Promoting Behavioral Health in Long Term Care Settings

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Overview

- What is healthy behavior within a nursing facility?
- Describe factors that contribute to behavioral health problems in nursing facilities:
  - Resident factors
  - Staff behaviors
  - Environmental factors
- Describe strategies for detecting:
  - Behavioral health problems
  - Excess disability
- Describe strategies for promoting:
  - choice
  - behavioral activation
  - emotionally meaningful experiences

What is “healthy” behavior within a nursing facility?

- Behavioral repertoire is supported
- Excess disability is prevented
- Behavioral functioning is “as good as it gets”
- Variety of behaviors are available to residents for:
  - Doing what they want to do, given circumstances
  - Accessing gratifying experiences
  - Coping with environment
- Motivation for behavior is positive
  - Person’s behavior is not chronically motivated by escape or avoidance of aversive consequences

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Strangers in a Strange Land

Is "behavioral health" possible in a nursing facility?

Residents: Who is likely to live in a nursing facility?

- Characteristics of people most likely to be placed in a nursing facility
  - Over age 85
  - Female
  - Unmarried or living alone
  - Recently admitted to a hospital
  - Lives in retirement housing rather than being a homeowner
  - Has no children or siblings nearby
  - Has some cognitive impairment
  - Has one or more problems with IADL

Resident characteristics

- Pain
  - Estimates of the prevalence are as high as 50%
  - High prevalence of pain comes hand-in-hand age-associated health problems (Rygaard & Jarlend, 2005)
    - Fractures
    - Arthritis
    - Osteoporosis
    - Neuropathic pain
    - Pressure sores
  - History of adversity, punishment, and stigma
    - Persons with psychiatric diagnoses
    - Persons with cognitive impairment

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### Barriers to detection of behavioral health problems in the nursing facilities

- **Resident factors**
  - Deficits in communication ability
  - Loss of ability to understand and label internal (private) experiences
    - Pain
    - Discomfort
    - Fear
    - Boredom
  - High risk of excessive disability
    - Complex medical and psychological histories
    - What is normal decline vs. excessive decline?

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### Staff characteristics

- **Nursing staff's limited resources**
  - Issues such as falls, incontinence, regular Activities of Daily Living (ADLs) need immediate attention
  - Low staff to patient ratios
- **Certified nursing assistants**
  - Skill
  - Knowledge and beliefs about resident behavior
  - Personal life stressors
  - Emotional challenges of job
    - May perceive resident behavior as bizarre
    - May be afraid of residents

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### Environmental characteristics

- **Lack of privacy**: We're most selective about who we want to spend time with in late life (Carstensen, 1993; Carstensen et al., 1995)
- **Nursing facilities force contact with strangers**:
  - Other residents
  - Staff
- **Well-intentioned social contact may actually be aversive for some residents**
  - Examples:
    - Activity programs are often designed for lower functioning residents
    - Socially anxious residents (e.g., due to history of trauma)
"I don't leave my room if I can help it. The people out there are crazy."

84 year resident of skilled nursing facility

Bloomington, IN

Social environment of nursing facilities

- Strict routine can limit freedom of behavior
  - Can be detrimental to well-being
  - Example: Sleep schedules
- Being overly helpful may actually harm the residents by making them more dependent than need be
- Promotion of dependence?
  - Independence may have negative consequences
  - Within nursing facilities dependence leads to most positive attention from staff (M. Baltes, 1994)
  - Greater isolation for those who are most independent

What we know from research on behavioral health promotion

- It's good to have lots of behaviors available
  - Evidence-based behavioral health strategies promote behavioral variability
- People who's behavior is chronically motivated by escape and avoidance of negative experiences are stressed and unhappy
- Access to pleasurable activities is vital for contentment and preventing depression
...Behavioral health prescription for long term care facilities...
- Preserve residents’ fragile behavioral repertoires
- Build in system for detecting and reversing excess disability
- Identify and reduce factors that cause fear and escape motivated behavior in residents
  - Example: Resistance to care is often motivated by fear
- Promote access to preferred activities

“"I’m 94 years old and he thinks I’m too young to watch an R movie”
- Resident of a skilled nursing facility responding to activity director’s statement “We only show G rated movies here.”
  - Reno, NV

Building environments that promote behavioral health
- Staff education: Caregiving basics
  - Building staff’s own resilience and ability to manage the stress of caregiving
    - Promote mindfulness and stress management techniques
  - Knowing the facts about cognitive and psychiatric disorders and how they affect behavior
    - Describe dementia and subtypes
    - What is normal behavioral loss vs. excess disability
    - Example: Confusing medication side effects with symptoms of diagnosed disease
Staff education: Communication

- How not to communicate with residents:
  - Patronizing speech
  - Inflexible or baby "talk"
  - Inappropriate use of first names
  - Terms of endearment: "Honey," "Sweetie"
  - Assumption of greater impairment than may be the case
  - Cajoling to demand compliance
- Persons with dementia become very sensitive to nonverbal cues, such as tone of voice, facial expression, body gestures, and mood.
- If staff are angry and upset, residents are more likely to act the same.

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Staff education: Effective communication with verbally impaired residents

- Tool #1: Caring detachment
  - Compassionate misdirection
  - Do not use long explanations; keep explanations to the care recipient
- Tool #2: Being P.O.L.I.T.E. (McCurry, 2006)
  - Patience
  - Organize and observe
  - Laughter
  - Ignore what you can
  - Tone of voice
  - Eye contact and body posture
- Tool #3: Distracting the care recipient

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Staff education: The importance of preserving residents' behavioral repertoires

- Preventing challenging behaviors
  - While preserving adaptive behavior
  - Avoid any intervention that causes premature loss of behavior... aka "Restrain"
- Understanding excess disability
  - Emphasize verbal impairment reduces the ability to self-report
  - Tragic consequences of misattribution of behavior change to cognitive impairment rather than a reversible condition
- Assessing and treating pain and adverse events

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Staff education: Preventing challenging behaviors

- Changes in affect and behavior labeled "behavior problems" are not a normal symptom of cognitive impairment
  - Aggression
  - Disruptive vocalizations
  - Agitation
- Residents with degenerative dementia eventually become unable to label and communicate their internal psychological or physiological states.
- May respond to conditions such as pain, infection, adverse medication reactions, and fear with changes in affect, behavior, or cognition that resembles the decline expected due to degenerative dementia.

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Staff education: Monitoring adaptive behavior to detect excess disability

- At admission identify stable, frequent, long-standing behaviors for each resident
  - Joking
  - Eye contact and hand-shaking
  - Flirting
  - Tinkering
- Precipitous change in these behaviors is a signal to rule out an adverse event

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Detecting excess disability

(Saugher & Baines, 2007)
Behavior Checklist

Case example: Resident referred for behavior problem “crying”

Eye Contact and Crying in a Two-Week Period

Consequences of misattributing behavior changes

- The first line intervention for many behavioral and affective changes due to untreated or undertreated adverse event is often psychotropic drugs (Verma, Davidoff, & Kamhampetti, 1998)
- This is problematic because:
  - Not treating the problem
  - Older people are at increased risk of adverse drug interactions (Ketona, 2001)
  - Risks of polypharmacy
  - Age-related changes in drug metabolism
Consequences of misattribution of behavior

- Behavior changes conceptualized as "non-cognitive" symptoms of dementia
  - Treatment: Reduce or eliminate the "symptom"
- Lack of treatment for reversible conditions
  - Infection
  - Medication adverse effect
  - Injury
  - Delirium
- Excess disability
- Premature death

Outcomes of undertreated pain in older adults

- Depression and anxiety
- Sleep disturbances
- Nutritional disturbances
- Functional disability
- Impaired cognition
- Social isolation
- Disruptive or aggressive behavior
- Overall decrease in quality of life
- Higher mortality and morbidity rates

(American Geriatrics Society Panel on Persistent Pain in Older Persons, 2002)

Pharmacological interventions for behavioral and affective changes

- Possible adverse psychotropic interventions in older adults (Hien et al., 2005; Scheneider, et al, 2007; Leipzig, 1992; Wadsworth et al., 2005; Ballard, et al., 2009)
  - Sedation
  - Increased cognitive impairment
  - Incontinence
  - Increased risk for falls
  - Delirium
  - Extrapyramidal symptoms
  - Higher mortality rate
Increased mortality in elderly receiving long term antipsychotic medication

Residents with dementia versus residents without dementia
- Patients with a cognitive impairment diagnosis and a pain-related diagnosis
  - prescribed significantly less analgesic medication than patients with similar pain-related diagnoses but no cognitive impairment diagnosis (Fogges & Tsai, 1998)
  - dosage prescribed to the patients with a cognitive impairment diagnosis was significantly lower than to patients without the cognitive impairment diagnosis.

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Research on pain and staff knowledge of dementia
- Studies of staff beliefs and knowledge about pain in persons with dementia (Zweekaten et al., 2007; Jones et al., 2004; Kansalainen et al., 2007) found beliefs:
  - Pain is a normal consequence of aging
  - Aging results in significant reductions in pain sensitivity
  - Patients with dementia cannot feel pain
  - Potential side effects of opioids in older adults make them too dangerous for the aging metabolism
  - Absence of pain report indicates the absence of pain
- These studies also focused on attitudes about pain, such as when and how much pain treatment is justified.

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Nursing staff decision-making

- Nygaard & Jarland (2005) found that a label of "dementia" increased the risk of inadequate pain treatment when compared to residents with similar mental status scores and medical conditions.

Alternative view: Precipitous behavior change in dementia is due to an adverse event

- Rule out reversible condition:
  - Medical (e.g., medication side effect, pain, infection, injury)
  - Emotional distress (depression, fear, boredom)
  - Environmental (abuse, punishment, overly demanding environment)

Excess disability and challenging behaviors

Diagram showing the relationship between challenging and adaptive behaviors over time.
Staff education: Positive approaches to challenging behaviors
- After ruling out adverse event
- The contextual ABCs of dementia care
  - Searching for Clues Part 1: Antecedent Interventions
  - Searching for Clues Part 2: Consequent Interventions
- Designing restraint free interventions
  - Maintain behavior
  - Increase access to pleasant consequences

Increasing access to pleasurable activities
- Promoting freedom in long term care facilities
- Emphasize role of personal history and current preferences
- Observe behavior of those who cannot describe preferences
  - Behavior demonstrates what words cannot
- Behavioral activation: Promoting pleasurable activities (Lewinsohn, 1973)
  - Pleasant events menus can be very helpful (Lewinsohn, 1973)

Case example: Reducing depression through behavioral activation
- Increasing access to preferred activities
Thank you!

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