

Evaluating Behavioral Disorders of Nursing Home Patients

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International Psychogeriatric Association Consensus Conference Statement

Consensus Definition of Behavioral and Psychological Symptoms of Dementia:

“Symptoms of disturbed perception, thought content, mood, or behavior that frequently occur in patients with dementia.”

Source: Finkel et al. *Am J Geriatr Psychiatry*. 1998;6:97-100.

Definitions of Agitation and Aggression

- **Agitation:**
 Inappropriate verbal, vocal, or motor activity not explained by apparent needs, confusion, medical condition, or social/environmental disturbance
- **Aggression:**
 Hostile actions directed toward others, self, objects
 Can be verbal, physical, vocal, sexual

Behaviors Reported in Agitation and Aggression

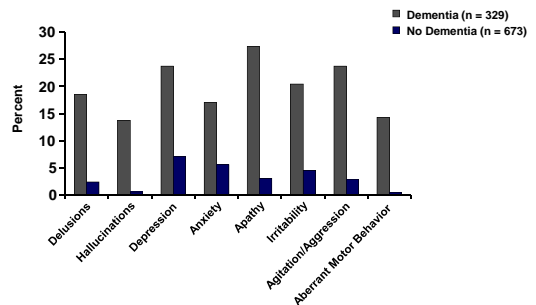
- **Agitation**
Physical: pacing, inappropriate robing/disrobing, trying to get to a different place, handling things inappropriately, restlessness, stereotypy
Verbal: Complaining, requests for attention, negativism, repeated questions/phrases, screaming
- **Aggression**
Physical: hitting, kicking, pushing, scratching, tearing, biting, spitting
Verbal: threats, accusations, name-calling, obscenities

Prevalence of Symptoms of Psychosis and Agitation in Dementia

- Cache County Study of Memory in Aging (CCSMA)
- First US population study of behavioral disturbances in dementia
 - Evaluated the prevalence and severity of mental and behavioral disturbances in the elderly
 - 5092 individuals were screened
 - Participants with dementia (n=329) were compared to control group without dementia (n=673)

Source: Lyketsos CG et al. *Am J Psychiatry*. 2000;157:708-714.

Prevalence of Mental and Behavioral Disturbances: Dementia vs Nondementia



1. Lyketsos CG, et al. *Am J Psychiatry*. 2000;157:708-714.

Delusions in Alzheimer's Disease

- Delusional thought content (eg, paranoia) is common (studies suggest 34% to 50% incidence)
- Common delusions
 - Marital infidelity
 - Patients, staff are trying to hurt me
 - Staff, family members are impersonators
 - People are stealing my things
 - My house is not my home
 - Strangers living in my home
 - Misidentification of people
 - People on TV are real

Sources: Deutsch et al. *Am J Psychiatry*. 1991;148:1159-1163; Drevets. *Biol Psychiatry*. 1999;25:39-48.

Sexuality in the Nursing Home

- Goal is to create environment that will help residents fulfill their needs and desires, while maintaining dignity and protecting rights of competent and incompetent residents
- Little agreement in literature as to what constitutes sexually inappropriate behavior
- Competing principles and values: right to privacy, right to experience a loving relationship, right to make one's own decisions
- Too easy to project one's own religious, cultural, personal beliefs onto another

Epidemiology and Etiology of Sexually Inappropriate Behaviors in Dementia

- Prevalence in dementia 2.9-15%
- Some evidence linking sexual behaviors to frontal and temporal lobe pathology
- Usually acute onset when follows stroke, vascular insult, head injury
- Differential diagnosis includes delirium, mania, seizure disorder, dopaminergic drugs, social isolation and boredom, genital irritation
- Manifestations of dementia that may be misconstrued as hypersexuality (misidentification)

Sexually Provocative Behaviors in the Nursing Home

- Flirting
- Excessive flattery
- Commenting on caregiver's behavior or appearance
- Making sexually explicit jokes or comments
- Touching caregiver in sexually suggestive manner
- Asking staff personal questions

Sexually Inappropriate Behaviors in the Nursing Home

- Genital exposure
- Public masturbation
- Propositions to others for sexual intercourse
- Fondling another person's genitals or breasts
- Requesting unnecessary genital care from staff
- Openly reading pornographic material

Evaluation of Sexual Behavior Problems

- Describe and document the behavior accurately
- Consider the reactions of others
- Identify why the behavior is occurring
- Evaluate competency and consent
- Evaluate risks and benefits
- Report assessment back to resident and family

• Conn et al., *Practical Psychiatry in the Long-Term Care Home*, 2007, p. 175

Evaluation of Sexual Relationships Between Residents

- Explore residents' awareness of the relationship
- Consider residents' ability to avoid exploitation
- Evaluate residents' awareness of potential risks
- Are both residents consenting and appreciate the situation?
- Discussions with families: may be ethically challenging

• Conn et al., Practical Psychiatry in the Long-Term Care Home, 2007, p. 175

Differential Diagnosis

- Dementia
- Delirium
- Psychosocial triggers
- Physical discomfort
- Primary psychiatry illness

Dementias in Older Adults

- Percentages of patients referred to dementia clinics in Canada^{1,2}
 - Alzheimer's disease (AD), 47.2%
 - Mixed AD, 27.5%
 - Mixed others, 6.3%
 - Vascular dementia (VD), 8.7%
 - Frontotemporal dementia (FTD), 5.4%
 - Parkinson's disease dementia (PDD), 0.6%
 - Dementia with Lewy bodies (DLB), 1.9%
 - Unclassifiable, 1.8%
 - Other, 0.7%

1. Feldman HH, et al. Can Med Assoc J. 2008;178:825-836. 2. Feldman H, et al. Neuroepidemiology. 2003;22:265-274.

"A Peculiar Disease of the Cerebral Cortex"

Alzheimer's Original Case Report (1907)

The first case report of Alzheimer's disease highlighted the presence of psychosis and agitation in these patients

- "The first noticeable symptom of illness was suspiciousness of her husband...believing that people were out to murder her"
- "She screams that her doctor wants to cut her open; at times, she seems to have auditory hallucinations"

Source: Alzheimer A. Allgemeine Zeitschrift für Psychiatrie. 1907;64:146-148.

Alzheimer's Dementia: DSM-IV-TR Criteria

- Memory Impairment
 - and one or more of the following:
- Aphasia (loss of language)
- Apraxia (loss of ability to perform motor activities, such as ADLs)
- Agnosia (loss of recognition of people and items)

Alzheimer's Dementia: DSM-IV-TR Criteria (cont.)

- Loss of Executive Functioning (ability to plan and organize things)
- Impairments are gradual and slowly progressive, cause impairment in social or occupational functioning
- Not due to a medical cause

Distinguishing Delirium From Dementia

Delirium

- Marked psychomotor changes (hyperactive or hypoactive)
- Altered & changing level of consciousness
- Strikingly short attention span
- Disturbed sleep-wake cycle with hour-to-hour variation
- Disorientation is an early symptom

Dementia

- Psychomotor changes occur late in the illness unless depression or apathy develops
- Consciousness not clouded until terminal stage
- Attention span not characteristically reduced
- Disturbed sleep-wake cycle with day-night reversal or no disturbance
- Disorientation often develops after months or years

Source: Adapted with permission from Guttman R, Seleski M, eds. *Diagnosis, Management and Treatment of Dementia: A Practical Guide for Primary Care Physicians*. Chicago, Ill: American Medical Association; 1999.

Distinguishing Delirium From Dementia (cont.)

Delirium

- Acute onset
- Acute illness, generally lasting days to weeks
- Usually reversible, often completely
- Prominent physiologic changes

Dementia

- Gradual onset that cannot be dated (although may be suddenly "unmasked")
- Chronic illness that characteristically progresses over months to years
- Generally irreversible, often chronically progressive
- Minimal or no physiologic changes

Source: Adapted with permission from Guttman R, Seleski M, eds. *Diagnosis, Management and Treatment of Dementia: A Practical Guide for Primary Care Physicians*. Chicago, Ill: American Medical Association; 1999.

Possible Contributors to Delirium

- UTI
- Respiratory infection
- Undiagnosed pain
- CHF
- COPD causing hypoxia
- Renal insufficiency
- Anemia
- Hypo-perfusion states
- Recent surgery
- Sensory impairment
- Cataract, hearing loss

Sources: Lipowski ZJ. *JAMA*. 1987;258:1789-1792. Lipowski ZJ. *Psychiatr Clin North Am*. 1992;15:335-346.

Other Triggers of Agitation

- Psychosocial
 - "A demented patient's behavior disturbance may have more to do with the nursing home roommate than with dopamine or other receptors in the brain"
- Physical discomfort
 - Pain or constipation

Source: Stimmel G. 1995.

Primary Psychiatric Illnesses and Behavioral Symptoms

- Schizophrenia and Other Psychotic Disorders
- Depression
- Bipolar Disorder
- Substance Use Disorders
- Personality Disorders

Schizophrenia and Behavioral Symptoms in the Nursing Home

- 20% of schizophrenia patients remit, 20% worsen
- Onset of schizophrenia after age 40 in 23% of patients
- Prevalence in nursing homes estimated at 12%
- Women with paranoia account for more cases of late-onset schizophrenia
- Very late-onset schizophrenia (>60) : more vivid and dramatic hallucinations and delusions
- In one study (Bowie et al., 2001) severity of positive symptoms predicted verbal aggression in nursing home patients

Substance Use and Behavioral Symptoms in the Nursing Home

- Frequently overlooked in nursing home patients
- 2.5 million older adults with alcohol-related problems
- High psychiatric comorbidity (anxiety, depression, bipolar disorder)
- Highest rate of completed suicide is in older white men who become depressed and drink heavily following the death of their spouses
- Complications include Korsakoff's Psychosis, falls, depression, dementia
- Increasing rates of illicit drug and prescription medication abuse in elderly

Personality Disorders and Behavioral Symptoms

- Onset in adolescence or early adulthood
- Chronic and enduring maladaptive pattern of impulse control, interpersonal functioning, emotional response, and cognitive perception
- Personality traits may be exacerbated by depression or brain disorders
- Rates lower in older than younger people
- Difficult to treat, take up disproportionate amount of staff time and evoking angry, punitive responses

Personality Disorders and Behavioral Symptoms (cont.)

- Definition of manipulative behavior: using others to validate, promote, or elevate self
- Splitting: playing one person/shift/facility against another; people are either all good or all bad
- Behaviors include lying, threatening staff, asking personal questions, bullying facility
- Interventions include consistent staffing, setting limits of "reasonable care," developing behavioral agreement with patient

Selected Scales for Assessing Neuropsychiatric Symptoms in AD

- The following are selected scales used to measure neuropsychiatric symptoms in patients with dementia¹
 - Cohen-Mansfield Agitation Inventory (CMAI)
 - Neuropsychiatric Inventory (NPI)
 - Brief Psychiatric Rating Scale (BPRS)
 - Behavioral Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD)
 - Revised Memory and Behavior Problems Checklist (BMBPC)
- These scales should be used in conjunction with a full neuropsychiatric examination¹

1. California Workgroup on Guidelines for Alzheimer's Disease Management. Guideline for Alzheimer's Disease Management.

Diagnosing Behavioral Changes: NPI Questionnaire

Please answer each question honestly and carefully. Ask for assistance if you are not sure how to answer any question.

Delusions	Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way?	Severity: 1 2 3 Distress: 0 1 2 3 4 5
Hallucinations	Does the patient act as if he or she hears voices? Does he or she talk to people who are not there?	Severity: 1 2 3 Distress: 0 1 2 3 4 5
Agitation or aggression	Is the patient stubborn and resistant to help from others?	Severity: 1 2 3 Distress: 0 1 2 3 4 5
Depression or dysphoria	Does the patient act as if he or she is sad or in low spirits? Does he or she cry?	Severity: 1 2 3 Distress: 0 1 2 3 4 5
Anxiety	Does the patient become upset when separated from you? Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?	Severity: 1 2 3 Distress: 0 1 2 3 4 5
Elation or euphoria	Does the patient appear to feel too good or act excessively happy?	Severity: 1 2 3 Distress: 0 1 2 3 4 5
Apathy or indifference	Does the patient seem less interested in his or her usual activities and in the activities and plans of others?	Severity: 1 2 3 Distress: 0 1 2 3 4 5
Disinhibition	Does the patient seem to act impulsively? For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings?	Severity: 1 2 3 Distress: 0 1 2 3 4 5
Instability or lability	Is the patient impatient and cranky? Does he or she have difficulty coping with delays or waiting for planned activities?	Severity: 1 2 3 Distress: 0 1 2 3 4 5

From Cummings JL, et al. Am Fam Physician. 2002;65:2263-2272. Adapted with permission from Kauter DL, et al. Validation of the NPI-Q, a brief clinical form of the Neuropsychiatric Inventory. J Neuropsychiatry Clin Neurosci 2000;12:233-9. Copyright © J.L. Cummings, 1994.

IDIR Model

- I**dentify the problem in behavioral, measurable terms
- D**ecode the behavior
- I**nterventions
- R**eassess

IDIR (cont.)

- Step One: Identify the problem in behavioral, measureable terms
 - Mapping the progression of behavior
 - Sensory disequilibrium → behavioral symptoms
 - One problem at a time

IDIR (cont.)

- Ask staff to prioritize among many problems
- Translate into behavioral and measureable terms
- 3 “W’s”
 - What is the key behavior?
 - Where does it occur?
 - When does it occur?

IDIR Examples: Identifying the problem

“Mrs. Jones fights with us” → Mrs. Jones hits staff (**What**) during bathing in the morning (**When**) in the tub room (**Where**).

Identifying the Problem (cont.)

“Bob shouts all day long” → When Bob is in his room, (**Where**) he shouts (**What**), especially before meals (**When**).

Identifying the Problem (cont.)

“Mr. Richards takes his clothes off.”

Mr. Richards disrobes (**What**), especially in the afternoon (**When**) in the day room (**Where**).

Step Two: Decoding Behavior

- “Trigger” often occurs prior to when staff identify the behavior
- Break down behavioral sequence into frames

Decoding Behavior (cont.)

- Recognizing key antecedents and consequences around the behavior
- Identify the trigger point in the behavioral sequence

Examples: Decoding Behavior

#1: Mrs. Smith hits the CNA who attempts to dress her in the morning in her room. Here are the “frames”:

- CNA approaches Mrs. Smith who is in bed
- Mrs. Smith ‘looks’ confused by the CNA’s approach

Decoding Behavior (cont.)

- CNA attempts to get Mrs. Smith out of bed (without orienting info)
- Mrs. Smith backs away from the CNA
- CNA tells Mrs. Smith she is going to get dressed
- Mrs. Smith hits CNA

Decoding Behavior (cont.)

- CNA leaves the room
- Mrs. Smith is negatively reinforced (removal of a negative stressor)

Step Three: Intervention

- Choose the intervention point (the “trigger” feature).
- The staff member alters her behavior to change the behavior sequence.
- Alter the behavior sequence by doing something different

Step Four: Reassess

- Continuous feedback loop
- Successive attempts in order to get it right
- Behaviors change, new problems occur

Case Example: Combativeness during ADL care

78 year old WWF residing in skilled nursing facility. Staff report that “Mrs. Smith fights with us whenever we try to get her up.” MedOptions NP/psychiatrist has seen Mrs. Smith, and she is on Seroquel 25 mg nightly. Mrs. Smith has a daughter who comes to the facility to visit periodically. Mrs. Smith has been diagnosed as having Alzheimer’s disease.

Identify the problem

Mrs. Smith is physically combative when the aide attempts to get her up in the morning for ADL care in her room.

Decode the behavior

- Aide approaches Mrs. Smith who is in bed.
- Mrs. Smith looks ‘frightened’ as the aide approaches her.
- Aide attempts to get Mrs. Smith out of bed (says, “Mrs. Smith, its time for you to get out of bed.”)

Decode (cont.)

- Mrs. Smith begins to protest verbally and physically, pulls the covers up.
- Aide tells Mrs. Smith that she must allow aide to help her now (aide’s voice takes on an edge). Aide reaches to pull the covers down.

Decode (cont.)

- Mrs. Smith hits aide.
- Aide leaves the room feeling frustrated.
- Mrs. Smith is negatively reinforced (removal of a negative stressor)

Interventions:

- Aide monitors the patient’s reaction to her approach.
- Aide uses orienting information (“Hello Mrs. Smith, I’m Doris. I’m here to see if I can help you this morning.”).
- Aide uses soothing voice, short phrases or sentences.

Interventions (cont.):

- Comforting references from the past can be used. The daughter could be a resource to get this information. “I understand that you are from Pittsburgh.” “I hear that your daughter plans to visit you today.”

Interventions (cont.):

- Aide can give something comforting or familiar to Mrs. Smith to hold, which would give her something to do with her hands.
- If the aide leaves the room to get help, keep voice soothing and reassuring.

Summary and Conclusions

- Nursing homes have the highest rates of violence of any workplace setting
- Evaluating behavioral disorders involves thorough identification of problem and focus on differential diagnosis
- Behaviors aren't always dementia driven
- Non-pharmacologic strategies increasingly critical