

**A case-specific approach to challenging
behaviour associated with dementia:
*Problems with the prevailing model***

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Medical model

The traditional approach to the diagnosis and treatment of illness as practiced by physicians in the Western World since the time of Koch and Pasteur. The physician focuses on the defect or dysfunction within the patient using a problem-solving approach. The medical history, physical examination and diagnostic tests provide the basis for the identification and treatment of a specific illness.

Anderson et al (1994) cited in Macquarie Dictionary

Syndrome – standard treatment model

Agitation:

Anti-depressants

BPSD:

Staff education

Aggression:

Atypical anti-psychotics

Screaming/yelling:

‘White noise’ through headphones

Neuropsychiatric Inventory (Cummins et al., 1994)

Delusions

Hallucinations

Agitation/Aggression

Depression/Dysphoria

Anxiety

Elation/Euphoria

Apathy/Indifference

Disinhibition

Irritability/Lability

Aberrant motor behaviour

Sleep

Appetite/Eating Disorders

Syndrome – standard treatment model

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Reviews of 'discrete' psychosocial approaches

Aromatherapy

Person centred bathing

Carer education

Music and sound therapy

Multi-sensory stimulation

Simulated family presence

Personalised recreation

Validation therapy

Relaxation training

O'Connor et al., (2009)

International Psychogeriatrics

Staff training

Environmental modification

Sensory stimulation

Behaviour management

Structured activity

Special care units

Validation and social contact

Simulated presence therapy

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Case-specific approach to challenging behaviour associated with dementia

What is the person with dementia actually doing that is causing a problem?

Does it place the person or others at significant risk?

Is it a manifestation of distress by the person with dementia?

What factors are causing the behaviour to be perceived as a problem? Who is it distressing, and why?

What environmental and other factors are causing the behaviour or escalating it to intolerable levels?

What causal factors can be changed in this case at this time, and how do we change them?

Angela 74: Nursing Home Resident with dementia

Problems:

Yelling and stripping off in lounge

Causes:

Chronic back pain

Recent bereavement

Total disorientation due to:

- **large doses of anti-psychotics and benzodiazepines**
- **lack of structure and no-one speaking Italian**
- **Permanently tired because woken several times a night for toileting**
- **Recent bereavement?**

Staff know little about dementia, nor that behaviour usually has causes

Interventions

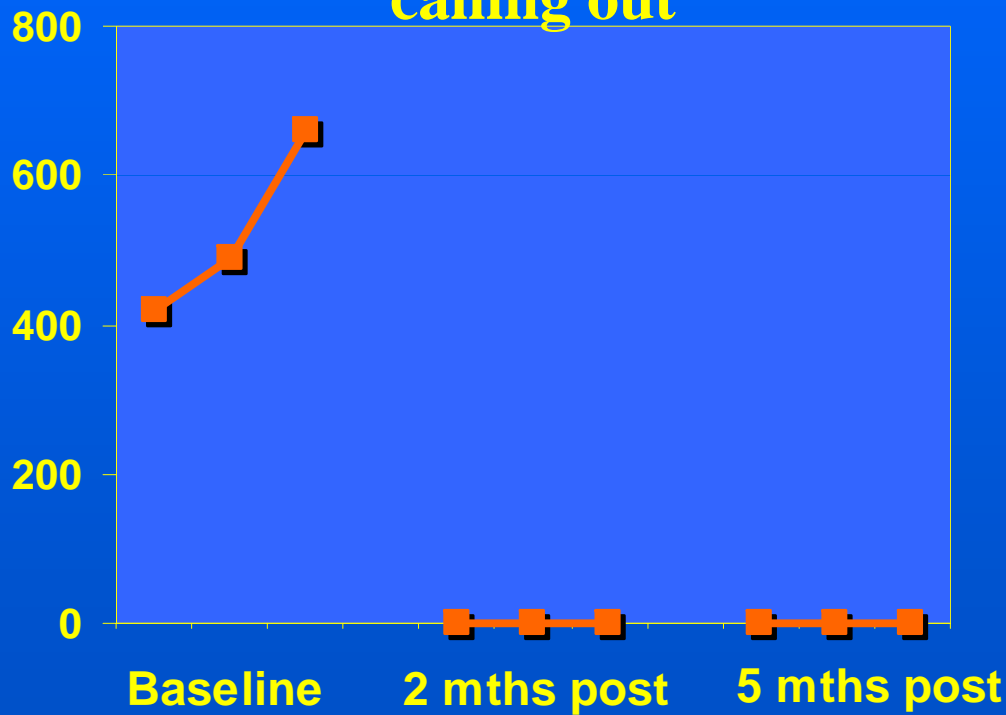
- **Cessation of neuroleptic and reduce benzodiazepines**
- **Pain management including analgesics, massage, heat treatment**
- **Activity programme involving Italian radio, visits from Italian priest, and walks with family**
- **Allowing her to sleep through night even if wet**
- **Using difficult to remove clothing plus re-dressing her or pre-empting attempts and showing her Italian signs that this was a public place**

Plus

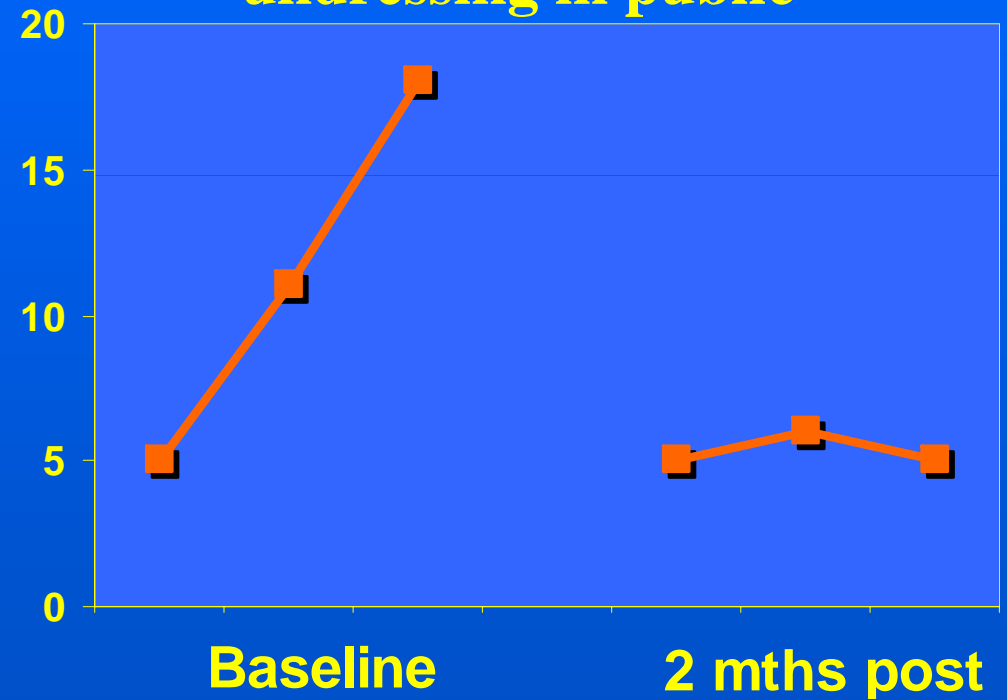
- **Developing rapport with staff and engaging them as co-therapists**
- **Helping staff understand the effects of dementia, and also see person behind the behaviour rather than just the behaviour**

Angela

Frequency (per hour) calling out



Frequency (per day) undressing in public



Stress down a lot, Coping much better, Problem severity down a lot

Dusty 62: Psychiatric inpatient

Problems

- **Stuck in psychiatric ward, multiple diagnoses ('mad')**
- **Screeching, temper outbursts.**
- **Cocktail of psychotropic medications**

Causes

- **Institutionalised (both Dusty and staff)**
- **Pain, hypothyroidism, catheter - frequent infections**
- **Massive frustration because of physical limitations**
- **Traumatic life, abusive former husband**
- **Death of unborn daughter following abuse**

Interventions

Anger management ('volcano' triggers) and arousal reduction

Development of distracters

Learning social skills

Pain management – including appropriate wheelchair

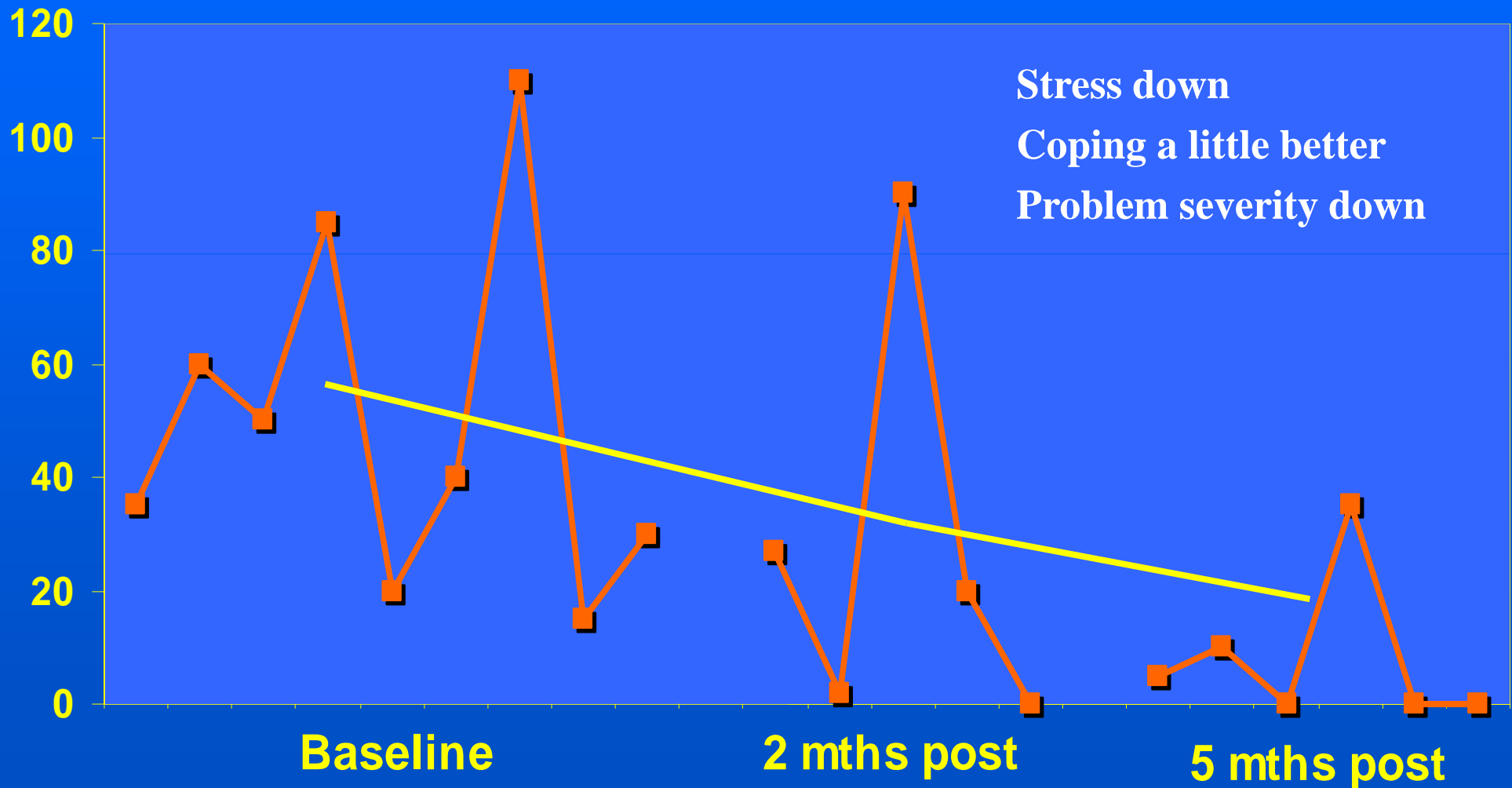
Sorting out medications (geriatrician)

Monitoring for infections and treating them promptly

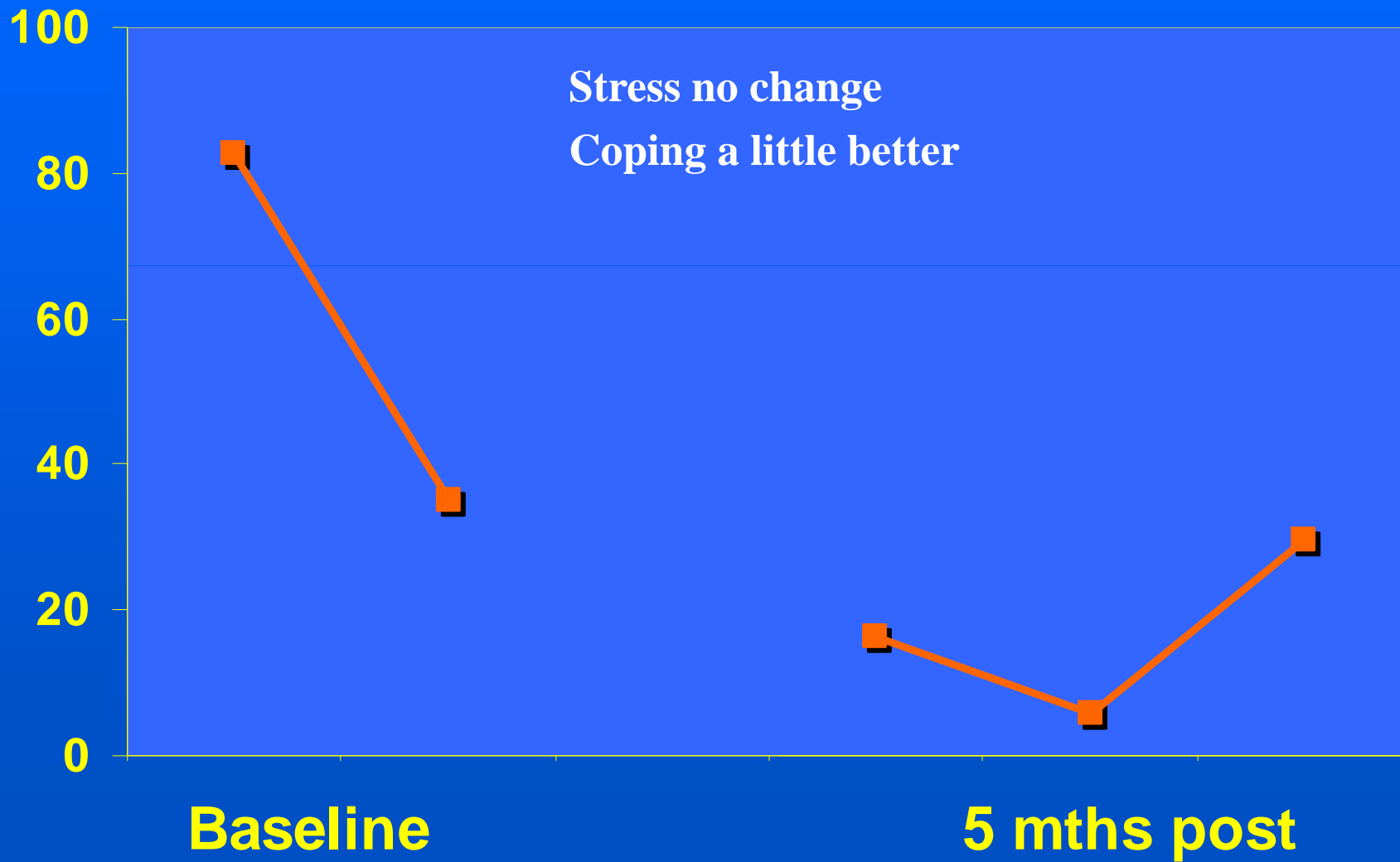
Psychotherapy with PGU staff – noticing when Dusty was trying to be, and being 'good'

Education for staff at RACF, and on-going support and 'booster sessions'.

Patrick: Duration (minutes per day) of calling out



Bill: Frequency (per hour) of calling out



Why does current adherence to the syndrome – standard treatment model matter?

Internal causes of challenging behaviour can remain untreated, for example pain, infections, depression, bodily discomfort

Other causal factors such as the care environment, or the reasons the patient is seen as a problem often remain un-addressed

Holds back grappling with the real complexities of challenging behaviour in dementia, including development of the methodologies to assess the case-specific approach

It means that anti-psychotic medication and frequent poly-pharmacy will continue to be the front-line treatment for some time to come.

Slim grounds for hope

Australian Government DBMAS programme

NSW Health BASIS programme (including reform of CADE units)

Case-specific trials

Hinchliffe et al. (1995): Int. Jnl. Geriatric Psychiatry

Fossey et al. (2006): British Med. Journal

Bird et al. (2007) Int. Psychogeriatrics; (2009) Ageing & Mental Health

Cohen-Mansfield et al. (2007): Jnls. Gerontology

Davison et al. (2007): Int. Jnl. Geriatric Psychiatry

“There is no magic pill for BPSD”

Sink et al., (2005)