

Geriatric Mental Health Training Series: Revised

Back to the A-B-C's

# Understanding & Responding to Behavioral Symptoms in Dementia

Lecturer's Script

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*From original content in the module  
"Acting Up and Acting Out: Assessment and Management of Aggression  
and Acting Out Behaviors" by*

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PUBLISHED BY THE JOHN A. HARTFORD CENTER OF GERIATRIC  
NURSING EXCELLENCE (HCGNE),  
COLLEGE OF NURSING, UNIVERSITY OF IOWA

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## **Back to the A-B-C's Understanding and Responding to Behavioral Symptoms in Dementia**

### INTRODUCTION AND OVERVIEW

#### **>>Title slide**

Today we're going to talk about a particular approach to understanding, assessing, and responding to behavioral symptoms in dementia. The method follows the Antecedent-Behavior-Consequence, or ABC model, which is often used in psychology to help people change their behaviors. When the ABC approach is used in dementia care, it provides a “framework” to help caregivers figure out what is causing or contributing to behavioral symptoms so that interventions may be developed to help the person with dementia become comfortable and functional again.

#### **>>Culture Shift in Dementia Care: Old Culture**

##### **\*\*Refer to handout: New vs. Old Culture of Dementia Care**

Before we talk about the ABC model and its use, let's think about changes in dementia care in the last two decades. New knowledge based on research and clinical practice is having an important impact on how we think about the person with dementia and the behaviors he or she may experience.

Early in dementia care, care was more “illness-oriented.” Most providers and caregivers thought MORE about the disease, loss abilities, dysfunction and “problems,” than they did about the PERSON. There was a sense that because dementia was “incurable,” there was “nothing to be done”. *How could you possibly help the person with an incurable illness?! What was the point of even trying?!* For a long time, everything the person did was blamed on the disease – often without considering other medical or psychiatric causes, the impact of the environment, or even longstanding personality traits. Along with this hopeless attitude, we tended to use a lot of negative labels – like aggressive, difficult, disruptive, and distressing to describe behaviors. People with dementia who needed help at mealtime were called “feeders” and those who resisted personal cares (like dressing or bathing) were labeled as “hitters” or worse.

#### **>>Culture Shift in Dementia Care: New Culture**

In more recent years, there has been an increasing shift AWAY from negative labels. This “new culture” of dementia care focuses on the PERSON and his/her long-standing habits, traits, abilities and resources. Instead of thinking about what the person can NOT do because of losses associated with dementia, caregivers are asked to think about the persons' retained abilities and strengths.

- ✓ What can he or she still do and enjoy?
- ✓ What makes life a meaningful experience?

- ✓ How can caregivers support the person to remain engaged in activities that contribute to self worth? Or a sense of productivity?

We have gained important insights about the role of the environment, unmet needs, and long-standing personality traits and habits in the development of behavioral symptoms. Yes, losses associated with dementia DO CAUSE changes in behavior. But EXCESS DISABILITY, or loss of ability beyond what is expected based on the state of disease is a real issue!

We now understand how powerful environmental factors are in causing behavioral symptoms, or, when used in a positive way, in reducing and resolving behaviors. Likewise, long-standing habits, personality traits, and life experiences also influence what type of behaviors occur.

The role of UNMET needs in causing behavioral and psychological symptoms in dementia is also increasingly understood. Behaviors rarely “come out of nowhere” but instead are based on some need. Because the person with dementia has difficulty “formulating” what is wrong AND difficulty expressing their needs in language, it shows up in behavior. The behavior is a SYMPTOM of something else – and it’s up to caregivers to figure out what that is!

**>>Caution: “Labeling” = Attitudes: Adjust language to reduce negative labels**

**//Trainer: If possible, give an example from your experience about negative labeling to help staff understand the point being made.**

One of the most important things that we all can do to promote quality of care and quality of life for those with dementia is to *change how we talk!!* Too often, the negative labels that are applied to the person’s behavior – like “aggressive” or “disruptive” – end up being generalized to the person. We start thinking about the person as a “hitter” – and hitters are “bad people” who should be “avoided” – or who do not deserve the same time, attention and compassion as “nice” people.

Caregivers don’t do this ON PURPOSE – but it DOES HAPPEN. We all know that there are the “nice little old confused ladies” that everyone “loves” and the “horrible, mean, awful screamers” that are a “pain” to care for.<sup>1</sup> Labels are powerful. They effect how we think about the PERSON – *not just the behaviors!!!* And once negative labels are applied, they are difficult to stop. Everything the person does as a “hitter” is viewed from that context.

**>> Caution: “Labeling” = Attitudes: Yes, behaviors may be troubling...**

We are not saying that behavioral symptoms in dementia are not troubling. They absolutely are – to staff, and family, and others around the person.

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<sup>1</sup> Note: Negative labeling is used purposefully to illustrate the point. Although calling the person a “nice, little old confused lady” is not as clearly detrimental as using negative names, the label is still condescending and disrespectful to the older adult because it ignores the PERSON a unique human being.

But we need to focus on the PERSON with dementia FIRST and foremost!!! Behavioral and psychological symptoms MOST OFTEN signal distress and discomfort to the person who experiences them! Their behavior is a “red flag” to pay attention! They are not trying to upset, frustrate, or annoy caregivers!! Instead, the behavior is COMMUNICATION – we just need to figure out what that “message” really is!!

### REFRAME DEMENTIA CARE

#### >> **Caution: “Labeling” = Attitudes: Reframe dementia care – Person-Centered**

The word “re-frame” may be a good one to use as we think about changing our attitudes and language about persons with dementia. As you know, the “frame” you put around a picture effects how it looks. It shapes your view of the image. That is what we want to do in dementia care as well – change our view of the person with dementia.

An important place to start is by thinking carefully about the PERSON, and his/her longstanding habits, personality traits, values and experiences. *Who has this person been their whole life long?*

Instead of calling the person a “feeder” or a “hitter” – or even “a demented person” (which emphasizes their disease), put the person FIRST. Call them a PERSON with dementia, or maybe just a person – as is used throughout this program.

#### >> **Caution: “Labeling” = Attitudes: Reframe dementia care – Behavior**

Next, we need to reconsider the behaviors that are often observed in association with dementia. First, think about the behavior as a SYMPTOM. Ask yourself: What is different? What is going? Why is the behavior occurring NOW?

And while it is important to describe behaviors accurately, labeling behaviors as “aggressive” or “agitated” or “disruptive” do not provide much useful information!" *That's like telling your mechanic that your car has "engine problems" and expecting him to know exactly what to do to fix it!!* And as we discussed, these negative labels often do more damage than good in promoting quality of life and care for those with dementia!

So work to substitute “neutral” labels for negative ones!

- Behavioral and psychological symptoms of dementia (BPSD), the label used by the International Psychogeriatric Society,
- Need-Driven Dementia-Compromised Behaviors (NDB), a label used by a group of nurse researcher, and
- Behavioral symptoms or just behaviors – as is used throughout this program.

>> **Caution: “Labeling” = Attitudes: Reframe dementia care – Interventions**

And although we did not mean to be disrespectful by using terms like “behavioral management” in relationship to behavioral symptoms, the word “manage” implies that we have to “control” the person with dementia. And having to “control” the person suggests that they are “out of control.” And being “out of control” is often considered “bad” or “wrong” or even “deviant”!

There are a lot of subtle, unspoken implications in our use of language. Often the speaker does not intend to imply something negative – *but that is the “message” that listeners receive.* So instead of “managing behavioral symptoms,” let’s try to think in terms of

- ✓ Responding to the person’s unmet needs,
- ✓ “Listening” to the behavior for the “message” the person is sending,
- ✓ Using redirection, reassurance, distraction, and other measures to assist the person to be as functional and comfortable as possible, and
- ✓ Offering pleasurable activities that are *meaningful to the PERSON.*

BEHAVIOR AS COMMUNICATION

>>**Behavioral Symptoms: A form of communication**

The primary point that caregivers should try to keep in mind *at all times* is that behaviors in dementia are NOT PURPOSEFUL. The losses associated with this progressive brain disease cause a long list of problems for the person – and those problems are compounded by the way caregivers approach the person, other sources of stress and disability, and what is going on in the environment.

In most cases, behavioral symptoms are a form of COMMUNICATION. As before, the person is not able to “name the problem” but is UNCOMFORTABLE in some way. In many cases, the person has an UNMET need – for food, pain relief, privacy, quiet time, companionship, exercise, entertainment – or something else. As caregivers, we need to stop, think about the behavior, and ask, “*What is the person telling me?!*”

>>**Behavioral Symptoms: A component of a wide variety of illnesses, diseases, and disabilities**

A long list of problems *other than dementia* cause or contribute to the development of behavioral symptoms. As important, behaviors can occur in diverse ways, ranging from mild to severe, and differ considerably in terms of their

- ✓ Frequency, intensity and duration

- ✓ Degree of threat to the person or others around him/her (e.g., it might be “annoying” but isn’t “dangerous” – or it might be quite dangerous to the person, like becoming lost outside in the cold)
- ✓ Amenability to current interventions (e.g., some are “easy” to resolve; others persist in spite of “best efforts” and require that caregivers to adjust what *they do* in order to accommodate the person’s behavior)

The last point – which relates to our ability to “solve problems” – is an important one. As we are about to review, *taking time to assess and problem-solve about behavioral symptoms is OFTEN successful in finding a way to reduce or eliminate the behavior.*

### USING THE A-B-C APPROACH

#### **>>ABC Approach: Prevention is the best medicine**

##### **\*\*Refer to handout: The A-B-C Approach**

When we are trying to reduce or eliminate behavioral and psychological symptoms in dementia, "Prevention is truly the best medicine." There ARE things that we CAN DO to prevent or minimize the risk of that the person will feel “threatened” by our actions, become fearful or uncomfortable – *and show that discomfort in challenging behaviors.* By understanding situations in which behaviors occur, we can begin to anticipate the “problem” and use preventative methods. Understanding what is “really” happening, and WHY, relies on accurate assessment!

#### **>>ABC Approach: Intervene early to DEFUSE the situation**

The old saying "*one thing leads to another*" is pretty accurate when caregivers we look at the potential for behavioral symptoms. Caregivers often can SEE those "RED FLAGS" that signal that the person is uncomfortable or threatened. Learning which situation tends to "stress out" the person with dementia allows caregivers to act preventatively.

By watching the person, and INTERVENING EARLY, we have the ability to keep the person calm and comfortable. Our interventions "DEFUSE" the situation, *just like pulling the fuse off a bomb to keep it from exploding!* Even more important, we can create an environment in which the person does not become overly stressed in the FIRST PLACE.

#### **>>ABC Approach**

As this circle represents, the A-B-C approach is not a single step, but is *a continuous process of assessing the person with dementia, adjusting interventions, evaluating care, and starting again.* The three main things we want to assess, and then try to adjust in our interventions are:

**Antecedents:** A is for antecedent, the events or factors that PRECEDE the behavioral symptom and contribute to its occurrence. Antecedents are also called “triggers” because they “set off” behaviors.

**Behaviors:** B is for the specific behavioral symptom that is of concern, looking at ONE behavioral symptom at a time in the problem-solving and care-planning process.

**Consequences:** C is for consequences, the things that happen AFTER the behavior occurs. That includes ALL the reactions and responses to the person, including those by other residents, family, visitors, volunteers, AND staff caregivers.

### ASSESSMENT: CHECKING IT OUT

#### **>>ABC Approach: Assess the person and the situation**

To actually use the idea that "prevention is the best medicine" caregivers need to carefully ASSESS the PERSON and the SITUATION. Knowing who in the facility may be "at risk" for challenging behaviors allows us to monitor the person and environment to watch for warning signs that say "difficulty ahead."

#### **>>ABC Approach: Check it out Sherlock!**

That means that we REALLY have to "check it out!" This is the KEY to the whole approach. We have to GET THE FACTS -- all of the facts! We can't just take the situation "at face value." We need to dig around, and think, and probe to get an accurate picture of what is going on, and why! Remember: Observe, listen, read, and ask!!

STOP and QUESTION the behavior.

Look for clues about WHAT IS going on and WHY.

LISTEN and TALK to others to get the WHOLE picture!!

Remember, the goal is to figure out ways to reduce or eliminate the person's DISCOMFORT, and as a result, reduce or eliminate the behavior! And when the person with dementia is calm and comfortable, caregivers' work lives are a lot more pleasant as well.

#### **>>Assessment? Everyone's job**

One of the biggest challenges to problem-solving about behavior symptoms is getting EVERYONE to believe what they see and know makes a difference! Like the slide shows, it is easy to think

- ✓ That's not my job!! That's the doctor's responsibility, not mine!
- ✓ That's what the nurses get paid to do!
- ✓ I'm not trained to do this assessment stuff! or
- ✓ I just don't have time to do any more assessments!!

The reality is that, *at some level*, assessment is EVERYONE'S RESPONSIBILITY. We each see things, hear things, and know things about the resident. And although the nurses may be able to interpret those facts differently from the nursing assistants, or the doctor may understand something more than the nurse, *assessment is simply collecting the information so that SOMEONE CAN MAKE SENSE OUT OF IT!* One person can “collect” the information and another person can “interprets it.”

So the absolute first step in reducing behavioral symptoms is to DESCRIBE THE BEHAVIOR, and all the things that may lead up to that behavior!

### >>A-B-C's: Describe the Behavior

#### **\*\*Refer to handout: Assessment: Checking it out**

First we need to DESCRIBE THE PROBLEM BEHAVIOR. What is the real concern? Look at it carefully! It's not enough to say, "He's agitated" or "He's confused." What do you mean by that?

**//Trainer: Throughout this section, the questions that are in bulleted format (✓) are also listed in the handout. Some questions/concepts are also on the slide. Use as many as needed to illustrate the point and make it meaningful to your group.**

- ✓ What is the real concern?
- ✓ What is the resident doing? Where is it happening?
- ✓ How often does it happen?
- ✓ How long does it last?
- ✓ Does it seem to get worse over time?
- ✓ Who is it really a problem for? the resident? the family? or the staff?"
- ✓ Is the behavior SAFE? Or is it dangerous?
- ✓ Are OUR expectations realistic?
- ✓ Are the RESIDENT'S or FAMILY'S expectations realistic?
- ✓ Are we (or the family, or their roommate, or whoever) wanting MORE from the resident than is practical, given their limitations?

Remember, we have to work on ONE problem at a time, and set our priorities!!

### >>A-B-C's: Next, Antecedents

Once you have described the specific behavior, back up and really dig for all the possible causes of the behavior – the ANTECEDENT conditions – that contribute to the behavioral symptom. To reduce or eliminate behavioral symptoms, and help the person be calm, comfortable, and functional, we need to understand what all is contributing.

- ✓ Where does the behavior occur?
- ✓ What else is going on around the person?
- ✓ Who is there? What are they doing?
- ✓ What is going on in the environment?
- ✓ Has the person had a “change in status”? Physical? Mental? Social?

Remember, the behavior is NOT “JUST” DEMENTIA!

>>**A-B-C's: Antecedents – Also called “Triggers”**

Antecedents are also called TRIGGERS, the things that may be "setting off" the person and causing the behavioral symptoms. To find those triggers, we need to think carefully about where the behavior happens, when it happens, and with whom.

- ✓ Did someone just say or do something to the person with dementia?
- ✓ Did the behavior occur while trying to provide personal cares?
- ✓ Does it happen at a certain time of day?
- ✓ What might be going on inside the resident?

Remember, the person with dementia ALWAYS has memory problems and other disabilities related to that disease – but that person does NOT always have behavioral symptoms! Typically, the behaviors occur in episodes.

One of the biggest mistakes caregivers make is assuming that there IS NO REASON for the behavior. The behavior is "written off" as being the result of the person being "senile" or "manipulative" instead of asking "WHY??" Why here? Why now? What set this off? *What else is going on?*

>>**A-B-C's: Antecedents – Understanding complex factors is key**

As we said earlier, behavioral symptoms in dementia are *often related to a number of DIFFERENT factors*:

Long-standing personality traits, habits, preferences, past experiences that are unique to the individual person;

Physical and mental health conditions that are not part of the dementia, but that overlap and cause distress to the person;

Environmental factors, like over- or under-stimulation, long corridors, large rooms, or television or radio that is not understood;

Personal discomfort related to hunger, thirst, pain, boredom – and many others!

As important, behaviors are rarely the result of only ONE THING. More often, several things are going on at once! Before we go on, let's think more carefully about some of the most common causes of behavioral symptoms – the things that often are the antecedents or triggers to behaviors in dementia.

**>>Antecedent: Cognitive impairment**

**//Trainer: If you have not taught the modules on dementia (particularly Part I), take some time to review common losses associated with dementia and be prepared to offer illustrations.**

As the training modules on dementia emphasized, there are many losses associated with dementia:

Memory, both short and long-term, which contributes to confusion and disorientation;

Language (aphasia) which interferes with the person's ability to communicate needs and interact with others;

Movement (apraxia) which regularly causes gait changes and increases risks for falling, or interferes with simple movements like tying shoe laces or buttoning buttons; and

Loss of ability to recognize and use common objects (agnosia) which interferes with functional abilities and can cause "odd" behavior like trying to clean the carpet with a hairbrush or urinating in a closet that the person thinks is a urinal.

These cognitive losses can directly cause "strange" behaviors, but more often "combine" with other factors to cause behavioral symptoms. For example, the person *cannot remember that they live in the facility now, so they try to leave to "go home"* – and we call it "elopement." The person *cannot use language to tell us movement HURTS during their bath, and they strike out at us* – and we call it "aggression."

So an important FIRST step is to understand the type and extent of losses associated with dementia in THIS PERSON.

- ✓ What type of dementia does the person have?
- ✓ What stage of disease are they in? Early? Middle? Late?
- ✓ What is their "baseline" level of function? What can they do when provided the right type of assistance?

**>>Antecedents: Psychiatric illness**

It is also important to ask if the person has overlapping PSYCHIATRIC ILLNESS that is contributing to the behavior – like depression, delirium, or psychotic illness.

Think about the resident's MENTAL STATUS *at the moment that the behavior occurs*.

- ✓ What are they thinking or feeling that might be causing this behavior?
- ✓ Are they *actively hallucinating*? (e.g., seeing or hearing something that we do not)
- ✓ Are they responding to those hallucinations?
- ✓ Are they experiencing *upsetting or frightening delusions*? (e.g., false, fixed beliefs)
- ✓ Do they think you or someone else is “out to get them”?
- ✓ Are they acutely confused due to a medical illness?
- ✓ Are they depressed, which is associated with increased behavioral symptoms in dementia?

### >>Antecedents: Sensory impairment

As important, check out possible SENSORY IMPAIRMENTS.

- ✓ Is the person seeing, hearing, or understanding what is going on?
- ✓ Is there enough light to see?
- ✓ Are they misinterpreting their environment??
- ✓ Is that misinterpretation contributing to MISBELIEF that is part of the problem?
- ✓ What do THEY see, hear, feel?
- ✓ What possible misinterpretations may be contributing to anxiety or fear – like thinking someone is spying on them when they see their own reflection in a dark window?

Look around and ask yourself: What do THEY see, hear, and feel? What possible misinterpretations may be contributing to anxiety or fear – like thinking someone is spying on them when they see their own reflection in dark glass?

### >>Antecedents: Level and type of stimulation

**//Trainer: Much of this content relates to the PLST model. Take time to help staff see relationships between factors that contribute to stress and antecedent conditions discussed here.**

As before, factors in both the physical and social environment are important to consider.

- ✓ What is going on in the physical environment?
- ✓ Is it too noisy or confusing?
- ✓ Too cold, busy, dark, or crowded?
- ✓ Is the behavior related to television or radio that they do not understand?
- ✓ Does it occur in large public areas (like the dayroom, dining room, or activity room) that tend to be busy and over-stimulating?

- ✓ Do certain people seem to trigger the behavior?
- ✓ Does it seem to happen when the family is here? or after certain “outings” or activities?
- ✓ Has there been a lot of change in staff caretakers?
- ✓ Is it worse or better when certain staff are working?

**>>Antecedents: Internal biological tensions**

As we discussed earlier, lots of physical sensations and unmet needs may contribute to behavioral symptoms. Loss of language interferes with the person explaining their problem or need to us, and instead we observe behaviors that signal their distress.

That means that we need to look for things like PAIN or DISCOMFORT. We need to wonder if the behavior is triggered by BASIC NEEDS like hunger or thirst. Even the lack of TOUCH and tactile stimulation can be a factor for persons with dementia.

- ✓ Is the person in pain or discomfort?
- ✓ Is the person hungry or thirsty?
- ✓ Does the person need human contact or touch?
- ✓ Is “wandering” an expression of need for exercise? Or is the person “looking” for someone or something that is “lost”?

**>>Antecedents: Unmet psychological needs**

Along that same line, we tend to forget about the psychological needs of persons with dementia. Loneliness, sadness, and boredom may be just as troubling to person with dementia as they are to you and me! These issues are VERY important to consider when the person’s language is impaired. They may not TELL US that they are feeling a certain way, but if we pay good attention to their appearance, facial expressions, and body language, AND know their past history, we often can “tell” what is going on.

As important, caregivers too often forget to explain who they are, what they are doing, and why it is important. The person with dementia does not talk – so neither do we! We forget the value of being “social” with the person – talking with them, using language they can understand.<sup>2</sup>

- ✓ Is the person lonely? Are they seeking companionship?
- ✓ Is the person bored? Are they seeking meaningful activity?
- ✓ Is the person sad or blue? Do they need reassurance or one-to-one time?
- ✓ Does the person need someone to talk to? Who will reminisce with them?

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<sup>2</sup> Refer to communication strategies taught in Dementia Part II, for additional information about ways to simplify language and promote effective communication.

- ✓ Are they missing a friend? Family member? Pet?
- ✓ Are they missing a favorite activity or pastime? What are those activities?

### >>Antecedents: Health status

People with dementia are also likely to have physical health problems in addition to their dementia. Medical conditions like arthritis and osteoporosis can cause pain that triggers a reaction during movement (e.g., bathing or dressing). Other health conditions, like heart and lung diseases may interfere with the person getting enough oxygen. Lack of oxygen, called hypoxia, contributes to *greater confusion* and behavioral symptoms. Also, recent acute illness, like urinary tract infections or flu, can cause acute confusion (called delirium) that overlaps on top of dementia and causes additional behavioral symptoms. In short, paying attention to the person's physical health status is important.

- ✓ What medical conditions does the person have?
- ✓ Has there been a change in that condition?
- ✓ Does the condition cause or contribute to pain?
- ✓ Does the person have an acute illness that is causing acute confusion?

### >>Antecedents: Medications

Along that same line, the medications that are used to TREAT health problems can also *cause or contribute to OTHER PROBLEMS* – like behavioral symptoms!! As noted on the slide, medication side-effects, interactions between medications, and too much medication can all be a problem. In other cases, too much or too little of a medication is the root of the problem. Take time to check if medication type or doses have been changed recently.

- ✓ Has the person been prescribed a new medicine recently?
- ✓ Is the behavior related to an adverse reaction? Or toxicity?
- ✓ Is the medicine interacting with another medicine the person is already taking?

### >>Antecedents: Facility routines

Another whole set of issues revolves around the difference between living in one's own home – and living communally in a long-term care setting. Most people have NOT lived with large groups of people throughout their lives. Nor have they had to follow somebody else's "RULES."<sup>3</sup>

Moving to a facility creates a lot of change for older adults, some positive and some negative. For most, following facility "routines" and needing help from others is contrary to lifelong

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<sup>3</sup> This content relates to the module "Control & Power in Long-term Care." Review this content and offer examples to reinforce principle related to self worth and power.

patterns. Most have lived independently and made choices *for themselves* for many, many years. Adapting to the facility routine can be challenging!

- ✓ Is the behavior related to certain facility “routines” like rising dressing, eating, bathing, or going to activities?
- ✓ Does the behavior tend to occur in large groups activities? (e.g., meals, activities)
- ✓ Is it a response to certain people? (e.g., people at dinner table, particular residents or staff?)
- ✓ Does the behavior occur in certain locations (e.g., shower room) or during particular daily activities (e.g., dressing)?
- ✓ Is the person misinterpreting factors in the physical environment? (e.g., long corridors, dark windows, mirrors, shined floors)

### >>Antecedents: Facility routines, continued – Efficiency

Facility routines often promote efficiency – but don’t always think about the PERSON and his or her NEEDS. And as important, staff too often provide care in “8 hour shifts” instead of “24 hour days”! As the PLST model emphasized, stress that occurs on day shift, effects what happens on evening and night shifts – and visa versa. Effective care plans rely on both adjusting routines to accommodate INDIVIDUALIZED NEEDS and thinking about the “big picture” of care. *Cooperation and information-sharing among all caregivers, on all shifts, is critical!!*

### >>Antecedents: Staff approaches

**//Trainer: Many of these concepts relate directly to the PLST model that was taught in Dementia Part II “Interventions.” Remind staff of care principles and examples used in earlier training.**

Along those same lines, the strategies and approaches that are used by individual caregivers may have a HUGE effect on behavioral symptoms. Some of the most common errors that caregivers make include things like,

- ✓ Telling the person to “try harder”
- ✓ Asking the person use a skill that is lost (e.g., dressing without being cued to put clothes on in a certain order)
- ✓ Taking the person “by surprise” (e.g., not in the person’s visual field, failed to make eye contact before touching or speaking to the person)
- ✓ Forgetting to explain what is being done and why
- ✓ Using language that is too complicated for the person to understand
- ✓ Being “hurried” and doing things “to” the person instead of breaking tasks into steps and cueing them to be independent
- ✓ Using “you are wrong” messages (e.g., that is not your room; that does not belong to you; no, you cannot go home, you live here now)

- ✓ Assuming that the persons' dementia makes them unable to do anything independently

In too many situations, caregivers may UNKNOWINGLY contribute to behavioral symptoms.

### >>Antecedents: Staff approaches, continued – Hitting, biting, grabbing

Before we go on, it is important to emphasize that many of the most troubling behavioral symptoms, like hitting, grabbing, striking out, and biting, are aimed at caregivers. These behaviors are commonly called “physical aggression.”

However, the alternative term being used more often today is RESISTANCE, or RESISTIVE behaviors. Considerable research provides evidence that the person with dementia is “reacting” to something the caregiver is doing. The person's goal is to make you stop or go away – *not hurt or harm you!!*

### >>Antecedents: Staff approaches, continued – Resistance

Of importance, the vast majority of physical behavioral symptoms (like hitting, biting, grabbing, scratching, and pinching) occur during dressing, toileting, and bathing – all of which invade the person's personal space and privacy.

These care activities (bathing, dressing, toileting) may create distress and discomfort for the person with dementia for a variety of reasons. An important study (Hoeffler, 1997) found that factors listed on the slide were regularly associated with physical behavioral symptoms (e.g., “aggression) aimed at staff caregivers.

- ✓ touch or invasion of personal space
- ✓ frustration related to declining abilities
- ✓ anticipation of pain
- ✓ loss of personal control or choice
- ✓ lack of attention to personal needs

### >>Antecedents: Staff approaches, continued – Know the person

The best way to AVOID these kinds of reactions are by *knowing the person well!!* Day-to-day caregivers often know, better than anyone else, what is “baseline” for the person with dementia. Baseline behaviors are those that are “normal” behavior for this person, given lost abilities associated with dementia, and include characteristic preferences, habits, and traits.

Caregivers who know the person with dementia WELL can detect changes from baseline; they know when behavior is “out of the ordinary.” Like we said early, changes are a “signal” to pay attention!! If caregivers can learn what “pushes the person's buttons,” they can adjust course to avoid threatening the person – and unintentionally triggering catastrophic reactions!

### >>A-B-C's: Now Consequences

Consequences are what *happens AFTER the behavior occurs*. Consequences include all the reactions and responses to the behavior – by staff, family, visitors, volunteers, and residents of the care setting. Most reactions and responses are not PLANNED – they just “happen.” However, these consequences often affect the behavior,

- ✓ Allowing “low level” behavior to continue, hoping that it will just “go away” on its own;
- ✓ Allowing it to increase, like telling the person “No, you can’t do that! Stop it right now!” (which is a form of negative and restrictive feedback); OR
- ✓ Helping to reduce or eliminate the behavior by looking for possible unmet needs, and responding in a way to calm and comfort the person.

### >>A-B-C's: Consequences – Do WE fuel the fire?

No one has a “crystal ball” to know what is going to work *every time*, but we certainly want to STOP doing things that “fuels the fire” and makes the behavior worse. As before, staff DO NOT do these things on purpose to upset the person with dementia! However, “automatic reactions” regularly contribute to behavioral symptoms! Stop and ask: Are caregivers

- ✓ "Setting the person up" by expecting them to remember what we tell them? (e.g. lunch is in an hour; I'll be right back);
- ✓ Allowing the person to escalate to the point of crisis by avoiding them or ignoring the behavior;
- ✓ Increasing the persons' level of frustration or anger by trying to "rationalize" with them (e.g. in response to misbeliefs or delusions);
- ✓ Threatening the person with facial expressions, gestures or our tone of voice?

### >>A-B-C's" Consequences – Common caregiver responses

If caregivers do not understand that behaviors in dementia are a form of “communication” – AND if they get “caught up” in power struggles or having to maintain the facility routine, there are is greater chance that they will

- ✓ Feel angry at, resentful about, and frustrated by the person with dementia;
- ✓ Blame the person with dementia, thinking that he or she is “doing it on purpose” and could stop if he/she only wanted to;
- ✓ REACT NEGATIVELY to the behavior, by
  - AVOIDING or IGNORING the person , which typically causes the person to feel more frustrated, fearful, or alone with their discomforts – and in turn increases the behavioral symptoms;
  - Becoming DEFENSIVE in words or actions, scolding the person or telling them “you are wrong,” which challenges the person to "win" the "battle";
  - "PAYING THEM BACK" by "forgetting" things, being slow to answer calls, or not responding to requests, which makes the person more fearful and needy; and

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- Being INDIFFERENT, cold, or silent, which says "I don't care about you. You're not even worth paying attention to."

### >>A-B-C's: Consequences – Check out reactions

What caregivers DO, and DO NOT DO, *does make a difference*. And what we do *that we aren't really thinking about or conscious of* – our "AUTOMATIC" or "UNCONSCIOUS" reactions – can really fuel the fire. So we have to back up and look critically at our behaviors and the situation.

- ✓ What happens after the behavior occurs?
- ✓ Who respond, reacts to the behavior? Staff? Other residents? Family? Visitors?
- ✓ What is said or done – both in words and nonverbally? How do people look and act?
- ✓ What does the person with dementia do next?
- ✓ Are these “automatic” reactions (consequences) "making it worse"?
- ✓ What are the alternatives? What other reactions and responses are possible?
- ✓ What might be said or done to comfort, reassure or redirect the person?

In summary, we look real closely at the problem BEHAVIOR, looking at only one problem at a time. We need to look at the various antecedents and triggers that might be causing the behavior. At the same time, we need to look for consequences and reactions might be "fueling the fire" as well.

## INTERVENTIONS USING ABC'S

### >>A-B-C's: Make a plan

#### **\*\*Refer to handout: Interventions**

Once we have our assessment information, we're ready to develop an ACTION PLAN. That means that we are going to look for INTERVENTIONS that will help reduce the behavioral symptoms and increase healthier, more adaptive and comfortable behavior.

### >>A-B-C's: Set behavioral goals

The first step is to SET BEHAVIORAL GOALS. Now this may sound "easy," and even unimportant. But when we're dealing with behavioral and psychological symptoms in dementia, it's extremely IMPORTANT, and often very DIFFICULT, to decide *what it is that we really want from the resident*.

We all have moments when we'd like the person to “stop right now” – to "change over night" and become a "model resident." Of course, that cannot happen! *Instead, we need to develop a goal that is based on the resident's "REAL LIFE" SKILLS AND ABILITIES. And, we can only deal with one problem at a time!! Let's think about that.*

- ✓ Can we eliminate the behavior? Or decrease the frequency?
- ✓ What do we REALLY want the resident to do?
- ✓ Is the goal realistic?
- ✓ Is it specific enough to know when it's been reached?
- ✓ Is it a single step? Or do we need to break it down into little pieces to get the job done?
- ✓ Do we need to adjust our expectations?

### >>Change Antecedents: Add or subtract triggers

Once we decide on a reasonable and achievable behavioral goal, we need to look at the list of possible antecedents and triggers. What can we "add or subtract" to reach the behavioral goal?

Which antecedents or triggers can be eliminated or changed to reduce their negative impact on the person?

What new cues can we add to encourage functional behavior and comfort for the person?

For example,

- ✓ Would a rest period in the morning or early afternoon decrease the risk of "sundowning" behavior later in the day?
- ✓ Would allowing the person to eat in their room (to avoid the noise and confusion of the dining-room) decrease exiting behaviors at meal times?
- ✓ Would taking down pictures reduce the person's misbelief that his parents are still alive?

### >>Change Consequences: Add positive & reduce negative

Finally, we need think carefully about consequences, and how we can change OUR REACTIONS to the behavior. Think about all those things that may "keep the behavior going" and "fuel the fire."

Which consequences or automatic reactions can be eliminated or changed to reduce their negative impact on the person?

What new, neutral or positive responses can we add to encourage functional behavior and comfort for the person?

*For example,*

- ✓ Adjust interventions to fit the resident's ability to understand and use information.
- ✓ Speak in simple, easy to understand language.
  - Give one command or ask one question at a time.
  - Wait for a response and listen carefully for meaning.

- Don't try to reason with them.
- Monitor your tone of voice, facial expressions, and body language.
- ✓ Reduce environmental stress to calm the person.
  - Remove unnecessary people, turn off TV, etc.
  - Move to a quiet place (e.g. their room).
- ✓ Don't confront or challenge delusions or hallucinations.
  - Distract them to some other activity or topic.
  - Reassure them that they are "safe with you."
- ✓ Reduce misleading stimuli
  - Remove pictures/objects that lead to misperceptions.
  - Turn off TV, radio.
- ✓ Check for internal stressors that may be contributing. (e.g. Are they hungry, tired, uncomfortable?)

In many situations, the primary goal is to change *what is done in advance* – the ANTECEDENTS – in the hope that we can keep the person from having uncomfortable behavioral symptoms. However, we can't PREVENT all behaviors!

Caregivers who *know the person well* are OFTEN able to see early warning symptoms and respond THOUGHT – FULLY to help the person become comfortable again! For example,

Would offering the person a snack or activity distract him/her from wandering into other residents' rooms (which puts the person at risk for "negative feedback;" "Get out of here! Don't touch that!")?

Would providing specific information about what is being done help calm and reassure the person whose facial expressions signals fear, discomfort, or confusion?

Would stopping, asking "what is wrong" or apologizing to the person increase cooperation when the person pulls away, as if to say "stop"?

Finding ways to respond to the person in response to behavioral symptoms is critically important! Remember, behavior is "communication"! What is the "message"? And how can you respond in a positive way to reduce discomfort and help the person meet their needs?

>>**Evaluation: Did it work?**

**\*\*Refer again to handout: Interventions**

And we always need to EVALUATE how we're doing!! We have to constantly look at both our successes and our failures and ask ourselves what happened and why!

- ✓ Did the care plan work?

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- ✓ Did any part of it work?
- ✓ Why? or Why not?
- ✓ What got in the way? What made the difference?

EVALUATION is the MOST IMPORTANT PART of the whole process. Without it, we don't have the information needed to find a solution that DOES work!

### MANAGING A CRISIS

#### >>Yes, we do get caught off guard

The last point that I want to make is that we DO get "caught off guard" occasionally. Try as we might to know who in the facility is at risk, and to reduce the triggers and change our reactions, the crisis occurs before we know what is happening. In those situations, we want to follow some very basic principles to avoid further problems or even injury. But even in crisis intervention, we need to keep THAT PERSON'S skills and abilities in mind.

Let's take a minute now to look at the six basic principles of managing the crisis that are outlined in your handout.

#### **\*\*Refer to handout: Managing a crisis**

**//Trainer: Discuss the principles listed in the handout, applying them to the resident population that you work with. Continue to remind staff that what you do depends on the situation. There are no "black and white" answers. The goal is to 1) not threaten the person further, and 2) reduce their tension, and redirect or calm them so that they don't hurt someone. Refer to the handout for specific illustrations of the six principles listed below.**

1. First, tune in to your OWN ATTITUDES and FEELINGS about what is going on.
2. Keep track of what you are doing with your BODY and what that might mean to the person.
3. Think about WHAT you say and HOW YOU SAY IT.
4. Use directions or explanation that are appropriate for the person and the situation.
5. Listen carefully to what they are saying and try to respond to the message.
6. Try to calm or soothe them, remembering that the first priority is to PROTECT YOURSELF AND OTHERS.

It is critically important to remember that there are no completely "right" and "wrong" answers to responding to crisis situations. Each situation will be unique.

## SUMMARY

### >>Prevention is the best medicine

As we said before, PREVENTION IS THE BEST MEDICINE, and on-going assessment of the person and the situation is really the key ingredient to finding effective interventions.

First we need understand and describe the behavior in detail.

Then we need to carefully assess physical and mental illness, sensory deficits, internal biological tensions, unmet psychological needs, new medical problems, facility routines and staff approaches that can cause or contribute to the behavior symptom.

We need to think about automatic and thought-less reactions to the behavior and what can we substitute or change to reduce discomfort and promote function for the person with dementia.

Setting a specific behavioral goal – one that we can “see change” as the result of adding, adjusting, or eliminating antecedents and consequences – is essential. By tackling one behavior at a time, getting everyone involved in the problem-solving and care-planning process, and thinking carefully about what works, and what doesn't work, caregivers are often able to help persons with dementia *remain calm, comfortable, and functional!!*