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Senior PsychCare
4314 Yoakum, Houston, Texas 77006
District Manager: Jason Lacy
Regional Manager: Beryl Shorter
Ph: 713-850-0049 **Fax:** 713-850-0036

Senior Minutes

A Better Quality of Life Through Integrated Mental Health Care

SENIOR PSYCHCARE
IN AFFILIATION WITH
SENIOR PSYCHOLOGICAL CARE, LLC

WHAT NURSES AND FAMILIES CAN DO ABOUT DISRUPTIVE BEHAVIORS

Understanding Agitation in the Elderly

Inappropriate behaviors, or agitation in the elderly are of great concern. Controversies exist around many of the issues related to problem behaviors, including the domains included in and the etiology of these behaviors.

Domains Included in Problem Behaviors

Agitation has been defined as inappropriate verbal, vocal, or motor activity that is not judged by an outside observer to result directly from the needs or confusion of the individual. This includes:

- There is a range of behaviors. Problem behaviors include repetitive acts (e.g. walking back and forth or repetition of words); behaviors inappropriate to the social norms (e.g. going into someone else's rooms and handling their belongings or unbuttoning a blouse in public); and aggressive behaviors toward the self or others. These behaviors have been labeled problem behaviors, disruptive behaviors, disturbing behaviors, behavioral problems and agitation; all of these terms are generally used interchangeably.
- Behavior is in the eye of the beholder. In other words, problem behaviors are labeled as such by those who perceive them as inappropriate. However, a given behavior may or may not be inappropriate from the point of view of the older person. He or she may, indeed, have a need that explains the behavior but it is not obvious to the observer. Furthermore, this need may not be consciously known by the older person. For example, a person who is walking incessantly may be searching for the bathroom; not only does he or she not make this need known to others, but he or she also may not be consciously aware of this need because of dementia
- The behaviors are not necessarily disruptive. It is important to observe these behaviors because they may reveal the internal state of the older person. Repetitious mannerisms, although not bothersome to anyone, may indicate boredom.

- The behaviors are observable behaviors with no underlying emotional state. The problem behavior is an observable behaviors, and no underlying emotional state is assumed to cause the behavior. In this sense, the label agitation is deceptive. It was only chosen because it was traditionally been used by practitioners to describe these behaviors.

There are several reasons for differentiating between agitated behaviors and related constructs. For example, delusions and hallucinations may cause some agitated behaviors by introducing an unrealistic reality. In contrast, depressed affect may result from the same cause as the agitated behavior, such as when undetected pain may cause both repetitive vocalizations and depression. A different relationship is sometimes present between sleep and agitation in which lack of sleep and ensuing fatigue prompt a person to move restlessly, which in turn exacerbate the need for sleep. This process may continue for a while in a vicious circle.

Delirium, according to DSM-IV-TR (American Psychiatric Association 2000), is a "disturbance of consciousness….manifested by a reduced clarity of awareness of the environment" in which the "ability to focus, sustain, or shirt attention is impaired." This definition includes a change in cognition or the development of a perceptual disturbance. Delirium develops over a period of hours to days and tends to fluctuate during the course of a given day. Finally, there is evidence that delirium is caused by the direct physiological consequences of a general medical condition or a drug.

Continued on Page 2

Subtypes of Problem Behaviors

Based on factor analyses in both senior day care population and a nursing home population, Cohen-Mansfield et al. described problem behaviors as four subtypes:

1. Physically aggressive

2. Physically nonaggressive

3. Verbally aggressive

4. Verbally nonaggressive

The consistent relationship between cognitive impairment and problem behaviors naturally raises the question of what role dementia plays in causing these behaviors. Theories relating to this issue can be divided into four general categories, the first of which pertains to the direct impact of dementia; the other three focus on factors that interact with dementia or with the context of dementia.

The best model to understand agitation is when unmet needs interact with dementia. According to the unmet needs model, problem behaviors result from an imbalance in the interaction between lifelong habits and personality, current physical and mental states, and less-than-optimal environmental conditions. Most unmet needs arise because of dementia-related impairments in both communication and the ability to use the environment appropriately to accommodate needs. Agitated behaviors result from unmet needs in one of two ways:

1. the behavior represents a desire to alleviate the need either by meeting it (e.g. pacing to alleviate boredom and under stimulation) or by communicating it (e.g. making repetitive vocalizations), or

2. the behavior may signal the outcome of having an unmet need by communicating distress, frustration, or pain,

The relationship between healthy and physically aggressive behaviors is less clear, but a positive association between aggressive behavior and urinary tract infections has been reported. In contrast, people who engage in physically nonaggressive behavior (e.g. pacing) have been reported to have fewer medical diagnoses than other nursing home residents and to have better appetites. However, some people who pace suffer from akathesia, an inner sense of restlessness that is caused by a neurodegenerative disease or by an extra pyramidal reaction to an antipsychotic or other drug.

Sleep disturbance and fatigue are other aspects of health that have been linked to problem behaviors. The impairment of circadian rhythms that is characteristics of Alzheimer's disease may also be related to behavioral problems. In particular, an increase in behavior problems, such as in elderly individuals with dementia, that occurs in the evening hours, beginning at a time near sunset, has been termed *sundowning*.

General Principles for Difficult Behavior

Studies have used different therapists, ranging from psychologists to nurses, nursing assistants, and other health care providers. As the list of eligible providers of mental health services in long-term care settings expands, a question can be raised regarding whether the outcomes are equivalent with different professional providers. In a therapeutic approach; such as cognitive therapy, a special set of skills is necessary to assess patients appropriately had to conduct the therapeutic sessions. How much training and at which level best prepares therapists and produces the best patient outcomes is an important question for future research. There are no easy answers but try to keep it simple and talk to the patient. In addition, because disruptive behavior in patients with dementia is clearly a result of brain damage (neurological), medications are indicated. A psychiatrist should be involved in making a diagnosis and prescribing medication such as Ativan, Depakote, Namenda, atypical antipsychotics, and Aricept which controls and slows the deterioration.

Conclusions

Physically nonaggressive behaviors are not related to suffering, occur under normal conditions, and appear to be adaptive in providing stimulation. Aggressive behaviors are those least explained by the unmet needs model, but some behaviors appear to be the result of discomfort or an effort to communicate.

Problem behaviors are a complex phenomenon affected by an interaction of cognitive impairment, physical health, mental health, past habits, personality, and environmental factors. Agitated behaviors vary among individuals. Several subtypes of problem behaviors are differentially related to those factors. Three subtypes are useful in guiding the formulation of an individualized treatment plan. These subtypes are useful in guiding the formulation of an individualized treatment plan. Such a plan would involve several stages:

1. hypothesize which need underlies the agitated behaviors;

2. characterize the way in which the behavior results from the need (Does the behavior attempt to accommodate the need? Does it express discomfort? Does it attempt to communicate the need?); and

3. provide an intervention that provides for the unmet need or, if the behavior itself alleviates the need, provide a method by which the behavior can be accommodated. The goals of this plan are to improve the quality of life for the patient and to reduce the burden on caregivers. The Integrated Model of Treat that Senior PsychCare uses integrates the biopsychosocial approach which includes family and long term facility staff as partners to develop the most appropriate plan to manage this behavior.

Corporate Offices:

San Antonio: 1380 Pantheon Way Ste. 240, San Antonio, Texas 78232

District Manager: Lee Jones

Regional Manager: Charles Henderson

Ph: 210-366-8035 **Fax:** 210-496-1901

Dallas:

District Manager: Spencer Dunn

Regional Manager: Soni Rao

Toll Free: (800) 806-0465 **Toll Free Fax:** (800) 318-0120

For additional information please visit our website: