detail, and consider additional patient characteristics that may be related to wandering.

This article also suggests avenues for treatment based on classification of wandering. Use of identification and support systems, provision of appropriate physical and social activity, environmental modifications, treatment of concomitant behavioral and physical problems, and identification and modification of the antecedents of wandering are all strategies that caregivers can learn to use in their own homes. Future research is needed to evaluate the effectiveness of these interventions in reducing potentially dangerous wandering behavior and decreasing caregiver burden.

Finally, it must be noted that although the sample studied in this investigation is representative of individuals residing in the community who are seen by primary care physicians and in other community settings, participants had frequent contact with a caregiver. Individuals who have little or no supervision are likely at increased risk of danger, both from wandering and from other behavioral disturbances. A strong and readily available support system (whether family, friends, or paid care providers) is a critical component of care for AD patients in the community.

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WANDERING IN ALZHEIMER’S DISEASE

Poster 299

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