Geriatric Mental Health Training Series: Revised

Whose Problem Is It?

Mental Health and Illness in Long-term Care Centers

Lecturer's Script

Revised by Marianne Smith, A.R.N.P., C.S., M.S.

From original content by

Marianne Smith, R.N., M.S.

Kathleen Buckwalter, R.N., Ph.D., F.A.A.N

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

INTRODUCTION

>>Title of program

Today we're going to review some of the behavioral and psychological symptoms that may signal mental illness or emotional distress in older people who are living in residential care, whether that is assisted living, the nursing home, or another alternative environment besides the person's "original" home.

The primary focus today is on understanding the wide variety of things that cause behavioral symptoms -- not the solutions to reduce or eliminate the behaviors. In this first module we explore the "problem"[1] to better understand the experiences of older adults who experience behavioral symptoms AND the caregivers who often are often puzzled and frustrated by these behaviors. We ask "Whose problem is it?" because caregiver reactions are critically important to both reducing behaviors AND to making them worse. If we don't understand what is CAUSING the behaviors, we may "blame" the person and NOT respond in ways that provide comfort and security. This introductory program provides a basis for understanding other modules in *The Geriatric Mental Health Training Series*. Each of those additional topics takes an in-depth look at a particular symptom or diagnosis, and offers specific interventions.

>>Goals for today

The GOAL of this program is to

1) Improve the *quality of life for the residents*, by

2) Improving the *quality of knowledge of the staff*. At the same time, we hope that this knowledge will help

3) Improve your [the caregiver's] *feelings of competency and satisfaction with providing care to sometimes difficult-to-understand residents.*

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[1] To the extent possible, this revised edition of *The Geriatric Mental Health Training Series* avoids negative labeling of behavioral and psychological symptoms that perpetuate ageist stereotypes of older people. Labels applied to older adults with behavioral and psychological symptoms clearly influence attitudes and actions that ultimately shape their quality of life. Use of quotes implies that the word is perception-based and may be inaccurate. For example, the behavioral symptom *may not* be a problem for the person who experiences it, but challenges caregivers who lack the knowledge and skills to understand and respond appropriately.

>>Mental health and illness

To accomplish this goal, we need to think in terms of

1) MENTAL ILLNESS and its treatment, but also in terms of

2) MENTAL HEALTH – all the ways that we humans grow, develop, change, adapt, and cope; the things that make us feel like "life is worth living." *And along that same line, the things that may interfere with feeling content with life.*

>>Stop and look!

Unfortunately, we tend to neglect the second of these two, threats to mental health, particularly when we think about an old person living in an “artificial” environment like assisted living, residential care, or nursing facilities. As people move to care settings, they leave a lot behind, and that makes it difficult to “know” the real person. It's far too easy to look at this “wrinkled up, worn out, debilitated old ancient”[2] as though they have always been “wrinkled up, worn out, debilitated and old.”

>>Think again

We forget that they

-- were once children, and youths; that they

-- survived adulthood, and all of the experiences of that time in history; that they

-- made decisions about how to live, and what to do, and with whom they wanted to share this human condition of ours, whether that was marriage, or children, or a career.

We may overlook longstanding patterns of behavior that are still with them, but in a different form.

AND, we may expect them to "transform themselves" to get along in this new and unfamiliar environment, not realizing how difficult and painful it is to be at this place, to need our assistance, to live communally when so many years were spent alone.

[2] The language “wrinkled up, worn out, debilitated old ancient” is used purposefully to depict the ageist attitudes that too often pervade long-term settings, and our failure to see the older person as a PERSON first and foremost.

Without special attention to, and knowledge about all the things that can precipitate (or cause) difficult behaviors in residents, we may slip into thinking

-- they have "always" been this way; AND that

-- they are *incapable* of change, but

-- without offering them an *opportunity to change*.

So, mental illness and mental health, BOTH, are very important in understanding difficult behaviors.

BEHAVIORIAL AND PSYCHOLOGICAL SYMPTOMS: TWO ISSUES

>>Examine... the causes of behavioral symptoms

There are two basic approaches to dealing with older adults who have behavioral and psychological symptoms, and we need both to understand and respond appropriately.

First, we need to think about what causes the behaviors. By understanding what causes the behavior, we can try to think of ways to treat the real problem instead of just the symptoms. This is the same principle as treating an illness. It's okay to take cold medicines to treat the symptoms of a respiratory infection, but you need to take antibiotics to cure the thing. Otherwise those symptoms drag on forever, and often get worse!

Second, and perhaps even more important, we need to think about *how we can manage our own feelings* about those "difficult" residents. We may or may not be able to change the resident. But we can always exert *control over how we feel*. We have the ability to *not let it get to us*. And by taking an active role in managing how we feel about the resident's behavior, we are in a better position to keep our own stress at a manageable level.

>>What is the real problem?

****Refer to handout: Common causes of "problem" behavior**

Let's start by thinking carefully about the "problem" and what might CAUSE the difficult-to-manage scenes that caregivers encounter. One of the most important things to remember is that behaviors are "symptoms' and may be associated with a wide variety of underlying problems – whether that is a threat to the person's mental HEALTH or a symptom of mental ILLNESS.

It's also important to remember that many behaviors "look the same." For example, anxious, fearful, worrisome behavior can be the result of a real life problem, OR it can be caused by an anxiety disorder, OR depression, OR dementia. So even though behaviors may look the same, they have different CAUSES that require different solutions to help the person be comfortable, functional and safe.

>>Many possible causes

Remember, behavioral symptoms in residents are caused by many different problems, and often more than ONE problem, so we need to think broadly.

For now, let’s think about the most common causes of behavioral symptoms in each of the two main categories:

1) MENTAL ILLNESS, and

2) THREATS to our MENTAL HEALTH

As you can see on this slide, a number of problems are the result of mental illness. Depression and dementia are two big contenders. But other mental problems, like anxiety and paranoia, although less common, can also cause the older person discomfort (along with staff or family caregivers).

And, an equal number of "normal" problems related to loss, stress, and coping that can also cause difficulties. These are the mental "health" problems that are OFTEN OVERLOOKED. By that, I mean that the person isn't mentally ILL. Their mental health is being threatened

-- they are having problems coping, adjusting, or getting along;

-- they feel "out of sorts," stressed, or unhappy; and

-- their BEHAVIOR signals us "loud and clear" that they are "having a hard life!"

But their reaction to the stress or loss still falls in the range of "normal" behavior -- even when they are challenging to work with.

>>Reminds me of . . .

//Trainer: If you are using this program to train experienced staff caregivers, consider asking them to think about older adults they have cared for in the past using the handout. Take a few minutes to orient staff to the handout and its use.

****Refer to handout: Reminds me of...**

As we review various causes of problem behavior, try to think of older adults, current or past, that fit the descriptions. There's a handout called "Reminds me of..." in your packet. Get it out and jot down the names of older adults whose behavior "reminds you of" the behaviors in each of the eight categories. Don't be shy; there's nothing to lose. The point is to start thinking about how various types of behavioral symptoms may “fit” different people in your care. This may help you reconsider “why” the person acts the way he/she does, and possibly change the way you approach, assist, and comfort the person. As before, additional training modules in this series focus more on specific types of problems – like depression and dementia – and offer interventions that caregivers can use to support and assist older adults.

//Trainer: You may want to give an example of a resident who manifests the type of behavior described or ask for an example from your participants for one or more of the categories that follow.

****Refer also to handout: Common causes of problem behavior**

THREATS TO MENTAL HEALTH

>>Threats to mental health

Let's start with the problems that are caused by THREATS to mental health. It's important to remember that each person has "normal" or typical ways of living, and coping with life. Sometimes things happen that overwhelm the person's ability to cope and adapt – like needing an "outsider's" help to get along, and living someplace other than "home."

Difficult behaviors can emerge when a person's coping abilities have broken down somehow. The things they usually do to get along, and cope, and adapt to life's problems are not working. Extra assistance is often needed to help them rethink their problem, or find another way of managing. In other cases, caregivers need to adjust what THEY do to help the older person feel supported, and cared about, and like they are in control. That includes accepting them for who they are, and have always been.

>>Personality traits

For example, longstanding PERSONALITY TRAITS can affect behavior. The person who is demanding and hard to please in late life was probably like that as a young person as well. Some people have always been hard to please.

Some are just more

-- particular;

-- critical of others;

-- rigid in their view of the world;

-- likely to blame others vs. accepting responsibility for their own well-being;

-- inclined to use indirect ways of getting what they want;

-- UNABLE to directly say ***what they want and how they feel.***

These behaviors can cause some real problems for caregivers and often are part of what is labeled "manipulative behavior." The reality is that we ALL have "typical" ways of relating to the world, typical

-- ways of thinking about ourselves and what happens to us,

-- ways of relating to other people, and certainly

-- ways of trying to cope and get along.

That's all part of our *unique personality*.

>>Personality traits, continued

And just like some folks are typically kind, and sweet, and easy going, others are cold, and sour, and critical of others! And when they are put in a difficult situation (like having to live someplace other than their OWN HOME) they'll probably use their "typical" way of trying to solve their problems. That means that they may tend to

-- BLAME you for their unhappiness, because they never could take responsibility for what happens to them;

-- be CRITICAL of you, because no one *has ever* been able to "measure up" to their expectations; or

-- TALK ABOUT YOU behind your back because they *never could* handle conflict directly.

At the same time, it's important to remember that the person is probably uncomfortable, whether that's sad, lonely, feeling worthless, incompetent, or neglected and unloved. They are trying to make those uncomfortable feelings go away. Unfortunately, the ways that they go about losing those negative feelings often create more difficulties for you and for them.

>>Loss of self esteem

Another thing to consider when we think about the causes of problem behavior is the LOSS OF SELF ESTEEM. Loss of self esteem has a *big effect* on *how people act toward others*. How we feel, about ourselves and our lives, affects the way we behave toward others. That is true for everyone: *staff, families and residents alike*.

Self esteem is our sense of "being okay" and of having value as a person; of being comfortable with ourselves, our lives, and our abilities; it means that we feel secure. When we lose that sense of being okay -- and question whether we really do have value as a person -- we may show that in some pretty weird ways.

Although it seems contradictory, the person who is most likely to "build themselves up" by "putting others down" is a person who is most likely INSECURE, which means LOW SELF ESTEEM.

>>Symptoms of low self esteem

Some of the more common symptoms of low self worth are listed on this slide and are described in your handout.

//Trainer: Below is what is printed on the slide. Be prepared to explain or offer examples.

-- criticism of self
-- criticism of others
-- disturbed relationships
-- exaggerated sense of self
-- destructiveness toward others
-- minimizing their own abilities

Have you seen these things in any of our residents??

//Trainer: Wait 3 seconds for response.

We need to recognize that loss of self esteem is a real problem for many of the older people who have come to live in our facility. Many of them have had to *give up a lot of the things that they liked about themselves and their lives.*

Think about it. What makes <u>you</u> feel like a worthwhile person? How about your strengths and abilities? Your roles? How about feeling like you make a contribution -- to someone or something -- and that you're appreciated?

How about

-- being a good employee, a good friend, a good parent or spouse?

-- having certain skills, like sewing, or cooking, or needlework?

-- participating in certain activities, like church, or bowling, or volunteer work?

Now when we lose the ability to BE these things, or DO these things, our sense of self worth usually suffers.

>>Loss and change

//Trainer: Below is what is printed on the slide. Be prepared to discuss and give examples of any terms your staff may not understand.

-- Health
-- Sensory input
-- Activity changes
-- Mobility
-- Relocation
-- Finances
-- Loss of loved ones: death, divorce, separation

So we need to think about the LOSSES AND CHANGES that the "difficult" resident has experienced and ask ourselves what effect this has had on the person.

Keep the resident's perspective in mind as you think about these things. It is WAY too easy to impose our OWN values, beliefs, and experiences on other people. Try to back up, take another look, and ask: "What does this mean to her?" "How does he feel about it?"

The loss of one's home, of a beloved family member (particularly a spouse), and other losses that tend to cluster in late life can have a HUGE effect on behavior. So stop and think about what LED to the person moving here, AND what has happened since then. What might contribute to the person's "problem" behaviors?

>>Loss of control

Real or feared LOSS OF CONTROL is another powerful factor in causing behaviors that caregivers may not understand. Feeling "in control" is tied to both *self esteem and to feeling like a competent human being*. So threats to our feeling like "the boss" of our own life can cause all kinds of reactions. In the attempt to take control back, the person may become demanding, picky, and "hard to please."

When you see residents trying to "get their own way," stop and think again. Remember, being "in control" is linked to feeling like a worthwhile person. Trying to influence what happens, even using "unhelpful" or "unhealthy" methods, is STILL an attempt to maintain a sense of being in control and having personal worth.

>>Situational stress

SITUATIONAL STRESS can never be overlooked when we are trying to understand behaviors. Like everyone else, older adults in our facility will react to situations and events that hurt or upset them. And like everyone else, they may become unusually *cross, disagreeable, and uncooperative* as the result of that stress or loss.

A few minutes ago, we reviewed some of more common sources of stress that can occur in later life. But what about the stress of simply having to live here? Of having to

-- share a room with a stranger?

-- bathe in a shower room with other people around?

-- sit at a dining table with folks you don't like?

We also need to think about what is going on in the present moment that might be "making things worse." Is there a pattern to the behavior? Is it worse

-- at a certain time of day?

-- with certain staff members?

-- when you are short staffed and in a hurry?

-- when family is there? or just left?

As you can see, a number of "normal" things can cause lots of DIS-STRESS for our residents. And out of their distress, they may act in ways that we find difficult to understand and manage.

>>Threats to mental health: Key principles

****Refer to handout: Key principles of care – Threats to mental health**

There are lots of things that we can do to help people feel less distressed and more comfortable. In general, we want to think carefully about THIS PERSON, and then ask:

- What is the SOURCE of the distress, unhappiness, behaviors that we see, or complaints we hear?
- How has the person COPED in the PAST?
- What RESOURCES and abilities does the person have to change, adapt, and get along now?

In some situations we may not really know the person well. Using reminiscence, which involves reflecting and talking about the past, can be helpful. Ask the person about “hard times” and how they managed. Who or what made a difference? What brings them comfort or happiness now? What resources can they draw on? What makes life meaningful?

Sometimes people need help to see what is good or right about their situation. Gentle reminders about their positive points and resources can help reduce distress, and in turn, promote more healthy behaviors.

When we're looking for the CAUSE of behavioral and psychological symptoms, we also need to think about MENTAL ILLNESS as possibly being the culprit. So now let’s think about the type of behavior that might be caused by some of the common mental illnesses.

MENTAL ILLNESS

>>Dementia: Leading cause of behavioral symptoms

The most common cause of behavioral symptoms in late life is the loss of mental abilities due to Alzheimer's Disease or some other type of DEMENTIA. These losses will interfere with the resident's ability

-- to reason,

-- to control their impulses,

-- to remember what to do and how to do it.

The loss of mental abilities can make the resident’s care puzzling, and sometimes challenging. In the early stages, persons with dementia may *cover up* their memory losses by making up

answers, or becoming *defensive* and *nasty* with us when we ask them questions because they don't remember the answer.

They may become *suspicious* or *paranoid* -- thinking that others are stealing from them because they've forgotten where they put things. Later on, they will have difficulty dressing themselves, feeding themselves, or taking care of other day-to-day chores. In summary, there are a variety of ways that the resident with Alzheimer's disease, or some other kind of dementia, will present a challenge.

The losses that are part of dementia are caused by the *loss of brain cells*. Currently there is no cure for this type of disease but there are many things that we can do in terms of how we respond to and interact with the resident to help them get along better.

>>Depression

Another group of behaviors are caused by the resident who is depressed. Of importance, depression can affect the person's mood, making them sad and blue, but also can cause anxiety and paranoia. And in some people, the primary problem is that they lose their ability to experience pleasure!

In addition, fatigue, indifference, passivity, and lack of motivation are all associated with DEPRESSION. These characteristics make the person hard to deal with because

-- you can't "get them going";

-- they won't participate in self care because they "don't care";

-- they take more time because they are "slowed down";

-- they are sad, and can't be comforted;

-- or they constantly complain about aches and pains (somatization).

Depression is a mental illness. But unlike Alzheimer's Disease or other dementias, it has a cure. In fact, depression is often called "a reason for hope" because it is the most treatable of all mental illnesses. Unfortunately, it is also often masked, or hidden, in later life. And depression is often mistaken for "senility," or dementia, and written off as "incurable!"

>>Anxiety

ANXIETY is another common emotional problem in later life, and can appear in many different forms. Some complaints may relate to the person's mental or emotional outlook.

//Trainer: Below is what is printed on the slide.
-- A symptom of MANY disorders: Depression, dementia, delirium
-- The primary symptom of anxiety disorders – usually generalized anxiety disorder in older people
-- Emotional worry, apprehensive expectation
-- Different from FEAR: Can't identify WHAT is worrisome
-- Like depression, many physical symptoms

The resident may complain that they feel nervous, jittery, or uncomfortable. They may feel like something BAD is going to happen, even though they can't tell us what that is. They "wear you down" WORRYING about things that they can't even name.

OR the resident may complain about PHYSICAL distress -- physical distress that we can't find a "real" (medical or physical) cause for. They may say that

-- their heart is "beating out of their chest"; they must be having a "heart attack";

-- they are dizzy, or lightheaded;

-- their hands and feet tingle;

-- their stomach is upset; they have diarrhea;

-- they're too hot, or too cold.

//Trainer: Present the next paragraph as though it is spoken by an anxious resident.

And why don't you do something about it??!! Obviously, they are SICK! And you just aren't listening to them!! Call the doctor! Take care of them! Be sympathetic! What's wrong with you folks?

As you can see, this type of behavior can cause all kinds of negative reactions among staff!

>>Paranoia

PARANOID ideas and feelings can also cause tremendous difficulty for staff! The person is very suspicious and "on guard." They think that someone, or something, is "out to get them." Maybe that's you or maybe that's the facility administration. Maybe it's their son, or daughter, or even the FBI, the CIA, or the Russians!

//Trainer: Below is what is printed on the slide.

-- Delusions (false, fixed beliefs) that someone or something is "out to get them"
-- Perhaps the most "troubling" of all symptoms
-- Symptom of many mental illnesses: Depression, dementia, anxiety disorders, psychotic disorders
-- Primary symptom of paranoid disorder

The FEAR of being "picked on," "put down," or persecuted, comes out in behaviors – ones that caregivers often do NOT understand!!

- They are afraid, but they are also angry.
- They accuse you, or their roommate, or whoever, of stealing things or somehow trying to harm them.
- They verbally attack whoever is seen as part of the "plot."
- They isolate themselves in their room to "protect" their belongings (or "booby trap" their room).
- They are uncooperative with our requests since we are "probably part of the conspiracy."
- They may even become physically aggressive if they think that we are threatening them!

These behaviors may be particularly troubling to staff because attempts to "reason" or "explain" just don't seem to work.

>>Mental Illness: Key principles

****Refer to handout: Key principles of care – Mental illness**

Just like treating "threats to mental health," there are some basic things we can do if we believe the behavioral or psychological symptoms are caused by mental illness. As before, think carefully about THIS PERSON and then ask:

- What is the possible CAUSE of the symptom? Is there a mental illness diagnosis in the medical record? If not, does the person need to be evaluated by a professional?
- What is the primary complaint or problem? Is there any basis in "reality?" Take all concerns seriously and "check it out." Some times there is a real-life cause for distress, like seeing a shadow or reflection that is not understood.
- What can you do NOW to help the person feel safe and comfortable? Don't wait to "see what will happen." Once a person is distressed, it usually only becomes WORSE, not better, by waiting.
- What does the PERSON think is happening and why? What is THEIR interpretation? Try to take their point of view, using their abilities.

In summary, a number of things can cause behavioral and psychological symptoms, by themselves, or in combination with other things. As a result, the necessary first step is to ASSESS the problem and figure out what is causing or contributing to the difficult behavior. Once that is clear, INTERVENTIONS can be developed to try to correct, or at least decrease, the underlying problem.

>>What is really going on?

****Refer to the handout, Key Principles of Care – General Strategies & Summary**

Caregivers must ALWAYS ask themselves, *WHAT IS* <u>REALLY</u> *GOING ON HERE?*

- Is the person suffering from a mental illness, like depression, or dementia? Or even an anxiety or paranoid disorder? If so, what can we do to treat the disease or illness?
- Or, has the person been like this their whole life long?
- What kind of losses have they endured? Is stress the culprit? Or loss of control? Or low self esteem?

Some of these topics are described in depth in other modules of *The Geriatric Mental Health Training Series*. For now, the point is to understand that many different kinds of problems can all cause the same type of behaviors, AND that caregivers play a critical role in reducing those behaviors. But the first step is understanding what the symptoms might represent!

>>Believe!

The critical ingredient is to *BELIEVE THAT CHANGE IS POSSIBLE*

-- *in the residents,*

-- *in their families, and*

-- *in yourself and other staff around you!!!!*

<u>MANAGEMENT OF OUR OWN FEELINGS</u>

>>How we manage our own feelings

Going back to where we started, there were two main issues to examine when we think about difficult residents. We have reviewed some of the more common CAUSES OF BEHAVIORS.

The second and equally important factor is to think carefully about HOW WE MANAGE OUR OWN FEELINGS about the behavior.

Sometimes we can *recognize the underlying problems* and then help the resident change *their perspective* which also *changes their behavior*.

In other instances, we need to understand the behavior so that *we can manage* both the behavior and how it makes us feel. The behavior doesn't necessarily go away. Instead, we find ways to "contain it," AND to not be upset by it.

//Trainer: This is a very important point. Emphasize it.

NOT BEING UPSET BY THE BEHAVIOR IS THE MOST IMPORTANT FACTOR. When you are angry, frustrated, resentful, and generally annoyed with the person, *you are not in a position to help them or yourself!!!!* You suffer, they suffer, and other residents and staff suffer. NOBODY WINS.

Part of the problem is the resident's behavior. But part of the problem *is what the resident does to you*. Yes, they are frustrating. Nothing is ever good enough. They can't be pleased. They do or say things that are not appropriate to the situation at hand.

>>Physical distance

Sometimes, you may just want to get as far away from the person as possible. And maybe you do that -- PHYSICALLY DISTANCE yourself from the source of stress and irritation. Here we are using the old "out of sight, out of mind" way of keeping our feelings under control. If I don't have to see them or talk to them, then I don't have to be upset. *But that strategy NEVER works for long when we are trying to help a resident!* Yes, a brief "time out" can be helpful to get your feelings under control. However, on a day-to-day, minute-to-minute caregiving basis, "fleeing" isn't going to solve problems.

>>Psychological distance

The other thing that we can do that is equally effective is to get PSYCHOLOGICAL DISTANCE from the person. This is a skill that we can develop. It means that you are able to deal with the person, but without letting their problems become your problems, at least not for very long.

>>Cognitive control

The goal is to gain "COGNITIVE CONTROL." Now the word "cognitive" is just a fifty cent term for *our awareness, our perceptions, and our memory*. That is, our ability to understand what goes on around us. So gaining cognitive control means that you work on *being in control of the situation by knowing what is going on and why* – with the resident and with your own reactions and feelings.

The idea of having cognitive control is important because there are times when we *can't change the resident, but we can change how we think about the resident and we can change what it does to us – and that may be more important over the long haul.*

CAUSES VS. "COOKBOOK" SOLUTIONS

>>Warning! Focus on causes vs. cookbook cures

The emphasis in this and other programs in *The Series* is NOT ON COOKBOOK CURES. You know, do X followed by Y to get Z.

Instead, we'll keep returning to the question of symptoms vs. underlying problems, with an emphasis on dealing with the *underlying problem* whenever that's possible.

>>Chain of events

Our goal, then, is to avoid looking at a problem behavior *all by itself* -- whether it's controlling behavior, agitation, suspiciousness or something else -- but instead, look for THE CHAIN OF EVENTS that led up to it.

****Refer to handout: The goal of exploring problem behaviors**

>>Treat the real problem

By recognizing what may cause the behavioral and psychological symptoms that we see, we have the ability to

-- *reduce or extinguish those symptoms* by treating the real problem;

-- minimize the *risk of participating in the problems (by getting into power struggles)* and actually making things worse.

-- *do things to prevent problems*; and

-- *avoid personalizing* the problem; avoid feeling that the resident is *"doing it" to "us" -- on purpose* -- to make our lives unhappy. That is an error in thinking that can cause us a lot of grief!

>>Respond empathetically, and intervene

With increased understanding of some of the causes of "problem" behaviors caregivers are in a better position to

- RESPOND EMPATHETICALLY (that is, see the problem from the person's point of view) and to
- INTERVENE in a way that is helpful to the person AND to the caregiver.

I'd like to underscore, "intervene in a way that is helpful to caregivers," because many times we are best able to cope with difficult situations by changing the way that we think. By understanding WHY behaviors occur, caregivers are better able to respond in ways that

- ✓ are helpful to the person, which
- ✓ reduces the risk of power struggles and blaming, and
- ✓ promotes a sense of job satisfaction.

SUMMARY: KEY PRINCIPLES OF CARE

>>Summary: Key principles

****Refer to handout: Key principles of care – General Strategies**

In summary, STOP and think carefully about the person, and the situation from THAT PERSON'S point of view.

- Ask questions.
- Read the chart.
- Don't "assume" anything.
- Talk to others: other staff, family, friends, and the resident. What is REALLY going on? What is the CAUSE of the behavior you see?

>>Summary: Key principles, continued

Next, think carefully about how YOU can adapt and change what YOU do – in terms of your care routine, your approach, and altering the environment to help the person feel safe and secure. As before, there are no "COOK BOOK CURES" for behavioral symptoms, but some basic strategies tend to consistently make things better. For example,

- Being calm and CONSISTENT in your approach and routine. Feelings of safety and predictability (which is knowing what will happen next) are increased if ALL STAFF do things the same way.
- Encouraging a sense of CONTROL by giving the resident limited choices, and involving them in their daily cares.
- Making sure that basic HEALTH NEEDS, like thirst and hunger, are being met. Uncontrolled or unexpected pain, as with movement, can trigger behavioral symptoms.

- Make sure the person is getting accurate SENSORY INFORMATION by putting on clean, fitted glasses and hearing aides with functioning batteries. Make sure they see and hear you.

- Think carefully about their COGNITIVE, or thinking abilities. Do they have dementia? If so, how does that affect their ability to think, and reason, and function?

>>Summary: Key principles, continued

Finally, it's important to work together to solve difficult-to-understand situations!

- Behavior management TEAMS are one of the most effective ways to understand behavioral symptoms. Involve all types of staff, and staff on all shifts. Talk things over and find out what others see and think. Work together to develop an individualized plan of care.

- Document what you see in BEHAVIORAL LOGS to better see what and where behaviors occur.

- Carefully EVALUATE if any part of a plan worked. Is the behavior any less intense or frequent? Even a little?

- Work together and focus on what WORKS, but don't give up. Keep trying new and different ways of helping the person feel calm, secure, and comfortable.

>>Requirement of time & energy

This process requires that you slow down and take more time with the resident, BUT IT IS TIME WELL SPENT!!! We have to weigh the time spent trying to *minimize or prevent uncomfortable behaviors* against the time spent trying to restore comfort after they occur. Think about the amount of time spent

-- talking to other staff about what a "pain" the person is;

-- trying to figure out what to do with the situation;

-- getting your feelings under control so you don't take it out on other residents or staff;

-- feeling angry with the person and resentful toward them;

-- trying to reason with them, or keep up with the constant demands;

-- or time spent avoiding them!!!

IT ALL TAKES TIME. And while we can't fool ourselves into thinking that we can SAVE time by doing things preventatively, we probably aren't going to spend any <u>MORE</u> time by trying to prevent behavioral symptoms.

In summary, think about behaviors as *symptoms* of underlying problems. Get the facts about what is <u>really</u> going on with the resident. <u>Then</u> you will be in a better position to intervene *in a way that is helpful to the resident <u>and</u> to you!*

//Trainer: Solicit comments from the audience about "who came to mind" as you talked about the various causes of problem behaviors. Encourage staff to support their ideas by describing what kind of behavior they see. Be as nonjudgmental and supportive as possible.

Then, instruct staff to keep looking at the residents' behavior in light of the various causes that you've just reviewed. For example:

"During the course of your next working day, try to spend a little time observing the residents that you work with. Try to put yourself "in their shoes." Imagine what it is like to be in their place, living their life, and see if you can recognize any underlying problems that may make them behave the way they do. Then take a moment to think about how that person affects YOU -- How does he/she make YOU feel?"

Finally, ask staff to turn in their lists. Use their ideas to identify residents that can be used to illustrate certain points in upcoming programs. You may also want to prepare a composite, to see if staff agree about the causes of the problem behavior, or check records to see if the staff were "on target" in terms of their assessment. Use the results for discussion in future programs about specific types of behavioral problems.