



# Management of challenging behaviours in Parkinson's disease

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# Case Description



Brenda is a 64-year-old divorced lady who resides in an aged care facility due to the physical, emotional and psychological effects of Parkinson's Disease.

Since arriving at the facility approximately 6 months ago, the symptoms of her Parkinson's Disease (including tremors, initiation difficulties and "freezing") appear to have significantly worsened and she has become increasingly distressed.



# Developmental History

- Normal birth and childhood with appropriately timed developmental milestones
- Completed H.S.C., then studied office administration at T.A.F.E.
- Worked as a legal secretary
- Continued to work part-time after her two children were born
- Ceased work 10 years ago following divorce (due to Brenda's personality changes)
- Limited contact with adult children



# Medical History

- Reports no major illnesses prior to being diagnosed with Parkinson's Disease
- First diagnosed with Parkinson's Disease approximately 12 years ago after a long period of unexplained symptoms
- Had previously attended mental health services for counselling for relationship problems and G.A.D.
- Attending Consultant neurologist for 10 years, now considering infusion pump

# Medications

- Acimax 40mg daily - GORD
- Sinemet CR 200/50 1 six times daily
- Madopar 125mg tds
- Comtan 200mg bd – adjunct to Sinemet, Madopar
- Escitalopram 20mg daily – Major Depression
- Oestrone 1.25mg nocte
- Motilium 20mg qid – anti nausea
- Meloxicam 7.5mg mane - osteoarthritis
- Folate 5mg daily



# Side effects of medications

- Sinemet, Madopar – nausea, dyskinesias, postural hypotension, palpitations, sleep disturbances, hallucinations, delusions, anxiety, delirium , hypomania
- Comtan – dry mouth, blurred vision, constipation, urinary retention, delirium and memory loss



# Behaviours of Concern

Psychogenic seizures – i.e., falling/throwing herself to the floor in the foetal position

Vocally disruptive behaviours including loud screaming and repetitive cries of “Please help, please help”.

Refusal/inability to transfer from chair to bed despite indications of being functionally able to do so.

Mild cognitive impairment – cognitively rigid, concrete

# Psychogenic seizures

- “Functional” or nonorganic cause
- One type of somatoform disorder
- Misconception that “psychogenic equals fake”
- Side to side head shaking, pelvic thrusting, stuttering, weeping, opisthotonic posturing (arching backwards of head and back)
- Preserved awareness

(Benbadis, 2005)

# Parkinson's disease

- Slowness of movement (bradykinesia)
- Difficulty initiating movement (akinesia)
- Masked facies
- Muscular rigidity
- Shuffling unsteady gait
- Abnormal posture (stooped, slight flexion of ankles, knees, hips, elbows, back and neck)
- Tremor may or may not be present





# The Dilemma

- Behaviours physical or mental health cause or both?
- Treatment/medication contributing to symptoms
- Which should be treated first – mental or physical?
- Staff attitudes toward behaviour divided
- Behaviour described in value-laden, all-or-nothing language, e.g., “good” or “bad”
- Staff exhausted, overwhelmed and fed up



# Psychological Case Formulation

- Brenda interpreting physical sensations she experiences in a dramatic fashion
- Due to hyper-vigilance interprets innocuous physical sensations as indicators of serious illness
- Therefore, finds it difficult to discriminate between everyday physical sensations and those due to Parkinson's disease
- Interprets side effects of medication as indicator that Parkinson's disease is worsening



# Psychological Case Formulation

- These interpretations/thoughts lead to an increase in physiological symptoms and subsequent anxiety, i.e., the fight, fright or freeze phenomenon
- There is an increase in behaviours designed to avoid or reduce the physical discomfort associated with anxiety and thereby avert the catastrophic event, e.g. putting herself on the floor in the foetal position, refusing to transfer from bed to chair



# Psychological Case Formulation

- The temporary relief achieved from engaging in these behaviours further reinforces and strengthens them, i.e., she learns that lying on the floor in the foetal position makes her feel better, at least temporarily
- Brenda therefore does not have the opportunity to learn that the feelings will go away on their own as her anxiety decreases
- Notably, the fight, flight or freeze response is only a short term physiological mechanism used by the body to deal with perceived threats



# Psychological Case Formulation

- The regular occurrence of this pattern has led Brenda to scan her body more intently for possible symptoms making her hypervigilant and thus, more inclined to notice and identify symptoms
- When she engages in avoidance by refusing to attempt physical tasks of which she is capable her beliefs are further reinforced as the reduction of physiological symptoms shows her that her belief was correct
- The resulting panic exacerbates the already pre-existing symptoms of Parkinson's disease



# Carer Responses

Inadvertent reinforcement of behaviour due to distress of staff, other residents and visitors by:

- Assisting with self-care, mobility when not necessary
- Becoming angry and verbally aggressive when Brenda does not respond appropriately to requests
- Becoming overly anxious and attentive to her symptoms

Inconsistent responses

Extreme positions regarding the cause of the behaviours  
(physical vs. psychological)

# Environmental Considerations

- Behaviour occurs more frequently at times of stress, boredom or as a response to negative interactions
- Possibly due to increased anxiety and/or the tendency to bodily scan at these times





# Considerations for Intervention

- Person-centred care:
  - Collaborative with client, staff of RACF, family
  - Empowering
  - Aim to improve self esteem
  - Acknowledging unmet need (meaningfulness)
  - Addressing 'value-laden' labels
  - Validating expression of anxiety



# Psychological Intervention

## ■ Self soothing activities

- Brenda taken outside to lessen the chance of accidental reinforcement and allow her the opportunity to engage in self soothing activities
- Sensory awareness exercises used to bring her back to the present, e.g., focusing on sights and sounds around her
- Mental exercises as a grounding method, e.g., counting backwards by 7s, thinking of animals



# Psychological Intervention

- Differential reinforcement of other behaviours
  - 10 to 15 minutes attention to be given, preferably at the same time each day, when the target behaviours are not occurring
  - It is important to avoid responding to the behaviours **only** when they become unbearable
  - If this is the only time Brenda receives attention the behaviours will be strengthened, i.e., she will learn that in order to gain staff attention she needs to engage in this behaviour



# Psychological Intervention

- Selective ignoring of the behaviour
  - Not “total” ignoring, just responding in ways that acknowledge client need over staff emotions
  - When safe and appropriate
  - Awareness of accidental reinforcement due to excessive emotional responses
  - Assists the development of self efficacy
  - Allows the opportunity to find more socially appropriate ways of managing her illness
  - Be aware of learning theory schedules

# Activities and exercise

- Popular music
- Exercise program for lower limb movement by Physiotherapist
- Diversional Therapy groups such as cards, bingo
- Puzzles, games, books
- Family visits/outings





# Outcomes of Intervention

- Brenda is now more engaged in activities
- Staff are more engaged in her care
- Psychogenic seizures have ceased
- Walking more independently with assistance of frame
- Vocalisations markedly reduced – only occur at times of significant stress
- Anxiety decreased, mood improved

# References

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