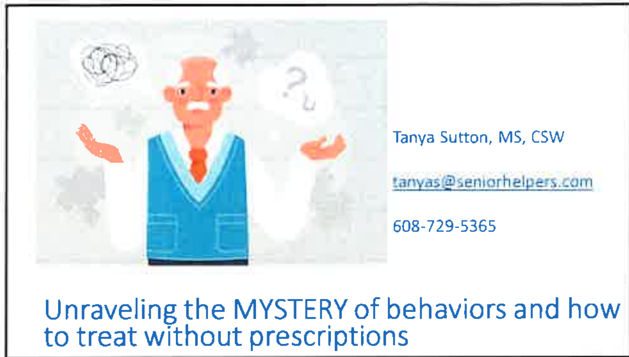

Tanya Sutton, MS, CSW

tanyas@seniorhelpers.com

608-729-5365

Unraveling the MYSTERY of behaviors and how to treat without prescriptions

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Learning Objectives

- **Explore common behaviors communicated by someone living with dementia**
- **Discuss how communication can help or hinder behavioral expression**
- **Discuss non-pharmacological approaches for behaviors**
- **Explore a case study and approaches for improving care situations**

2

Let's start with this- say with excitement

I'm ALIVE

I'm AWAKE

I FEEL GREAT!

Would this change how you communicate with others? Change your behavior or theirs, or both?

3

Behaviors

We all have them! Consider:

- Think about your normal day. Have you ever...
  - Yelled at anyone? Personal or professional
  - Swore when upset? Called someone a name, under breath or to them?
  - Became agitated/frustrated when told to do something you did not want to do/understand to do?
  - Even threatened or hurt someone in anger/perceived threat?

Why would we expect less from people living with dementia?

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Behaviors

Because of neurocognitive disorder, neurocircuits damaged, therefore regulation and executive function not affective to distinguish appropriate emotional responses or destroying ability to understand, organize, prioritize or respond to challenges

- Regardless of etiology, risk of behavioral/psychological symptoms is **100%**
- Can occur at any stage of the disease progression, but some more often in some stages (i.e. aggression more common in moderate to late)
- Symptoms can be clustered
- Symptoms are not due to cognitive impairment alone

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Behaviors

- Seen as a large challenge in care
- Increases burden/stress
- High risk for being hospitalized/institutionalized
- Financial costs
- Over medication or inappropriate medications
- Significant emotional distress for everyone involved
- Most can be prevented or treated
  - medical, caregiving and environment are modifiable

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Most Common Behavioral Expressions

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Causes

- Physical, psychological or social needs are not being met
- They are attempting to meet a need (if hot or itchy, taking clothing off)
- They are attempting to communicate a need to someone else (yelling help)
- Increased sensitivity to stressors
- Inability to control environment

HOW do we think about behaviors? Are we reactive or proactive?

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What is Communication?

Process of sending and receiving information through the exchange of thoughts, messages, or info, as by speech, visuals, signals, writing or behavior

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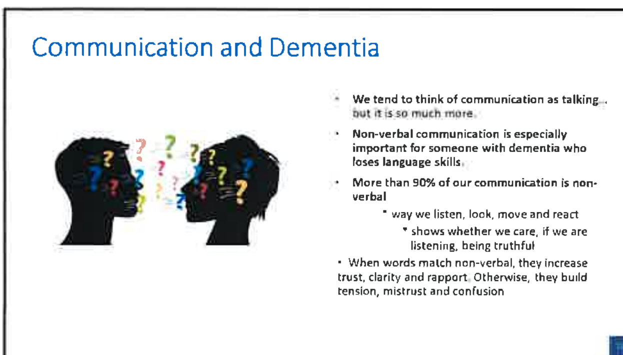

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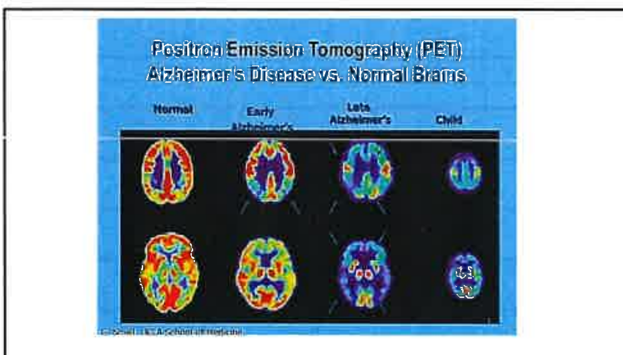

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Non- Pharmacological Approaches

Should be First line treatment in responding to behavior expressions

- Prevention is an essential conversation for the care team
- All focus on some aspect of caregiver behavior
- Should be individualized and specific to the person- personality, preferences, needs
- Focus on specific symptoms
- Should match their abilities and not cause more difficulty to their deficits
- Medications/drug interactions should be reviewed

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Non- Pharmacological Approaches

It is through our senses that we view the world around us.

1. One of the best approaches is TIME
2. Approach is Critical, establish connection- only 1 person talks
3. Environment- calm surroundings, limit people, location
4. Know the person- characteristics, abilities, history, routine, important people/things
5. Think about behavior- is it dangerous, who is the problem/issue for? Focus on one behavior at time
6. Explore other changes- health, brain change/progression, cares, providers
7. "unconditional positive regard" for person
8. Respond to their emotion and validate it
9. Self-awareness- your emotional verbal and non-verbals
10. Pain Management

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Non- Pharmacological Approaches

Common Behavior Expressions

AGGRESSION

- Avoid being in personal/intimate space
- Slow, firm, calm voice, fewer words
- Approach slowly, from front but off to side
- Posture should be open (know your body language)
- Break tasks down
- Time out if area safe
- Do not initiate/confront unless necessary
- Validate anger/frustration/fear
- Look for patterns (cares, boredom, pain, fatigue, environment)

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Non- Pharmacological Approaches

AGITATION/CALLING OUT

- Explore possible physical or emotional need not being met
- Physical activity/repositioning
- Offer sensory aids, individualized music
- Possible overstimulation, de-stimulate environment or move
- 1:1 interaction or very small group
- Look for triggers (clock, coat, mirror, tv, noise)
- Reminiscence "Tell me about"
- Remember we all can get stressed/agitated

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Non- Pharmacological Approaches

REPETITIVE BEHAVIOR

- Recognize your response- maintain calm tone, posture
- Remove triggers/objects
- Validate emotion/respond to need
- Use visuals- activity, memory board with detail, photos
- Physical comfort, senses
- Schedule/routine/movement

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Non- Pharmacological Approaches

RESISTANCE TO CARE

- Change approach to the task or modify the task
- Position/posture and be aware of personal space
- Less talking, more showing, no arguing, GO slow
- Focus on person more than the task
- Allow them to do what they can and not just take over
- Try someone new
- Know the person and their habits/routine, not to fit into our routine
- Sensory- environment, location
- Consider pain/discomfort

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Non- Pharmacological Approaches

WANDERING/PACING- 60% estimated

- Is it a problem or just annoyance? Allow pacing if safe
- What are they seeking? Comfort, item, person?
- Rest stations in seen area
- Boredom? Needs stimulation/purposeful activity
- Routine- is it happening at same time (i.e. waiting for kids to get off bus)
- Modify environment (noise, curtains, surroundings)
- Look at environment for safety concerns
- Outdoor activity if able

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Knowing your Resident- Case Study 1

Richard- goes by the name Dick, 85 years old

Lived in memory care- several care/placement transitions

Married (wife in memory care), has son and daughter

Conditions- Hx TIA/seizure, anemia, insomnia, incontinence, ADHD, Alzheimer's advanced, rhinitis, depression, anxiety, glaucoma. Recent L shoulder fx.- still has pain, constipation.

He is on Hospice services

Keys- trouble wayfinding, introverted, passive, fear of loud noise, low verbal skills, carpenter/tinkerer

Walks without device, falls. Sometimes w/c.

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Dick Crisis Incident

- Occurred around noon-1pm
- Went into someone else's room
- Became aggressive when approached, hitting at, throwing feces, yelling
- Hospice called, police called, family and CM called
- Secured in room. Family took to their home, and he was not allowed back.

Questions:

- What needs could have been unmet? What could have escalated the crisis? Anything that could have prevented it knowing what we know about him and what we have learned?

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Knowing your Resident- Case Study 2

Linda- 73 years old

New move to assisted living

Several recent transitions- home to hospital 5 weeks, rehab

Never married, no family involvement

Conditions- Ushers syndrome, paranoia, new dementia dx, recent sacral fx and is now bedbound, uncontrolled diabetes, skin concerns

Just enrolled in hospice

Keys- was Ind. Prior to hospitalization with assist 1x/wk, not med taker

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Linda incident

Occurred around 10 pm

POA called due to Linda punching staff, yelling

Linda then fell out of bed

Hospice called, facility ED called

Questions:

- What needs could have been unmet? What could have escalated the crisis? Anything that could have prevented it knowing what we know about him and what we have learned?

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Unmet needs

Unmet Psycho-social needs

- Comfort
- Compassion
- Occupational
- Attachment
- Identity
- Inclusion

Unmet Physical Needs

- Hunger and thirst
- Tired and/or overstimulated
- Bowel or urinary distress
- Discomfort/pain

Unmet Emotional Needs

- Anger
- Sadness
- Loneliness
- Fear
- Boredom

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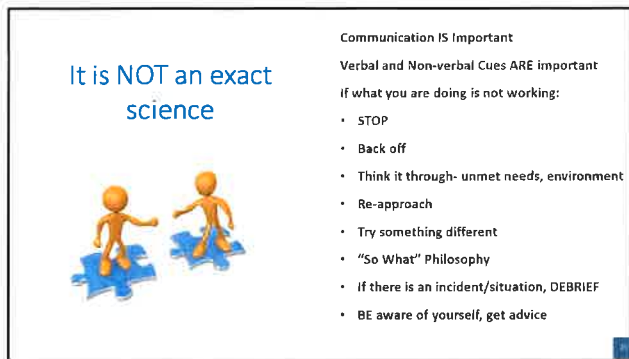

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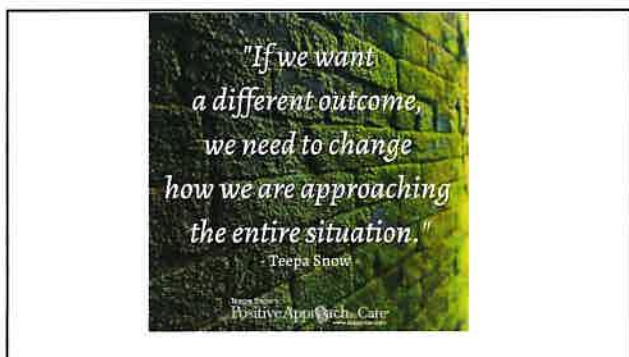

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Every day we're given small opportunities to bring someone joy that can make a huge difference in a life.

Delilah

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Questions?

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