

Geriatric Mental Health Training Series: Revised

Back to the A-B-C's

Understanding & Responding to Behavioral Symptoms in Dementia

Supportive Materials

Revised by Marianne Smith, A.R.N.P., B.C., Ph.D.(c)

*From original content in the module
“Acting Up and Acting Out: Assessment and Management of Aggression
and Acting Out Behaviors” by*

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PUBLISHED BY THE JOHN A. HARTFORD CENTER OF GERIATRIC
NURSING EXCELLENCE (HCGNE),
COLLEGE OF NURSING, UNIVERSITY OF IOWA

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**Back to the A-B-C's:
Understanding and Responding to Behavioral Symptoms in Dementia**

CONTENTS

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, provided in both PowerPoint format and in PDF (slides only). The module contains 46 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, 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.

Back to the A-B-C's

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 (6 pages)
- Handouts
 - ✓ New vs. Old Culture of Dementia Care (1 page)
 - ✓ A-B-C Approach to Dementia Care (1 page)
 - ✓ Assessment: Checking it out (5 pages)
 - ✓ Interventions: Changing Antecedents & Consequences (2 pages)
 - ✓ Managing the crisis (2 pages)
- Bibliography (4 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, “Back to the A-B-C’s: Understanding and Responding to Behaviors in Dementia” is revised and updated from a module titled “Acting Up and Acting Out: Assessment and Management of Aggressive and Acting Out Behaviors” 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:

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

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Back to the A-B-C's: Understanding and Responding to Behavioral Symptoms in Dementia

Purpose:

Behavioral symptoms in dementia are often troubling to staff, other residents, and family members alike. But most important, behaviors are form of communication and signal that the person with dementia is uncomfortable and needs assistance. Development of individualized, person-centered care plans depends on accurate assessment and preventative methods. This program uses the Antecedent-Behavior-Consequence (ABC) approach to help caregivers understand underlying causes of behavior, including the effects of personal, health-related, and environmental factors. Specific questions are introduced to assist caregivers in developing individualized care plans for persons with dementia.

Objectives:

1. Compare and contrast key aspects of the “old” and “new” dementia care cultures (i.e., attitudes, labels, focus of care and interventions).
2. Explain why “prevention is the best medicine” in dementia care.
3. Define the main components of the A-B-C approach to care.
4. Give an example of common antecedents or “triggers” in dementia care.
5. Give an example of common automatic reactions in dementia care,
6. Describe the relationship between behavioral symptoms, antecedents/triggers and consequences/reactions.
7. Develop a plan of care for a person with dementia using the A-B-C approach.
8. List crisis intervention techniques that may be used to calm and redirect a person who is intensely upset and threatened.

Content Outline:

Introduction and overview

Old culture of dementia care

New culture of dementia care

Adjust language to reduce negative labels

Behaviors are troubling to all, but primarily to person with dementia

Reframe dementia care

Person-centered care

Labels for behavioral symptoms

Labels for care, focus of interventions

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Behavioral symptoms are communication

Communicate unmet needs, stress, discomfort

Many problems other than dementia contribute to behaviors

Using the A-B-C Approach

Prevention is the best medicine

Intervene early to defuse the situation

ABC: Antecedents, Behaviors, Consequences

Assessment: Checking it out

Assessment: Everyone's responsibility

Describe the behavior

Identify antecedents and triggers

Examine consequences and reactions

Interventions: Managing and modifying

Set behavioral goals

Change antecedents and triggers

Change consequences and reactions

Evaluate effectiveness of interventions

Managing the crisis

Staff attitudes and feelings

Body awareness and movement

Communication: what and how

Situation specific directions, explanations

Listen, respond, soothe

Protect yourself and others

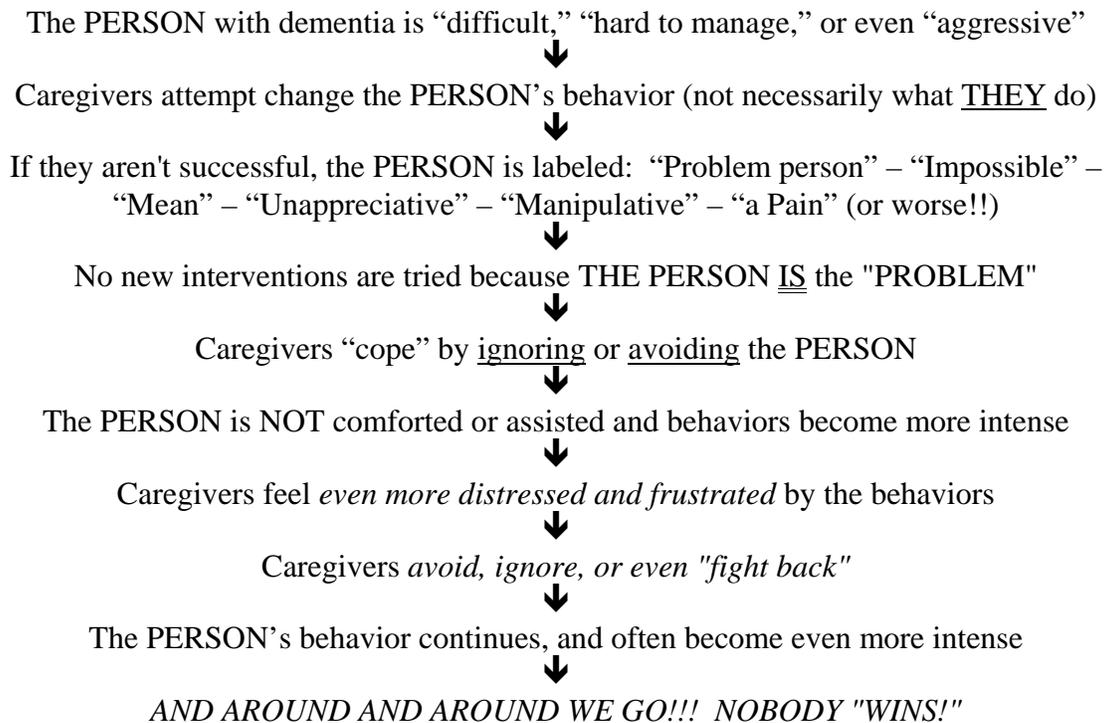
Summary

Notes for the Instructor

This program will be the most effective when taught after the introductory module (“Whose Problem Is It?”) and the two units on dementia (Dementia Part I and II). In this program, participants are provided a tool (the A-B-C model) to critically examine behavioral symptoms in dementia, and to think of the various ways that they might reduce or eliminate these behaviors.

We introduce this module by examining key aspects of the “old” and “new” culture of dementia care. We believe these ideas are particularly important when thinking about understanding, assessing, and responding to behavioral symptoms in dementia. Of note, when this module was first developed in 1993, the title was “Acting Up and Acting Out: Assessment and Management of Aggressive and Acting Out Behaviors.” Although the BASIC GOALS of this training module have not changed, the language throughout the module has been altered substantially to reflect the new culture.

As we discussed in the original model, negative perceptions, views, and labeling of persons with dementia contributes to the development of a CYCLE OF MUTUAL DISTRESS. Not only does the PERSON with dementia have "problems" that continue to go unresolved (compromising their quality of life), but CAREGIVERS also suffer: from feelings of frustration, incompetence, anger, and resentment. Those feelings, perceptions and labels contribute to a DOWNWARD SPIRAL in care:



Be aware: participants may want to “argue” that the person’s behavior IS A PROBLEM, and that “no harms is done” by labeling. However, the evidence does not support this belief. A movement

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is well underway to reduce and eliminate negative labels that stigmatize, unfairly categorize, and reduce quality of care for those with dementia. We hope that you, as a trainer, will think carefully about words and labels used, and the risk of generalizing negative labels about behavior to the PERSON with dementia.

Although the program doesn't review the idea of "COOKBOOK CURES" for behavioral symptoms (as taught in the first module, "Whose Problem Is It?"), we continue to follow these principles. That is, there are "no easy answers" or simple interventions for reducing or eliminating behavioral symptoms. Many times, staff want easy-to-follow, step-by-step instructions about what to do when someone "yells" or "insults" them, "pushes" or "grabs" them.

Note: Throughout the program materials we purposefully put labels in quotation marks (e.g., "yells," "insults," "pushes," "grabs," "problem") because the behavior is considered communication of some unmet need. Once we say the person is "grabbing, hitting, pushing, pinching" et cetera, we create an image of a "bad" person from whom staff must "protect themselves." Understanding WHAT that behavior represents is critically important. Thus, we use quotation marks to indicate that the label may be the best description available, but must be examined in the CONTEXT of care provided.

However, the "solution" or intervention is ALWAYS determined by *the specific details of THAT situation!!* What we DO depends on

- THE PERSON (type of dementia/stage of disease; retained abilities; longstanding personality traits, coping methods, experiences, habits, et cetera), and
- WHAT is going on *inside and around the person* that led up to the situation or "problem," AND
- THE CAREGIVER(s) (professional, para-professional; level of training; new vs. seasoned; knowledge about THIS person and his/her history, et cetera) and
- WHAT is going on *inside and around the caregiver* that is influencing the caregiver's reaction to the situation or "problem"!

Remind staff that the goal is to really "THINK IT THROUGH" and *look at the "problem" and situation differently*. The step-wise assessment outlined in this program is intended to help caregivers develop individualized approaches for *various types* of behavioral symptoms. However, it is critically important to address ONE BEHAVIOR AT A TIME.

We suggest that you select a person with behavioral symptoms *in advance of teaching the program*. For example, a person with dementia who asks the same questions over and over again, dresses strangely, gives the "wrong answer," becomes easily upset, resists care, or is particularly challenging to caregivers will provide opportunities for illustration and discussion.

Apply the A-B-C model to that person during the program, asking relevant questions about possible antecedents and consequences, and going step by step through the model. This "real life" experience should help caregivers use the principles with other residents in their day to day practice.

As you can well imagine, the interventions needed to calm, soothe, and comfort the various type of behavioral symptoms that might be observed may be very different from one another. However, the basic principles often are the same – focusing on the person's perceptions and internal experiences, thinking about lifelong habits or traits that might contribute, and trying to find ways to comfort, distract, or redirect the person to a more pleasurable activity.

In some cases, one or more underlying cause of the behavioral symptom needs to be addressed:

- Change in MEDICAL problem, or onset of acute illness needs to be treated.
- Overlapping PSYCHIATRIC ILLNESS, like depression, is causing excess disability, and needs to be evaluated and treated.
- Batteries need to be replaced on a hearing aide, or glasses need to be replaced or refitted to assure accurate SENSORY input to avoid misinterpretation and misbeliefs.
- MEDICATION changes are causing adverse consequences that are observed in behavioral symptoms.
- Some temporary, but still distressing, BIOLOGICAL TENSION – like hunger, thirst, or importantly, pain, is contributing to the behavioral symptoms.
- Unmet PSYCHOLOGICAL NEEDS, like loneliness, boredom, or longing for things now "lost" to the person (e.g., their home, loved ones, pets, involvement in meaningful activities) also make a huge contribution to behavioral symptoms.

In many cases, staff have not had, or taken, the opportunity to "look beyond" the behavior to discover underlying problems *beyond the loss of ability associated with dementia*. As we said in the first program, the behavior is only a "symptom" of some other underlying difficulty. And success in managing the behavior relies on knowing what those causes are!!

Staff may fail to think about the person with dementia as a PERSON who has the same basic human needs as everyone else – who gets hungry, tired, lonely, bored; who feels pain related to chronic medical conditions like arthritis or joint disease; who has sensory changes that may interfere with seeing and hearing things accurately; and who has lived a long, full life filled with unique experiences. Helping staff see the PERSON first, *as a human being that has preferences, habits, personality traits, and interests, just like everyone else*, can help reduce the risk that all behaviors are "blamed" on the persons' dementia!! And in turn, dementia is "incurable" and "hopeless" so there is "nothing we can do."

In practice, there are LOTS of things that caregivers can do – in the way that they talk to the person with dementia; how they approach and cue the person to be successful; and in monitoring

environmental factors that create stress and promote dysfunctional behaviors. As we discussed in the module, Dementia Part II, understanding what is stressful to the person with dementia, and adjusting those factors, is important to promoting function and comfort. Many of the principles discussed in this module BUILD on PLST principles and practices discussed in Dementia Part II. We highly recommend that you review these concepts with staff as you teach this module. The two programs work together, so try to help staff see the relationships.

Many of the adjustments in care require that STAFF CHANGE what THEY DO. In addition to thinking about the person's type and level of cognitive impairment, physical or psychiatric illness, sensory impairment, biological tensions, psychological needs, and medications, we must also think about the facility-related factors and staff approaches.

FACILITY-RELATED FACTORS create a "context of care" that may contribute to the occurrence of behavioral symptoms. The physical design of the facility, along with facility routines, policies and other environmental features (e.g., provision of safe outdoor area, use of noxious alarms on doors or public address systems) impact on the social climate. The social environment may either create opportunities, or provide "negative and restrictive feedback" that fosters the development of behavioral symptoms. As we discuss in the module, the LEVEL AND TYPE OF STIMULATION often serves as an antecedent to behavioral symptoms. These factors are often not controlled by caregivers, but are determined by facility policies made by administrative personnel.

In addition, formal and "informal" (unstated) facility policies create work expectations, and influence what staff feel they can, and cannot do, in adjusting or changing care routines. For example, the person with dementia (Harvey) may be accustomed to taking his bath in the evening, before going to bed. Harvey resists taking his bath in the morning, and often pushes, strikes, and yells at caregivers to "stop." Day staff would like to move Harvey's bath to evenings, but evening shift is unwilling since they have "other duties" and "less staff." They also feel "dumped on" by being asked to take care of a "difficult" resident. Finding a reasonable solution to this "stand off" will likely require administrative input.

STAFF APPROACHES to persons with dementia are also critically important to the occurrence of behavioral symptoms, and outcomes after the behavior occurs. As we emphasized in the Dementia Part II module, communication skills and strategies, including both verbal and nonverbal messages, are very important in dementia care. Changing HOW requests are made, as well as HOW caregivers approach and interact with the person, makes a huge difference in the outcome of care. For example, using strategies to help persons with dementia conduct their own activities of daily living – instead of "doing things to" them because it is "faster," (or the caregiver thinks the person is unable), can reduce reactions related to invasion of personal space and privacy. Developing skills in using validation, distraction, reassurance, and other comfort measures is essential.

These two factors – facility-related factors and staff approaches – have an ENORMOUS IMPACT on the occurrence of behavioral symptoms!!

The goal of this program, then, is to help staff *look beyond the immediate "problem,"* and search for factors that may be contributing to the behavioral symptoms. This is the "chain of events"

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idea that was introduced in the first program. The primary emphasis is on ASSESSMENT, because without thorough assessment, effective interventions are impossible.

As noted in the program materials, we believe that "*assessment is EVERYONE'S job!*" The person who makes the observations doesn't necessarily need to interpret them. This is critically important since the nursing assistants are often the most knowledgeable about the resident's behavior, but may not see themselves as having "assessment skills." Likewise, many staff who do not provide "direct care" – like housekeepers, nutrition aides or even activity staff, may SEE things that provide clues to the behavioral symptoms. Involving all staff in problem-solving is important. Help your staff understand that assessment is just a "fifty-cent" term for "observation." Be sure to discuss who and to whom those observations are best reported!! (E.g. Do nursing assistants report to the charge nurse? Or to a team leader? How is information about resident's behavior communicated?)

As the A-B-C model emphasizes, the first step in the assessment is to look at the resident's BEHAVIOR very carefully. Then ask staff to look at the antecedents and "triggers," and the consequences or "reactions" that may be encouraging the behavior to continue. As we said in the script, the person does not experience the specific behavioral symptom continuously. These behaviors occur in EPISODES. And that means that we need to look for other things that may be contributing or "setting off" the actual episode. Too often staff slip into the "nothing makes a difference" mode of thinking. Your job is to convince them that knowing the person well, and observing, listening, and thinking carefully about the person and situation OFTEN offers important clues.

Looking carefully at the behavior, and understanding what "keeps it going" in terms of "TRIGGERS" and "REACTIONS," assists the staff in two important ways:

1. It offers an explanation of WHY the behavior occurs and puts it in terms that are more "understandable": the person is UNCOMFORTABLE and/or feels THREATENED – which is quite different from "*doing it to me on purpose, and could stop if he/she only wanted to.*"
2. It offers staff a framework to guide their thinking about how to PREVENT the behavior by changing antecedents and replacing "automatic" reactions with HELPFUL RESPONSES when the behavior does occur.

The last segment of the program briefly reviews "crisis intervention" strategies that may be used if the person with dementia is intensely upset and threatened. The goal is always to avoid this type of situation, but there are times when intense behavior does occur. We have chosen to put most of the information in a handout, allowing you to spend as much or as little time on these concepts as you think is appropriate. We believe staff will benefit most from FIRST understanding the A-B-C approach, and then later developing additional skills about responding to a "crisis." The primary point is to *help staff avoid making the situation worse by what they say or do.*

After reviewing the program materials, think about the following questions and suggestions and make some notes to yourself in the margin of the lecturer's script or the handouts. Select a resident who is "known" for their "disruptive" behavior and then *do your homework!*

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1. Use the handout "Checking It Out", to assess the resident's behavior. What is really going on? What are all the possible triggers? Think about reactions and responses. What can you learn about the situation? Would it help to involve other staff or family as you assess the behavioral symptom?
 2. Think about possible interventions. What IS a reasonable behavioral goal? How could you change the triggers? What about the reactions and responses to the behavior?
1. Use the handouts as a "worksheet" and write down everything that you "know" about the resident, just from experience. Then back up and look at the chart, examine the behavior, and think about "what else" there is to consider. Use that as an illustration -- good or bad!
 2. Be prepared to discuss the case(s) that you explored and offer personal examples of how the assessment questions can be used. At the same time, listen carefully to the STAFF'S PERCEPTION of what is going on (e.g. what they think about the resident, the resident's behavior, their own behavior, etc.). Their interpretation of the person and the situation may give you some important clues about ATTITUDES OR BELIEFS that may interfere with effective care management.
 3. Think creatively about how you can encourage staff to actually use these principles in their day-to-day practice. What will help them pause and look "beyond the behavior?" What kind of reminders can you place in their environment? What kind of reinforcement can you offer them?
 4. Remember that the use of these ideas is not limited to "nursing practice with residents of long-term care centers." The concepts can be applied to *all kinds* of life situations: family, work roles, etc. The more practical and useful you can make the content, the more likely staff are to remember and use it!!
 5. Remind staff that you will be teaching programs about specific kinds of behavior problems in the future (powerlessness, depression). Let them know that you hope to return to these ideas again, and expand on them with more information on how to "manage" the negative behavior.

On a practical note, be alert that information that is on the assessment and interventions handouts will appear in bulleted lists in the lecturer's script.

- ✓ Information in the handout is listed in the script for your reference and use. Use as many questions or ideas as you think are needed to illustrate the point being made.

Finally, please remind staff that these basic ideas may be applied to lots of different problems and challenges associated with caring for older adults – as well as in our personal lives.

New vs. Old Culture of Dementia Care

	Old Culture	New Culture
Focus	<ul style="list-style-type: none"> ▪ Illness-orientation ▪ Lost abilities, what person cannot do ▪ Disability cause by dementia 	<ul style="list-style-type: none"> ▪ Person-Centered ▪ Retained abilities, what person can do ▪ Strengths, interests, skills ▪ Longstanding traits, abilities, preferences, experiences, habits
Attitudes	<ul style="list-style-type: none"> ▪ “Nothing can be done” ▪ “Incurable” ▪ “No hope” 	<ul style="list-style-type: none"> ▪ Person-first (aka, person-centered) ▪ Continued meaning in living ▪ Ability to enjoy life retained
Behaviors	All caused by disease	Brain changes (type of dementia, part of brain affected, stage of disease) PLUS <ul style="list-style-type: none"> ▪ unmet needs ▪ longstanding traits and habits ▪ environmental factors ▪ stress Behavior is COMMUNICATION; signals <ul style="list-style-type: none"> ▪ discomfort, distress ▪ need for assistance from caregivers
Labeling	Negative terms for BEHAVIORS: <ul style="list-style-type: none"> ▪ Disruptive ▪ Difficult ▪ Aggressive Negative terms for PERSON: <ul style="list-style-type: none"> ▪ “Hitters” ▪ “Feeder” ▪ Demented person 	Behavior as SYMPTOM <ul style="list-style-type: none"> ▪ Behavioral & Psychological Symptoms of Dementia (BPSD) ▪ Need-Driven Dementia-Compromised Behaviors (NDB) ▪ Behavioral symptoms, or just behaviors Person-Centered <ul style="list-style-type: none"> ▪ Person with dementia, or just person
Interventions	“Manage” behaviors <ul style="list-style-type: none"> ▪ “Control” person who is likely to “cause trouble” ▪ Contain behaviors, disallow negative influence on others in environment 	Understand & respond vs. “manage” or “control” <ul style="list-style-type: none"> ▪ Problem-solve about meaning of behavior ▪ Why here? Why now? ▪ Who has “problem”? ▪ Promote function & comfort ▪ Engage in pleasurable activities ▪ Distract, reassure, comfort person

A-B-C Approach to Dementia Care

Prevention is the "Best Medicine!" Remember to

- ✓ Identify the individuals who are “at risk” for developing behavioral symptoms
- ✓ Learn to recognize behaviors that signal person is uncomfortable or threatened
- ✓ Intervene early to defuse the situation, keeping the person calm and comfortable
- ✓ Create an environment in which behaviors are unlikely to occur in the first place

A-B-Cs Defined

Antecedents: A is for antecedent, the events or factors that PRECEDE the behavioral symptom and contribute to its occurrence. Antecedents are also called “triggers” because they “set off” behaviors.

Behaviors: B is for the specific behavioral symptom that is of concern, looking at ONE behavioral symptom at a time in the problem-solving and care-planning process.

Consequences: C is for consequences, all the things that happen AFTER the behavior occurs. That includes all the reactions and responses to the person, including those by other residents, family, visitors, volunteers, AND staff caregivers.

Assessment is Key to Success!

- ✓ Prevention requires that caregivers know the PERSON and the SITUATION well
- ✓ Think like a detective! “Check it out, Sherlock”!
- ✓ Get all the facts: Observe, listen, read, ask!

STOP and QUESTION the behavior.

Look for clues about WHAT IS going on and WHY.

LISTEN and TALK to others to get the WHOLE picture!!

Get EVERYONE involved in assessment!

Collecting information by watching, listening, and carefully paying attention is easy.
YOU don't have to "interpret" what you see. *Just pay good attention to the person
and his/her behaviors!!*

Assessment: Checking It Out

Describe the BEHAVIOR in detail.

- ✓ What is the real concern?
- ✓ What is the resident doing? Where is it happening?
- ✓ How often does it happen?
- ✓ How long does it last?
- ✓ Does it seem to get worse over time?
- ✓ Who is it really a problem for? the resident? the family? the staff?
- ✓ Is the behavior safe? Is it dangerous?
- ✓ Are our expectations realistic?
- ✓ Are the resident's or family's expectations realistic?
- ✓ Are we (or the family, or their roommate, or whoever) wanting more from the resident than is practical, given their limitations?

Identify possible ANTECEDENTS and TRIGGERS

- ✓ Where does the behavior occur?
- ✓ What else is going on around the person?
- ✓ Who is there? What are they doing?
- ✓ What is going on in the environment?
- ✓ Has the person had a “change in status”? Physical? Mental? Social?
- ✓ Did someone just say or do something to the person with dementia?
- ✓ Did the behavior occur while trying to provide personal cares?
- ✓ Does it happen at a certain time of day?
- ✓ What might be going on inside the resident?

Common Antecedents and Triggers include:

Cognitive Impairment

- ✓ What type of dementia does the person have?
- ✓ What stage of disease are they in? Early? Middle? Late?
- ✓ What is their “baseline” level of function? What can they do when provided the right type of assistance?

Psychiatric Illness

- ✓ What are they thinking or feeling that might be causing this behavior?
- ✓ Are they *actively hallucinating*? (e.g., seeing or hearing something that we do not)
- ✓ Are they responding to those hallucinations?
- ✓ Are they experiencing *upsetting or frightening delusions*? (e.g., false, fixed beliefs)
- ✓ Do they think you or someone else is “out to get them”?
- ✓ Are they acutely confused due to a medical illness?
- ✓ Are they depressed, which is associated with increased behavioral symptoms in dementia?

Sensory Impairment

- ✓ Is the person seeing, hearing, or understanding what is going on?
- ✓ Is there enough light to see?
- ✓ Are they misinterpreting their environment??
- ✓ Is that misinterpretation contributing to MISBELIEF that is part of the problem?
- ✓ What do THEY see, hear, and feel?
- ✓ What possible misinterpretations may be contributing to anxiety or fear – like thinking someone is spying on them when they see their own reflection in dark glass?

Level and Type of Stimulation

- ✓ What is going on in the physical environment?
- ✓ Is it too noisy or confusing?
- ✓ Too cold, busy, dark, or crowded?
- ✓ Is the behavior related to television or radio that they do not understand?
- ✓ Does it occur in large public areas (like the dayroom, dining room, or activity room) that tend to be busy and over-stimulating?
- ✓ Do certain people seem to trigger the behavior?
- ✓ Does it seem to happen when the family is here? or after certain “outings” or activities?
- ✓ Has there been a lot of change in staff caretakers?
- ✓ Is it worse or better when certain staff are working?

Internal Biological Tensions

- ✓ Is the person in pain or discomfort?
- ✓ Is the person hungry or thirsty?
- ✓ Does the person need human contact or touch?
- ✓ Is “wandering” an expression of need for exercise?

Unmet Psychological Needs

- ✓ Is the person lonely? Are they seeking companionship?
- ✓ Is the person bored? Are they seeking meaningful activity?
- ✓ Is the person sad or blue? Do they need reassurance or one-to-one time?
- ✓ Does the person need someone to talk to? Who will reminisce with them?
- ✓ Are they missing a friend? Family member? Pet?
- ✓ Are they missing a favorite activity or pastime? What were those activities?

Health Status

- ✓ What medical conditions does the person have?
- ✓ Has there been a change in that condition?
- ✓ Does the condition cause or contribute to pain?
- ✓ Does the person have an acute illness that is causing acute confusion?

Medications

- ✓ Has the person been prescribed a new medicine recently?
- ✓ Is the behavior related to an adverse reaction? Or toxicity?
- ✓ Is the medicine interacting with another medicine the person is already taking?

Facility Routines/Characteristics

- ✓ Is the behavior related to certain facility “routines” like rising, going to meals or activities, bathing, or bedtime?
- ✓ Does the behavior tend to occur in large group activities? (e.g., meals, activities)
- ✓ Is it a response to certain people (e.g., people at dinner table; particular residents or staff)?
- ✓ Does it occur in certain locations (e.g., shower room) or during particular daily activities (e.g., dressing)?
- ✓ Is the person misinterpreting factors in the physical environment? (e.g., long corridors, dark windows, mirrors, shined floors)

Staff Approaches

Is the behavior related to . . .

- ✓ telling the person to “try harder”?
- ✓ asking them to use a skill that is lost? (e.g., dressing without being cued to put clothes on in a certain order)
- ✓ taking the person “by surprise”? (e.g., not in the person’s visual field, failed to make eye contact before touching or speaking to the person)
- ✓ forgetting to explain what is being done and why?

- ✓ using language that is too complicated for the person to understand?
- ✓ trying to “reason” with the person’s misbeliefs?
- ✓ being “hurried” and doing things “to” the person instead of breaking tasks into steps and cueing them to be independent?
- ✓ Using “you are wrong” messages? (e.g., That is not your room; That does not belong to you; No, you cannot go home, you live here now)
- ✓ “resistance” – pulling back, avoiding, pushing you away, or other behavior that communicates they want you to stop?
- ✓ touch or invasion of personal space?
- ✓ frustration related to declining abilities?
- ✓ anticipation of pain?
- ✓ loss of personal control or choice?
- ✓ lack of attention?

Describe REACTIONS & RESPONSES.

- ✓ What happens after the behavior occurs?
- ✓ Who responds, reacts to the behavior? Staff? Other residents? Family? Visitors?
- ✓ What is said (in words and nonverbally)? How do people look, sound and act?
- ✓ What does the person with dementia do next?
- ✓ Are automatic reactions (consequences) "making it worse" instead of better?
- ✓ What are the alternatives? What other reactions and responses are possible?
- ✓ What might be said or done to comfort, reassure or redirect the person?

Common "unhelpful" automatic reactions include:

- ✓ Avoiding or ignoring the person (or their family)
- ✓ Becoming defensive in our words or actions
- ✓ “Paying them back” by “forgetting” or being slow to answer their calls or respond to their requests
- ✓ Being indifferent, cold, or silent, which says "I don't care about you. You are not even worth paying attention to"
- ✓ Feel angry at, resentful about, and frustrated by the person
- ✓ Blaming the person, thinking that he or she is “doing it on purpose” and could stop if he/she only wanted to
- ✓ Allowing “low level” behavior to continue, hoping will just “go away” on its own
- ✓ Trying to correct or set limits with the person. Telling the person “No, you can’t do that! Stop it right now!”

- ✓ "Setting the person up" by expecting them to remember what we tell them? (e.g. lunch is in an hour; I'll be right back);
- ✓ Increasing the person's level of frustration or angry by trying to "rationalize" with them (e.g. in response to misbeliefs or delusions)
- ✓ Threatening the person with facial expressions, gestures or our tone of voice

Note: There is considerable overlap between antecedents and consequences in the area of staff approaches. As noted before, behavioral symptoms tend to “escalate”, becoming worse in the absence of interventions that are designed to calm, reassure, comfort and redirect the person. Staff reactions and responses are critically important to reducing the risk that behaviors will continue or become more intense.

Interventions: Managing & Modifying

Set BEHAVIORAL GOALS.

- ✓ Can we eliminate the behavior? Or decrease the frequency?
- ✓ Do we need to adjust our expectations?
- ✓ What do we REALLY want the resident to do?
- ✓ Is that goal realistic?
- ✓ Is it specific enough that we'll know when it's been reached?
- ✓ Is it a single step? Or do we need to break it down into little pieces to get the job done?
- ✓ Do we need to adjust our expectations?

Change the ANTECEDENTS and TRIGGERS

Which antecedents or triggers can be eliminated or changed to reduce their negative impact on the person?

What new cues can we add to encourage functional behavior and comfort for the person?

For example,

- ✓ Does the person need a rest period so that they don't "sundown" in the afternoon?
- ✓ Should they be allowed to eat in their room to avoid the noise and confusion of the dining-room?
- ✓ Would it help to take down pictures to reduce the psychotic resident's delusion that their parents are alive?

Change CONSEQUENCES AND REACTIONS

Which consequences or automatic reactions can be eliminated or changed to reduce their negative impact on the person?

What new, neutral or positive responses can we add to encourage functional behavior and comfort for the person?

For example,

- ✓ Adjust interventions to fit the resident's ability to understand and use information.
- ✓ Speak in simple, easy to understand language.
 - Give one command or ask one question at a time.
 - Wait for a response and listen carefully for meaning.
 - Don't try to reason with them.

- Monitor your tone of voice, facial expressions, and body language.
- ✓ Reduce environmental stress to calm the person.
 - Remove unnecessary people, turn off TV, etc.
 - Move to a quiet place (e.g. their room).
- ✓ Don't confront or challenge delusions or hallucinations.
 - Distract them to some other activity or topic.
 - Reassure them that they are "safe with you."
- ✓ Reduce misleading stimuli
 - Remove pictures/objects that lead to misperceptions.
 - Turn off TV, radio.
- ✓ Check for internal stressors that may be contributing. (e.g. Are they hungry, tired, uncomfortable?)

EVALUATE their response to the interventions.

- Did my plan work?
- Did *any part* of it work?
- Why? or Why not?
- What got in the way? What made the difference?

Managing a Crisis

1. First, tune in to your OWN ATTITUDES and FEELINGS about what is going on.
 - Getting angry won't help and will probably make things worse.

Remember! Being caught "off guard" puts you at risk for "fueling the fire" (e.g. the first time it happens you "fight back" vs. assess and problem-solve through the crisis).

Likewise, if you are angry or resentful about past experiences with the person, you probably won't be effective.
 - Try to remain calm, cool, and collected, at least on the "outside."
 - Use positive self talk to get yourself under control. For example, remind yourself
 - "This person is "uncomfortable" and needs my help."
 - "I can handle this. I don't need to get upset, too."
 - "They're not really angry with me. They're just upset and I'm in the way!"
 - Avoid words or actions that might threaten the person even more.
 - If you can't get your own feelings under control, leave the area immediately, alerting other staff if needed.

2. Keep track of what you are doing with your BODY and what that might mean to the person.
 - Don't surprise them; move slowly and steadily.
 - Keep your hands out where they can see them, palms up and open, which is non-threatening.
 - Respect their "personal space;" the more threatened they are, the more distance you should give them.
 - Don't stand squarely in front of them (which is very confronting and threatening); turn slightly to one side.
 - Be careful to not stare, glare, or otherwise challenge the person with eye contact.
 - Don't turn your back on the person.
 - Always leave yourself an escape route.
 - Avoid standing over the person (if they are sitting or reclining), which can be very threatening.

3. Think about **WHAT** you say and **HOW YOU SAY IT**.
 - Speak in short, simple phrases.
 - Use a normal tone of voice and talk at a normal rate.
 - Communicate concern and caring.
 - Avoid sarcasm, insulting remarks, and even humor (which can easily be misinterpreted).

4. Use **DIRECTIONS** or **EXPLANATIONS** that are **APPROPRIATE** for the person and the situation. For example,
 - "I'm sorry if I upset you, that wasn't what I meant to do."
 - "Your behavior worries (frightens, upsets) me."
 - "How can I help you be more comfortable?"
 - "Mr. Smith, let's go to your room (a quiet place, etc.)."
 - "It's all right now. You are safe with me. I won't let anything bad happen to you."

5. Listen carefully to what they are saying and try to respond to the message they are trying to communicate.
 - Check for meaning, "You're saying that ..."
 - Avoid giving advice.
 - Respond to the "content" of their message (the actual meaning), not the way it's being said.
 - * Try to understand what they are upset about.
 - * Respond to that unmet need or feeling.
 - Don't assume that they have heard or understood you.
 - * Our focus becomes very narrow when we're anxious.

6. Try to calm or soothe them, remembering that the first priority is to **PROTECT YOURSELF AND OTHERS**.
 - Leave the room or area if they continue to threaten you.
 - Get assistance, even if you aren't sure if you really need it.
 - Use physical control only as the last resort!! Try everything else first!

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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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