Managing Difficult Behavior

A Mental Health Perspective

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The bottom line

- Improve quality of life for residents
- Improve quality of life for staff
- Improve metrics for the community

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Learning Objectives

- Understand the impact of mental illness and cognitive decline on behavior
- Be able to describe how different diagnoses impact behavior
- Be able to demonstrate techniques for managing problem behaviors
  - Broad principles
  - Problem/condition-specific principles

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Key Points

- Prevention is better than rescue
- Understanding our residents can help predict problems
- Mental health care can be a key part of prevention
- Preventing agitation and acting out reduces the pressure for inappropriate requests for medication solutions

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Diagnoses

Major Neurocognitive Disorder (Dementia)

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Forms of Major Neurocognitive Disorder (Dementia)

- Alzheimers (50 to 75%)
- Frontotemporal lobar degeneration (5 to 10%)
- Lewy body disease (10 to 15%)
- Vascular disease (10 to 20%)

It's important to keep in mind that more than one form of dementia can be present at the same time

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Rates of Major Neurocognitive Disorder (Dementia)

Overall, Plassman et al (2004)
- 71 to 79 — 4.97%
- 80 to 89 — 24.19%
- 90+ — 37.36%

risk increases with age, approaching or exceeding 50% in individuals over 90 who live in LTC

85% of dementia diagnoses are in individuals who are 75 or older

1/2 to 2/3 of SNF residents have some form of NCD

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Behavioral Challenges with Dementia

Resident experience
- Confusion
- Disinhibition (poor control of impulses)
- Poor emotional control
- Poor memory/attention

Resident behavior
- Wandering
- Refusing care
- Conflict with staff
- Conflict with other residents
- Falls
- More…

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Diagnoses

Major Mental Illness

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Major Mental Illness

- Schizophrenia/Schizoaffective Disorder
- Major Depressive Order
- Bipolar Disorder
- Anxiety
  - Generalized Anxiety Disorder
  - Panic Disorder
  - Others
- Posttraumatic Stress Order

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Schizophrenia and Schizoaffective Disorder

- Schizophrenia – hallucinations and delusions, patients often display incoherent speech and disorganized behavior, usually present with a flat affect and tend to speak less than the average person. May have mood symptoms but they are usually brief and mild to moderate
- Schizoaffective Disorder – same symptoms of schizophrenia along with symptoms of a mood disorder, such as depression and/or mania.

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Schizophrenia and Schizoaffective Disorder

- 1% lifetime prevalence (but only half get treatment)
- # Males (10-25yo) = # females (25-35yo)
- Financial impact greater than ALL cancers combined

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Depression

- Lifetime prevalence of Major Depressive Disorder in the US about 17%
  - 12 month prevalence about 6%
- In general, risk is lower in older than in younger adults, except in long-term care populations
  - medical conditions (neurologic, cardiac, metabolic, and inflammatory) increase risk

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Depression in the Elderly

- sex ratios change
  - 2:1 women to men in younger adult populations (even higher ratios in adolescents)
  - more men than women in the elderly
- as with many conditions, there are pharmacological considerations unique to the population

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Bipolar Disorder

- Bipolar disorder – mood disorder with severe high and low moods and changes in sleep, energy, thinking, and behavior.
- These patients usually have periods when they feel overly happy and energized (mania) and other periods of feeling very sad, hopeless, and sluggish (depression)
- Lifetime prevalence 4.4% (males and females about equal)

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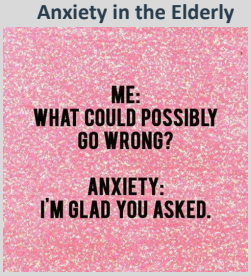
Anxiety in the Elderly



- health problems and changes in physical abilities can contribute to concerns
- the secondary consequences of many medications for anxiety become more serious in an older population
- increased prevalence

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PTSD

- Exposure to actual or threatened death, serious injury, or sexual violence in 1 or more of the following ways:
  - Directly experiencing the traumatic events.
  - Witnessing in person as the event(s) occurred to others.
  - Learning that the traumatic event(s) occurred to a close friend of family member.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s).

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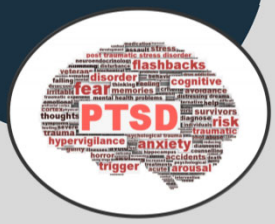
Symptoms of PTSD: Re-experiencing, Arousal, Avoidance



- Presence of 1 or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
  1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
  2. Recurrent distressing dreams in which the content and/or the effect of the dream are related to the traumatic event(s).
  3. Dissociative reactions in which the individual feels or acts as if the traumatic event(s) were recurring.
  4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
  5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

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Interventions

What do we do?

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Behaviors Associated with Mental Health Issues

- Changes from usual behaviors
- Withdrawal
- Volatility in emotions
- Decrease in functioning
- Problems thinking clearly
- Increased sensitivity
- Apathy
- Illogical thinking
- Odd behavior
- Sleep or appetite changes
- Nervousness
- Aggression

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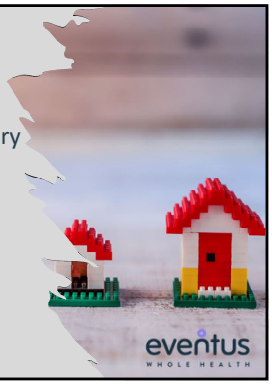
Building blocks

- We all behave based on our history
- Humans are creatures of habit
- Humans are basically social
- Confusion can be upsetting



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The Steps

- Define the problem
- Manage ourselves
- Address the problem

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Where do problem behaviors come from?

- mental health issues
- cognitive decline
- long-standing personality issues

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How we describe "problem behavior"

- "Resisting Care" or "Exercising choice"
- "Manipulating" or "using a strategy"
- Fast is slow; slow is fast

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Manage Ourselves

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The "4 C's"

- Clear
- Calm
- Caring
- Consistent

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Clear
One instruction at a time
Speak directly to the resident
Say what you are doing
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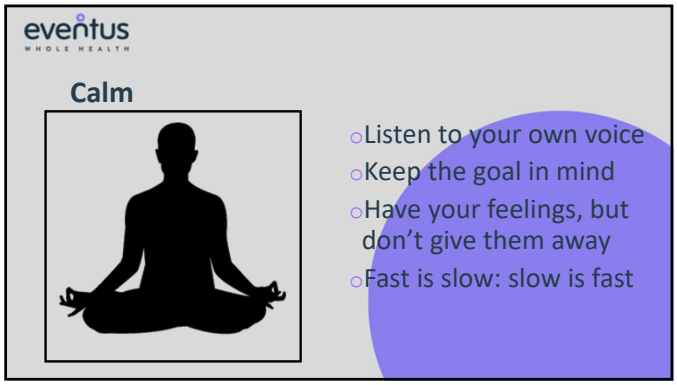
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Calm
Listen to your own voice
Keep the goal in mind
Have your feelings, but don't give them away
Fast is slow: slow is fast

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Signs and symptoms of stress too much stress

Cognitive symptoms	Physical symptoms
Memory and concentration problems Poor judgement Worry Poor judgement	Aches and pains Frequent colds or flu Loss of sex drive
Emotional symptoms	**Behavioral symptoms**
Unhappiness Anxiety Irritability Feeling overwhelmed	Changes in appetite and/eating Changes in sleep Social withdrawal Procrastinating Relying on alcohol or other drugs to relax

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Caring

- Deliver the message that you care
- Remember that negatives are more powerful than positives
- Express gratitude

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Consistent

- When a there is a plan for a resident, everyone needs to follow it.
- Don't break your own policy "sometimes" or "every once in a while"

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Why does Vegas work?

- "Intermittent reinforcement" is the way slot machines pay off.
- You only have to reward the bad behavior once in a while to sustain it

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Address the Problem

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What can you do?

- Manage the behavior in the moment
- Seek help from providers serving the facility
- Seek outside help
- Actions you can take to manage the behavior: You can help reduce the intensity of the emotional/behavioral reaction

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Working with Individuals with Cognitive Impairment

- Potential Solutions
  - Are the person's basic needs being met?
  - Can changing or adapting the surroundings help?
  - Can changing our reaction or approach help?

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Working with Individuals with Serious and Persistent Mental Illness

- Do not argue about delusional thoughts (the patient is not making an evidence-based argument)
- Pro-move: do not argue about anything ("I wish…")
- Align with emotions (it must be really hard to be on guard all the time)

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Principles for Interacting with All LTC Residents

- Keep the goal in mind
- Be respectful
  - Speak as if speaking to another adult
  - Listen to your own voice

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Depression

- Focus on bringing them "out of themselves"
- Use photographs and ask them to talk about what and who they see
- Encourage them to be around others and to "work with you" to help someone else
- If they will, encourage them to talk about what is upsetting them. Regardless if it seems "real" attempt to help them within their reality
- Talk to them even if it appears they do not understand

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Anger/Agitation

- Avoid direct confrontation. Stand to the side if possible. Dance with their energy rather than fighting it
- Make eye contact
- Start with a louder voice and deliberately reduce the volume
- Demonstrate visually decreased volume using hand gestures

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Anxiety

- Use a calming voice
- Close the door and reduce the volume
- Dim the light slightly
- Assure that they are comfortable (warm or cool enough)
- Be sure that they are not hungry
- Mirror their agitation and slowly relax yourself

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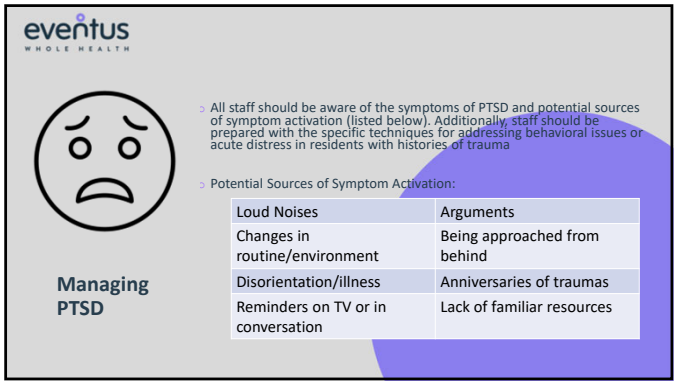
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Managing PTSD
All staff should be aware of the symptoms of PTSD and potential sources of symptom activation (listed below). Additionally, staff should be prepared with the specific techniques for addressing behavioral issues or acute distress in residents with histories of trauma
Potential Sources of Symptom Activation:
Loud Noises
Arguments
Changes in routine/environment
Being approached from behind
Disorientation/illness
Anniversaries of traumas
Reminders on TV or in conversation
Lack of familiar resources

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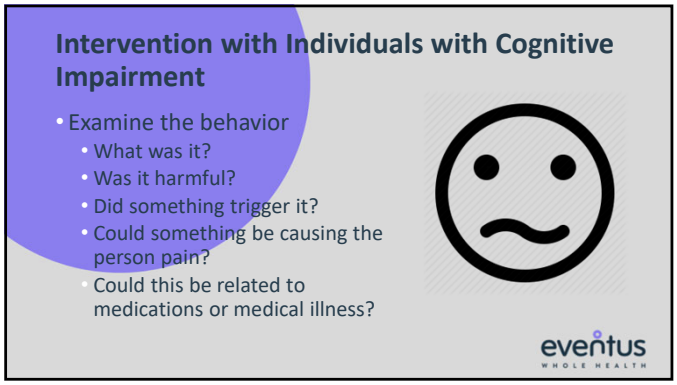
Intervention with Individuals with Cognitive Impairment
Examine the behavior
What was it?
Was it harmful?
Did something trigger it?
Could something be causing the person pain?
Could this be related to medications or medical illness?
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Resources
Facility Staff
Primary Care Providers
Psychiatry Providers
Psychotherapy
Community Resources
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Questions

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