

Geriatric Mental Health Training Series: Revised

Whose Problem Is It?

Mental Health and Illness in
Long-term Care Centers

Support Materials

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Whose Problem Is It? Mental Health and Illness in Long-term Care Centers

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The revised version of this training module includes the following components. To facilitate use, some components are combined in a file, others are located in independent files, and all are provided in at least two formats – the electronic processing format in which they were created (Microsoft Word or PowerPoint) and a PDF version. A brief description of each is provided to enhance overall use of these training materials.

- Statement of Intended Use: Contained in this file. Provides guidelines for use of the training materials.
- Statement of Purpose, Learning Objectives, Content Outline: Contained in this file. Provides guidance about both content discussed in the module and provides the basis for applying for continuing education credits for teaching the module to a group of people. The program is about an hour long.
- Notes for the Instructor: Contained in this file. Provides an overview of the goals of the module, along with suggestions to personalize the content and make the training more individualized to the audience.
- Handouts, Bibliography: Contained in this file. Handouts that address program content are provided. These may be used independently, or in conjunction with handouts made from PowerPoint. The bibliography is provided for your reference and consideration. As before, these materials are provided in two formats to best accommodate all users.
- PowerPoint Program: Separate file(s), provided in both PowerPoint format and in PDF (slides only). The module contains 38 slides. If opened using PowerPoint, they may be viewed and used in a variety of ways: 1) slides may be shown in Presentation View using a projector, 2) lecture content is provided in Notes View, and may be printed for use to lecture, 3) slide content may be printed as handouts. Because some users may not have PowerPoint, the slides have also been converted into a PDF file which allows you to print a hard copy and make overheads or 35mm slides if desired to accompany the training program.
- Lecturer's Script: Separate file (s), provided in Microsoft Word and PDF format. This content provides the narrative to accompany and explain the slides and is also found in Notes View in the PowerPoint program.

Supportive Materials: List

The following materials are found in this file:

- Statement of Intended Use (1 page)
- Purpose, Objectives, & Content Outline (2 pages)
- Notes for the Instructors (5 pages)
- Handouts
 - ✓ Common Causes of Behavioral Symptoms (3 pages)
 - ✓ Reminds Me of . . . (2 pages)
 - ✓ Key Principles of Care (3 pages)
 - ✓ The Goal of Exploring “Problem” Behaviors (1 page)
- Bibliography (6 pages)

Statement of Intended Use

This training module is provided by the Hartford Center of Geriatric Nursing Excellence (HCGNE), College of Nursing, University of Iowa, as a free service. The training program, “Whose Problem Is It? An Introduction to Mental Health and Illness in Long-term Care Centers” is revised and updated from a module by the same title that was first published in *The Geriatric Mental Health Training Series (GMHTS)*. The GMHTS was developed and evaluated during a five year grant from The Division of Nursing, Bureau of Health Professions, Department of Health and Human Services, Grant # D10NU2711801, between 1989 and 1994. Other titles in the GMHTS include:

- Getting the Facts: Effective Communication with the Elderly
- Help, Hope, and Power: Issues of Control and Power in Long-term Care
- When You Are More Than Just Down in the Dumps: Depression in the Elderly
- When You Forget that You Forgot: Recognizing and Managing Alzheimer’s Type Dementia, Part I (Introduction and Overview)
- When You Forget that You Forgot: Recognizing and Managing Alzheimer’s Type Dementia, Part II (Interventions)
- Acting Up and Acting Out: Assessment and Management of Aggressive and Acting Out Behaviors

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Whose Problem Is It? Mental Health and Illness in Long-term Care Centers

Purpose:

Mental illness is common among older adults who live in nursing home and other residential care settings, and a primary cause of behavioral symptoms that puzzle and challenge staff and other caregivers. However, threats to mental health may also precipitate behavioral and psychological symptoms, and are an important focus of daily care. Common types of mental illness and threats to mental health are briefly reviewed in this introductory program. An emphasis is placed on accurate identification of the underlying causes of the difficult-to-understand behavior, and on the staff's management of their own feelings about behaviors.

Objectives:

1. Identify 8 main sources of behavioral and psychological symptoms in older adult who live in nursing homes and other residential care setting.
2. Describe the advantages of understanding the "chain of events" that lead up to the difficult-to-understand behaviors.
3. Discuss the importance of understanding and managing your own emotional response to these behaviors.
4. List key principles of caring for older adults who have mental illness or are experiencing threats to their mental health.

Content Outline

Introduction

Goals of the program

Mental illness vs. mental health

Importance of long-standing patterns of behavior

Behavioral & Psychological Symptoms: Two issues

Causes of the problem behaviors

Management of own (staff's) feelings

Many factors interact to cause behaviors

Threats to Mental Health

Personality traits

Low self esteem

Loss of control

Situational stress

Key principles of care

Mental Illness

Dementia

Depression

Anxiety

Paranoia

Key principles of care

Management of own feelings

Physical distance

Psychological distance

Causes vs. cookbook solutions

Chain of events

Goals of assessment and interventions

Summary: Key Principles

Stop and consider problems

Adapt care processes

Work together to solve problems

Time commitment

Notes for the Instructor

This program should be taught first since it provides an "overview" of the various sources of behavioral and psychological symptoms that may be observed in older adults who reside in nursing homes and other residential settings. Please note that an important change made in revising *The Geriatric Mental Health Training Series*, is to reduce use of negative labels that were commonly used at the time of the original writing. In keeping with current thinking about positive aging and person-centered care, every effort has been made to eliminate language that might imply that older adults who experience mental and emotional problems ARE the problem. Thus, words like disruptive, distressing, difficult, disturbing and problematic are used sparingly, and are often placed in quotation marks to emphasize that these terms are "perception-based." By that, we mean that staff caregivers may interpret and label behavior as a "problem" when in fact it is a "message" related to unmet needs. Once the person is labeled, efforts to problem-solve about the meaning of the behavioral symptom too often subside, and quality of care is compromised. Thus, changing labels is intended to help change attitudes and actions that influence the quality of care, and hence, quality of life for older people. As a substitute, the phrases "behavioral and psychological symptoms," "behavioral symptoms," or simply "behaviors" are used. The term "symptom" emphasizes that the observed behavior is part of a larger issue or problem – often a mental disorder or emotional problem.

Overall Program Goals

The goals of this introductory program are to:

- 1) introduce the idea that MANY things may cause or contribute to difficult-to-understand behaviors,
- 2) emphasize that some "problem" behaviors are NOT the result of mental illness, and
- 3) stress the importance of looking for "interaction effects" between the staff and the residents.

This program emphasizes that not ALL behavioral and psychological symptoms are the result of mental illness. Although mental illness IS a major problem in nursing homes and other residential care settings like assisted living facilities today, many of the "problem" residents are NOT mentally ill! In contrast, many older adults are *trying to COPE with THREATS to their mental health, albeit in a MALADAPTIVE way.*

Consequently we have divided the "causes of behavioral symptoms" into two groups: threats to mental health, and mental illness. Under each main heading, we have included four topics. However, there are many more possible causes that might be included for both.

Threats to Mental Health

Longstanding personality traits. Of all the things that DO change as the result of advancing years, *PERSONALITY isn't one of them.* Most research supports the notion that personality

remains stable from young adulthood into later life. Only when the person has some type of brain disease, like dementia, should the person's personality change. Otherwise, we can expect to see "more of the same."

However, staff may fail to appreciate that "this" is the way the person has always been, *their whole life long*. And as you know, giving up one's independence is not an easy thing for lots of people. Because this is an extremely important consideration, taking time to individualize the content to help staff "know" the older adults in their care is important. For example, talking about social histories and the important role of family in knowing the person's long-standing traits and habits may facilitate greater tolerance and understanding by staff.

Loss of self esteem. Another important antecedent to behavioral symptoms is low self worth, resulting from the multiple changes and losses that tend to cluster in late life. Emphasize the point that *most residents have given up a lot*, in terms of health, mobility, self care, etc., and that may affect how they behave. Other residents may have always had problems with low self esteem, and their "coping" methods (e.g., blaming others, finding fault, criticism) are entrenched. As before, thinking about the person and his/her long-standing habits and traits may help staff be more tolerant of oddities and/or negative behaviors aimed at them.

Loss of control. Feeling that your behavior *does not affect what goes on around you* can also have devastating effects. The problems that result from loss of control are typically labeled "manipulation." Remind staff that this topic is so important that a whole program has been written about it ("Help, Hope, and Power: Issues of Control and Power in Long-term Care"). Offer encouragement that you will be coming back to these ideas again in the future.

Situational stress. Stress is a "household" word these days, a concept that nearly everyone understands. Most staff will have no trouble understanding that loss and life change create stress for your residents. Although we could have easily discussed stress as part of the discussion of either loss of control or loss of self esteem, we wanted to emphasize that even "little things" contribute to the "bigger problem."

Staff may not think about *simple, day-to-day "hassles" as contributing to the person's experience of stress*. They may not appreciate that nursing home residents are vulnerable to "little" problems, *just like everyone else*. Everyone has a point at which the "straw breaks the camels back." By that, we mean that everyone has a stress threshold, and these "little problems" can accumulate, complicate other problems, and *precipitate behavioral symptoms*, if we don't intervene. In many instances, the person appears to "handle" the BIG problems, and FALL APART over the little ones. Thinking carefully about the person and recent social, health, or family problems may help staff be more understanding.

In summary, there are a number of THREATS to residents' mental health. The goal in this program is to help staff see those potential underlying problems. Most of them are quite manageable, *if we identify them and treat them*.

Mental Illness

The problems that we review under MENTAL ILLNESS include the following four topics: dementia, depression, anxiety and paranoia. As noted before, these only a few of the possible causes of behavioral symptoms. Other common causes include delirium (which is also called acute confusion) and mild cognitive impairment (MCI), as well as long-standing and severe mental disorders like schizophrenia and bipolar disorders. Be sure to make staff aware that this review is just a “sample” of possible mental disorders.

Dementia. Loss of mental abilities due to dementia interferes with residents’ ability to use information from their own memory OR from their environment. In general, two sets of problems result from dementia: 1) problems that occur as staff *care for the resident with dementia*, and 2) problems that occur when the person *isn't recognized as having a dementia*. The latter is almost more dangerous than the former. Unrecognized or early impairment may cause problems that staff attribute to “manipulation,” “stubbornness” or other problems that are within the person’s *control to change*.

As many as 80% of all nursing home residents have some type of dementia, and recent evidence suggests that as over 65% of those living in assisted living also have dementia. Although a diagnosis may be buried somewhere in medical record, day-to-day care providers are too often unaware of the diagnosis AND implications for care. Staff expect the resident to perform in a way that is far in excess of the person's real life abilities. Not realizing that the person is mentally impaired (or not realizing how dementia interferes with function), they may label the person as “difficult” or “manipulative.” As before, once the label is applied, efforts to problem-solve and find ways to promote comfort and function too often stop. Because this is an extremely important topic, a separate two-part program, “When You Forget That You Forgot: Understanding and Managing Dementia, Part I and Part II” is provided as part of *The Series*.

Depression. Depression is a REAL problem for LOTS of older adults, and is the cause of many behavioral symptoms. Of importance, depression in later life may be harder to detect and diagnose because of the multiple physical problems that the person has. Again, this topic is of such importance that there is an entire program about it, “When You Are More Than Just Down in the Dumps: Depression in Older Adults,” in *The Series*.

Anxiety. Anxiety is a symptom of many illnesses (both physical and mental), and the primary symptom in a group of illnesses called Anxiety Disorders. Although Anxiety (and Paranoid) DISORDERS are not that common, the SYMPTOMS are! As a result, staff may be confronted with overly worried, irritable, or fearful folks, but NOT identify anxiety as the underlying cause. Anxiety, like depression, may also be masked by physical illness or medications, and consequently may not be identified and treated. Again, *The Series* offers a separate optional program on anxiety titled “Apprehensive Elders: Understanding and Managing Anxiety.”

Paranoia. Like anxiety, paranoia is both a symptom of several illnesses (schizophrenia, paraphrenia, dementia, depression) as well as the primary symptom in a group of illnesses called Paranoid Disorders. Although Paranoid Disorders aren't particularly common in long-term care settings, paranoid behavior (in conjunction with Alzheimer's Disease and other dementias) is very frustrating and disruptive, *for staff, other residents, and family members*, when it does

occur. Overt paranoid behavior (thinking the CIA or Mafia are after them) is fairly easy to identify, but low level suspiciousness, which also will influence behavior, may not be. At the same time, staff may fail to appreciate that those paranoid beliefs are *quite real to the person who is experiencing them!!* Again, we offer an entire program on this topic.

In summary, the first goal is to help staff see that a VARIETY OF THINGS may be causing the problem behaviors that they observe. Also, it is important for staff to understand that *MORE than ONE thing* may be causing the behavioral symptoms!

Key Principles of Care

Although the PRIMARY point of this introductory module is to get staff thinking about common CAUSES of behavioral symptoms, and things they may be inadvertently doing that actually make those symptoms worse, each of the two sections ends with a few “key principles” of care. These principles include both suggestions for responding to the older adult, and questions that may be useful in better understanding the “problem” from the resident’s perspective.

In addition, some general strategies are offered to help staff start thinking about what THEY DO, or more importantly, what they may not be doing but should, to help residents feel safe, secure, and comfortable. The handout offers some important ideas that are discussed and expanded upon in later modules of *The Series*.

Importance of Staff Behavior

The second primary goal of this program is to put staff in touch with the idea that *THEIR BEHAVIOR does, indeed, influence how residents behave!* That’s why we emphasize the need to look for “interaction effects” between residents and staff.

The most simple explanation of “interaction effects” might be to say that “it’s a two-way street” when it comes to understanding and reducing behavioral symptoms. Although staff may not *consciously* promote negative behavior, they certainly CAN contribute to the difficulties by getting into POWER STRUGGLES with residents, or by PERSONALIZING the resident’s problem behavior! So in this program, and all subsequent programs, an emphasis is placed BOTH on “what the resident is DOING,” AND “what the resident is doing TO ME” (staff).

The latter of these two, “what the resident does TO ME” isn’t something we give a lot of thought to. We know that they upset us, or make us angry, but we may not stop to think about WHY. WHY are we so frustrated? Why do they “get to us?” In lots of instances, the resident makes us feel incompetent; they damage our self worth. When they are demanding or “difficult,” they don’t allow us to feel like an “effective, competent worker” or even a “good and caring person.”

They exasperate us, but they also THREATEN us (at some level) by *not complying with our requests*. After all, “*Who IS in charge here, anyway?*” In lots of instances, staff feel the need to be “in charge.” And if a resident “acts up,” they may attempt to “correct” the behavior, feeling they need to make the person comply with the routine or the request. They may believe that they can’t let them “get away” with it, or the behavior will get even worse. Unfortunately, that attitude further threatens the resident and the behavior occurs again. Staff feel progressively

more frustrated, angry, demoralized, and dissatisfied with their role. Like we say in the script, **NOBODY WINS.**

*Consequently, it is extremely important that you help staff see that they may not be able to change the resident's behavior, but they can **ALWAYS** change how they react to (and feel about) the resident's behavior!!* This is a **SKILL** that is **LEARNED**. It does not "come naturally," except perhaps to saints! But the idea of getting "psychological distance" and exerting "cognitive control" is well worth learning!! Not only will it help staff manage difficult residents, they can also apply the ideas to friends, family, co-workers, and acquaintances.

Again, these ideas may be difficult for staff to understand and apply. Your job, as the trainer, is to check for understanding (as best you can) at the time that you teach the program. **THEN**, look for ways to help staff "put those ideas to work" in their day-to-day practice. **USE** the terms "cognitive control" and "psychological distance" when you see a staff member mumbling about a resident. Ask them, gently and with humor, "Do you need to get a little 'psychological distance' from Mrs. Smith?" Encourage the natural leaders (*the nurses or nurse aids that people listen to and respect, not necessarily the staff who are in positions of leadership*) in your facility to help you out with this.

Remember, the **REAL GOAL** is to see the program content reflected in the way that staff work with the residents. If the ideas are left at the door when people walk out, then we aren't "hitting the mark." That's true for all of the programs in this series. And you, as the trainer, are the key person in helping staff take it "out of the classroom" and into their daily lives.

As we noted in our "General Instructions," we do strongly urge you to "try out" the materials in advance of teaching the program so that you can relate, from your own personal experience, how the concepts or interventions may apply to your real life setting with your real, live residents!

Although there are no specific interventions to be tried out in advance, we suggest that you develop your own "Reminds Me Of..." list. (This is a handout to be used during the program.) In addition, take time to ponder the following questions. If you don't know the answers, think about who in your facility might and ask them for assistance.

1. Who in your facility seems to be "failing" in terms of their memory and orientation, although the diagnosis of dementia, or Alzheimer's Disease, *is not in the chart*? Do they do things that are frustrating or puzzling to staff? What are those things?
2. What are the most common (favorite) labels that staff use for difficult residents in your facility? E.g. Are residents typically described as "manipulative?" As having a "big ego?" As being "naughty?" Integrate these terms and labels into the program to personalize the content to your facility.
3. Who has had lots of losses (health, friends, family, etc.)? Can you mention these during the program as an illustration?

4. Think about the social history that you (the social worker, admissions specialist, etc.) collect from the patient and family. What does it tell you about longstanding personality traits, patterns, and habits? How is that information shared with staff? Or is it? How might you get that type of information "into the hands" of the people who may need to use it, the direct-care staff?
5. Can you give an example of a power struggle that has occurred in your facility? Between a staff member and a resident? Or even between two staff members?
6. Can you offer an example of someone (a resident, staff member, or even a friend or family member) who really "gets to you" in terms of bringing out a not-so-healthy and rational reaction? Someone who pushes YOUR buttons? What do they do? How does it make you feel? Compare what you may *think* or know to what you *feel*.

Throughout this process, remember that "tasteful" HUMOR is important. Try to avoid any illustration, story or comment that is belittling to staff or residents. The intent is NOT to make fun of staff's real life problems. *In contrast, we hope that these real life examples will stimulate your staff to "look beyond" the behavior itself and ask "WHY?"* Why is the person behaving this way? What is the cause of the problem? Are they mentally ill? Or are they having a hard life? What am I (the staff member) doing to make the situation better? AND IMPORTANTLY, is it possible that I am actually doing something that makes it WORSE?!

Common Causes of Behavioral Symptoms

THREATS TO MENTAL HEALTH

Personality Traits -- Are long-standing and deeply ingrained patterns of behavior that are established very early in life and continue throughout adulthood and aging. Personality traits are our unique, yet "typical" ways of relating to the world, typical ways of

- thinking about ourselves and what happens to us;
- relating to other people;
- trying to cope and get along.

Loss of Self Esteem -- Can be caused by unwanted changes in our bodies, roles, abilities, and activities. Low self esteem occurs when the person's behavior doesn't match what they "want to be," their "ideal." Symptoms of low self esteem include:

- criticism of self and self pity: may say they are "stupid, no good, a born loser";
- criticism of others: things are never good enough; uses "put-downs";
- exaggerated sense of self importance: attempts to compensate for their low opinion of themselves by acting "above it all" and "better than you (others)";
- destructiveness toward others: reduces their own self hate by directing it to victims in the environment;
- disturbed relationships: takes advantage, mistreats, abuses others; or is passive-dependent;
- minimizing their own abilities: avoiding, neglecting, or refusing to see their real assets and strengths allows them to "never fail" because they "never try." They convince themselves that they are "no good."

Loss of Control -- Can be caused by the loss of ability to make even "simple" decisions and "do for yourself." This causes some folks to feel "powerless" or "out of control," which threatens their sense of being a competent and worthwhile human being. They "fight back" against these negative feelings by

- trying to prove that they ARE in control;
- telling you (and others) "what to do" and "when to do it";
- wanting things "done their way" and on "their terms"; and by
- seeming to be demanding, picky, or hard to please.

Situational Stress -- Can cause or contribute to lots of behaviors. The resident may be "short-fused," "on edge," or even passive and uncooperative because of stress. Some of the more common sources of stress include:

- discomfort caused by physical illness or disability;
- loss of health and ability to function independently;
- loss of loved ones through death and relocation;
- financial problems or concerns;
- difficulties adjusting to communal living after living alone.

MENTAL ILLNESS

Dementia, or Alzheimer's Disease -- Involves a progressive loss of ability caused by brain cell death. Over time, the person loses their

- memory: ability to remember both recent and long-term events is lost; recent memory fails first, then long-term;
- judgment: ability to use "social skills" is lost; doesn't realize their behavior is offensive to others;
- impulse control: ability to "hang on" to a thought, desire, or need is lost; will say or do whatever "comes to mind";
- abstract thought: ability to reason and use logic is lost; can't predict or plan events;
- language: ability to use language is gradually lost; starts with word-finding difficulties and ends with being mute.

Depression -- Is the most common psychiatric illness among all age groups and a common problem among older adults. Symptoms include:

- feeling sad, blue, down in the dumps, depressed; crying, feeling discouraged, that nothing is fun anymore; feeling irritable, anxious, or even paranoid;
- withdrawal from usual activities, doesn't feel pleasure; feels worthless, hopeless; is overly critical of self and others; has delusions and/or hallucinations;
- paces, wrings hands, rocks; sleep disturbance, loss of appetite, loss of weight; fatigue, loss of energy; preoccupied with physical health, thinks they have a fatal disease; thoughts of death, or suicide; constipation; heart beating "out of their chest" (tachycardia).

Anxiety -- Is the primary symptom in a group of illnesses called Anxiety Disorders and a symptom of several other mental illnesses. The way that anxiety presents itself will vary from individual to individual, but often includes:

- shakiness, jitteriness, jumpiness, trembling, tension, muscle aches;
- sweating, heart pounding, cold clammy hands, dry mouth, dizziness, light-headedness, tingling in hands or feet, upset stomach;
- feels anxious, worries, ruminates (thinks about bad/upsetting events from the past), and expects something bad to happen to him/herself or others;
- feels "on edge," impatient, or irritable.

Paranoia – Like anxiety, paranoia is a symptom of several different mental illnesses (schizophrenia, dementia, depression), but is also the main symptom in a group of illnesses called Paranoid Disorders. The primary symptom is the feeling that they are being harassed or persecuted. The paranoid person may

- be suspicious and guarded, showing lack of trust, exaggerated jealousy, anger, argumentativeness, or anxiety;
- think people are looking at them, talking about them, or spying on them;
- believe that no one is trustworthy;
- believe an organized plot is directed at them (CIA, Mafia, FBI, foreign agents);
- complain of unexplained losses or irregularities; e.g. people stealing or rearranging possessions.

Reminds Me of . . .

THREATS TO MENTAL HEALTH

1. **Personality traits:** Long standing patterns of behavior; family and friends say "that's the way they've always been."

2. **Loss of Self Esteem:** Has trouble liking "who they are as a person." Don't really see themselves as having value and being worthwhile. May find fault with others to "build themselves up" by "putting others down."

3. **Loss of Control:** Feels like they are being "pushed around" and have lost "control" over their own life. They don't feel that their actions actually make a difference in what happens to them and as they try to take control back, they may seem "controlling" in negative ways - - picky, demanding, hard to please.

4. **Situational Stress:** Loss, change, and even daily "hassles" can push the person into being cross, disagreeable, and uncooperative. Recent losses and having to accept "facts" that are unpleasant are often key.

MENTAL ILLNESS

1. **Dementia:** Progressive loss of memory, judgment, impulse control, abstract thought, and language. Shows up as changes in behavior and emotion.

2. **Depression:** Disturbances in mood or emotions (sadness, crying, irritability), perception of themselves and their life (feeling worthless, hopeless; withdrawal from activity; loss of ability to feel pleasure) and bodily changes (constipation, sleep disturbance, loss of appetite and weight, fatigue) are key symptoms.

3. **Anxiety:** Feeling jittery, shaky, and nervous is common. Complains of their heart beating "out of their chest" or shortness of breath, dizziness, trembling, or sweating. Is very worrisome, feeling that "something bad is going to happen" but often can't say what. Is impatient, irritable, and "on edge."

4. **Paranoia:** The person feels that they are being harassed or persecuted; they are suspicious and guarded, lack trust, and may have exaggerated jealousy, anger, argumentativeness, or anxiety. They feel "picked on," singled out for harassment, and believe that there is a plot against them.

Key Principles of Care

THREATS TO MENTAL HEALTH

Primary Goal: Support the resident to cope and adapt. We assume the “problem” behavior is a signal that the resident is feeling emotional distress that he/she is not able to resolve. The person’s usual coping methods are not working. Our job is to help them to manage feelings of distress in healthier ways. *These methods work well with residents who have the ability to process information, consider alternatives, and problem-solve with us.*

1. Identify the SOURCE of distress, unhappiness, or conflict.
 - What is the problem or issue *from the resident’s perspective? What are THEY distressed about?*
 - What problems or losses may have contributed to this problem?
 - Is something currently happening within the facility (e.g., problems with other residents, staff) that is contributing?
 - What do you know about the person’s long-standing patterns of personality and coping?
2. Focus on PAST COPING methods. How has this person coped with similar kinds of problems in the past?
 - Reminisce with the person about their life-long habits. What kind of problems have they experienced? How did they cope then?
 - Discuss what or who was helpful to them. How did they eventually “feel better”? What made a difference?
 - Remind them of their strengths and abilities. Most older people have survived many problems and stressors in their lifetimes. Gently remind them that they have the ability to cope and adapt, even though it is difficult and perhaps painful.
3. Identify and use current RESOURCES that may be available to the person.
 - What current sources of support, assistance, or comfort may be available to the person?
 - What can you/others do to reduce problems such as loneliness, unhappiness, frustration?
 - How can you involve the resident in MEANINGFUL activities that may distract the person from negative feelings and promote a sense of meaning and purpose in living? What helps the resident feel like a worthwhile person?
 - What role does family play (both positive and negative) in providing needed support to cope with stressors?

Key Principles of Care

MENTAL ILLNESS

Primary Goal: Support residents to function at the highest level possible, given the type of mental disorder they have. In mental illness, behavioral and psychological symptoms are often more severe and persistent, and may require medication interventions to reduce their frequency and intensity. By adjusting responses and reactions to “unusual” or “unwarranted” behaviors often helps promote comfort and safety. Many of the same methods for helping the person who is experiencing threats to mental health will also work with the person who has mental illness (e.g., distraction, redirection, involvement in meaningful activities). However, “correcting” and “confronting” should be avoided.

1. Identify the CAUSE of behavioral symptoms to determine appropriate treatments and interventions.
 - Does the person have dementia, depression, or some other mental illness?
 - What diagnoses are written in the medical record? Describe behaviors carefully so others can understand the kind of problems you are experiencing with the resident.
 - Discuss problems and challenges with other staff. What do others experience? How often? How long? Where and when do behaviors occur? DESCRIBE behaviors so an accurate diagnosis can be made.
2. Take all concerns SERIOUSLY, even if they don't make any sense to you, or you know there is no “real” problem or threat (e.g., unrealistic fears).
 - Avoid general reassurances like “Its fine.” “Don't worry.” “You're okay.” Instead, be as specific as possible: “I will keep you safe.” “Let's go look at that together.”
 - Avoid confronting false beliefs, which is like telling the resident they are “lying” or “wrong.” Instead, use distraction, redirection and reminiscence. For example, instead of saying “You live here now” to a person with dementia, try asking about their home: “I've forgotten . . . tell me about your home. Where is it? Who do you live with?”
3. Respond PROMPTLY to all behaviors; don't “wait to see what will happen.”
 - Behavioral symptoms signal distress and discomfort. If “left alone” that distress often gets worse. The person cannot “solve the problem” alone and needs your help.
 - Offer support, assistance, reassurance, or redirection when you see the behavior STARTING.
 - As always, *try to understand the problem from the resident's point of view!*

Key Principles of Care

GENERAL STRATEGIES/SUMMARY

1. STOP and reconsider the behavior you see. ASK: *What is really going on?*
 - Does the behavior represent a *threat to mental health*? If so, what is the threat?
 - Does the behavior represent *mental illness*? If so, what type of mental illness?
2. Adapt CARE PROCESSES (e.g., routines, approaches, and factors in the environment) to promote safety, security and a sense of predictability.
 - CONSISTENCY in staff approach and routines is critical to maintaining a sense of safety and being able to know what to expect (predictability).
 - Encourage a sense of CONTROL by involving residents in their care and offering choices (e.g., Now or later? Blue or red dress? Juice or water?).
 - Ensure basic HEALTH NEEDS, like thirst, hunger, or pain that may increase behavioral symptoms, are met.
 - Compensate for SENSORY LOSS that can lead to misunderstanding. Make sure the person can hear and see you and their environment.
 - Adjust routines and demands to accommodate COGNITIVE decline and deficits.
3. Work as a TEAM to understand and solve problems.
 - Develop and maintain BEHAVIORAL LOGS to document where, when, and how often behaviors occur to identify possible triggers.
 - Implement BEHAVIOR MANAGEMENT TEAMS that include staff from all disciplines and all shifts. Share information with one another. DISCUSS your experiences and observations, and make plans together.
 - EVALUATE if any part of your care plan worked.
 - Monitor successful changes, develop new plans, stay focused on “priority” behaviors, and START AGAIN.

The Goal of Exploring "Problem Behaviors"

Instead of seeing a problem behavior *all by itself* -- whether it's difficult, controlling behavior, agitation, depression or something else -- we need to look for the chain of events that led up to it. By recognizing what may *cause the behavioral and psychological symptoms* that we see, we have the ability to

1. Reduce or eliminate those symptoms by treating the real problem;
2. Minimize the risk of participating in the problems (power struggle) and actually making things worse;
3. Do things to prevent problems;
4. Avoid personalizing the problem; that is, avoid feeling that the person is "doing it" to "us" -- on purpose -- to make our lives unhappy. This is an error in thinking that can cause us a lot of grief!
5. Respond empathetically (that is, see the problem from the person's point of view); and
6. Intervene in a way that is helpful to the person and to US. Many times we are best able to cope with difficult situations by changing the *way that we look at them* rather than by *actually changing the situation*.

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¹ Note: Older references that provide the foundation on which additional research and clinical practice are based are purposefully retained here for easy reference to original sources.

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