Understanding Behaviour that Challenges

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‘Violence is the voice of the unheard’ – Martin Luther King
Exercise

• If there was one thing you would like other people to know about you, what would it be?

• Think about in the context of not being able to communicate your needs when cared for by someone else.
What is BC?

• Defining BC in terms of behaviour detracts from underlying causes.

• “… actions that detract from the well-being of individuals due to the physical or psychological distress they cause within the settings they are performed. The individuals affected may be either the instigators of the acts or those in the immediate surroundings” (James, 2011, p.12.)

• E.g. Hitting, spitting, throwing objects, shouting, self harm, repetitive questions, pacing, excessive eating/drinking, smearing, hoarding, falling intentionally, masturbating in public, urinating in inappropriate places…. (and not limited to those with Dementia).
Contributing Factors

P - Pain
I - Infection
N - Nutrition
C - Constipation
M - Medication
E - Environment
H - Hydration
Difficulties with the more traditional approaches

- Traditionally seen as neuropsychiatric symptoms of dementia – BPSD.
- BUT… Why are only some people with dementia ‘challenging’?
- Challenging behaviour is not a diagnosable disorder.
- Challenging behaviour is not a symptom of dementia despite the term Biological and Psychological Symptoms of dementia (BPSD).
- It is socially constructed, context and time-bound.
1. Group task: What are the behaviours/actions of others that we find difficult in our work and home lives.

2. Think of times when you might have engaged in similar behaviours/actions. What needs were attempting to be met? How might that feel?

3. What might we appreciate from others in this situation?
Maslow’s Hierarchy of need

- Physiological Needs
  - Hunger
  - Thirst
- Safety Needs
  - Security
  - Protection
- Social Needs
  - Sense of belonging
  - Love
- Esteem Needs
  - Recognition
  - Status
- Self Actualisation

Diagram showing the hierarchy of human needs.
Challenging behaviour is……

**An expression of need!!**

It does not exist in a vacuum it is an interaction between social physical, environmental, psychological, historical and cultural factors. (Kitwood, 1997)
PEOPLE with dementia

Person with DEMENTIA

PERSON with dementia.
Person centred care

- A positive social environment to enable the person with dementia to experience relative well being.

- Enabling – we need to recognise the strengths & abilities of people with dementia & ensure opportunities exist for them to be utilised.

- Understanding the person as a whole being – knowledge of what was important & how spiritual comfort was achieved.

- The individuality of people with dementia with their unique personality & life experiences among the influences on their response to the dementia.

- Personhood – the recognition of a sense of self, who we are & the place we hold in the world around us.
Rementia is possible

- The meaning of ‘recovery’ can vary from person to person. However, the general message is one of hope in empowering people to lead fulfilling lives even though they may experience difficult symptoms as a result of mental health problems, (Lester & Gask, 2006).

- Recovery represents a move away from pathology, illness and symptoms to health, strengths and wellness (Read & Sole).
The Needs led Approach - Assessment & Formulation

• CB is an expression of need but we may not know exactly what the need is.

• Assessment helps us get to know the person, their life history and what the needs are likely to be.

• We use this understanding to help us know how to intervene.
Model of Unmet Need (Cohen-Mansfield, 2000).

- Background details of the person, environment and diagnosis
- Information about behaviour

Understanding of behaviour and interpret as a way of communicating a need - e.g. physical (pain), security, occupation (boredom), social contact, respect, dignity

Resolution through managing need rather than purely focusing on behaviour
  How a subsequent need can be met in a practical way
Links between behaviour and causes (James 2011)

Environment and carer interactions

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Behaviours

- Medication – side effects

Beliefs – I’m 28 years of age; I still work the early shift

Mental Health Perceptual difficulties

Personality Physical Difficulties

Cognitive changes – e.g. frontal lobe

Metabolic changes - appetite, energy, irritability

Surface
Being Detectives

• How do we work out what the behaviour is telling us – the unmet need (what a person is thinking and feeling)?

• How do we work out what to do as a result?

• The more information we collect about a behaviour (or different behaviours) the more accurate our picture will be.
Our behaviour and the environment

• The systems around clients (including ourselves) might unwittingly be inadvertently making unhelpful behaviour stronger or making helpful behaviour decrease – this should be part of the understanding.

• e.g. environment, trying to reason with people, bringing people into our time frame, being offended by behaviour.
Understanding the Person - Discovery

- Our history and experience moulds and shapes who we are today.
- We learn important lessons from our past - about our selves, the world and others.
- We learn how to relate to others through experience.
- We are all individuals that see the world differently.
- Important to consider a person’s history, their ways of relating to others, likes/dislikes, roles in life.
- REMEMBER – behaviour is more than dementia (it involves an interaction between social, physical, environmental, psychological, historical and cultural factors).
Mental Health—life experience/beliefs/rules
e.g. impact of past difficulties

Life Story (including hobbies, likes/dislikes)—
e.g. impact of previous loss and trauma during process of dementia

Social Environment (past and present) –
Structural and social environment affect wellbeing – having some control/choice is important for us all

Cognitive Abilities
Strengths as well as difficulties
e.g. impact of frontal lobe damage on behaviour – disinhibition, poor planning/decision making, concrete thinking.

Personality–
Carries on through dementia – e.g. religion, food, superstition

Physical Health/medication–
e.g. visual/auditory problems, arthritis, backache, toothache, constipation, difficulties related to chiropody.

Appearance
Can give clues to feelings – scared, anxious, angry, low etc.

Trigger (A)
Anything seen prior to behaviour

Behaviour (B)
Exactly what happened – labels like aggression/wandering not helpful in knowing what they are doing or why they may be doing it

Consequences (C)
How behaviour responded to and it’s impact on behaviour

Interpersonal relationships
Impact on intervention – e.g. relationship with family and staff

Conversation/Vocalisations
Include yells, moans, repetition

What is the person trying to communicate? What are their needs?
What Happens Next?

Intervention linked to understanding of the person
Types of interventions

Enjoyable activities, increase activity, Art/dance, distraction
Music Therapy
  – e.g. can reduce agitation at mealtimes (Chang et al., 2005) – history of likes/dislikes important
Giving space – leave and return
  1:1 time
Pain relief
Favourite food/drink
Offer simple choices
Reassurance
Appropriate touch – hold hand
  Therapeutic lies
Team consistency including beliefs
Interventions

Memory cues and environmental orientation
- signposting
Ensuring environment isn’t over or under stimulating
- Impact of background noise

Reminiscence/life story
- person with even severe dementia can benefit e.g. favourite record (history taking important re difficult experiences due to cognitive deficits making memory more difficult to manage)

Methods to promote dignity in care situations
Communication
- tone of voice, pace, use of visual aids. Validate feelings, may need to give space, don’t argue.

Aromatherapy
- results from lavender and lemon balm though efficacy scarce.

Doll therapy
Snoezelen
- sensory stimulation

Pets for Therapy
Interventions

**Reality Orientation**
- Confusion often caused by problems with memory/orientation.
- Orient to present e.g. clock, calendar, newspaper, signs, picture boards, conversation.
- Needs to be done sensitively. Some disadvantages – e.g. can lead to repeated confrontation and reminders of deterioration.

**Validation**
- Argues against the need to orientate
- Acceptance of reality and personal truth of another’s experience (Kitwood, 1996).
- Works on feelings rather than facts.
- Aim isn’t to disagree or agree but to understand and empathise with emotion.
Remember...

• What works on one occasion might not be appropriate the next time

• Not about finding an ultimate cure but is ongoing, flexible and based on the person’s needs
Measures

• The Cornell Depression Scale (Alexopoulos et al., 1988)
• Rating Anxiety in Dementia (RAID; Shankar et al., 1999).
• Challenging Behaviour Scale (CBS; Moniz-Cook et al., 2001).
• The Montreal Cognitive Assessment (MOCA; Nasreddine, 2003). www.mocatest.org
• Kingston Standardised Cognitive Assessment (KSCA; Hopkins & Killik, 2009).
References/Reading list


Reed, L., & Sole, K. Recovery and Older People Presentation. Downloaded 2010.


Any Questions?

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All behaviour is a means of communication – THINK!