### Behavioral Health Issues in Older Adults: Differentiating and Intervening

Linda K. Shumaker, R.N.- BC, M.A.  
Pennsylvania  
Behavioral Health and Aging Coalition

### Behavioral Health Problems of Older Adults

- Are not a normal part of aging  
- Are treatable  
- Behavioral Health issues are debilitating and affect overall health and quality of life in older adults (Geriatric Mental Health Foundation).  
- Recent data estimates that 20.4% of adults 65 and older meet the criteria for a mental disorder. (American Psychological Association)  
- More than 80% of all seniors in need of mental health services do not get the treatment they need.
Behavioral Health Needs of Older Adults

• 20% of Americans over 55 years of age experience specific “mental disorders” that are not part of normal aging.
• Less than 3% of older adults report seeing mental health professionals for treatment.
• >80% of older individuals in long-term care facilities have a “mental disorder”.
• 20% of Pennsylvania’s population is over 60 years of age, however they account for the smallest portion of clients in the County Mental Health Programs.

Behavioral Health Problems of Older Adults

• Mental disorders among the elderly often go unrecognized or are masked by somatic complaints.

• Clinical presentation of mental disorders in the elderly may be different, making diagnosis of treatable illnesses more difficult.

• Detection may also be complicated by co-existing medical disorders.
Depression

Depression and the Older Adult

- As many as 10% of older adults in primary care have clinically significant depression.
  - Only ½ are recognized
  - Only 1 in 5 received effective treatment


- 16 to 25% of all reported suicides in the United States are in the 65 plus population.
- Individuals with dementia have a 25 - 30% risk of getting depressed.
Depression and the Older Adult

- Community surveys have found that depressive disorders and symptoms account for more disability than medical illness.
- Medical illness is the most common stressor associated with major depression and it is the most powerful predictor of poor outcome.
- Relationship between chronic illness and mental health.
- Untreated depression can lead to physical illness, institutionalization, psychosocial deterioration and suicide.

Causes of Depression in Older Adults

- Causes may be physical, social, and/or psychological in origin, including:
  - Specific events in a person's life, such as the death of a spouse, a change in circumstances, or a health problem that limits activities and mobility.
  - Medical conditions, such as stroke, Parkinson's disease, hormonal disorders, heart disease, or thyroid problems, which may cause physical changes resulting in depression.
Causes of Depression in Older Adults (cont.)

- Causes may be physical, social, and/or psychological in origin, including:
  - Chronic pain
  - Nutritional deficiencies, including a lack of such vitamins such as B-12 and folic acid
  - Genetic predisposition to the condition
  - “Chemical imbalance in the brain”

Depression and the Older Adult

- May not complain of feeling depressed
- May present with anxiety or confusion
- Somatic equivalents
- Loss of motivation, withdrawal and irritability
- May become suicidal
- Brain chemical changes
Depression

• Major Depressive Episode
  • Depressed mood
  • Loss of interest or pleasure
  • Appetite disturbance
  • Insomnia or hypersomnia
  • Psychomotor agitation or retardation

Depression

• Major Depressive Episode
  • Fatigue or loss of energy
  • Feelings of worthlessness or guilt
  • Decreased concentration indecisiveness
  • Thoughts of death or suicide
  • Impaired level of functioning
Late Onset Depression

- Depression occurring for the first time in late life – onset later than age 60
- Usually brought on by another “medical illness”
- When someone is already physically ill, depression is both difficult to recognize and treat.
- Greater apathy/ anhedonia
- Less lifetime personality dysfunction
- Cognitive deficits more pronounced
- In some individuals late life depression may be a precursor to dementia

Assessment of Depression

- Previous treatment history
- Family History
- History of response to treatment
- Alcohol use
Depression Scales

- Geriatric Depression Scale - Short and Long Form - (Yesavage)
- Patient Health Questionnaire PHQ-9 for Depression
- Center for Epidemiologic Studies Depression Scale
- Beck Depression Protocol
- Cornell Scale for Depression in Dementia

Treatment Interventions for Depression

- Behavioral Interventions
- Therapy
- Medications
- Electroconvulsive Therapy
Behavioral Interventions for Depression

- Structured activities
- Maintain social contacts
- Exercise
- Sleep hygiene
- Relaxation techniques
- Consistent staff
- Issues of autonomy and choice

Behavioral Interventions for Depression

- **Get outside** - Exposure to bright light for 30 minutes a day through artificial light, or perhaps even sunlight, can help with your circadian rhythm. This ensures a good night’s sleep, and in turn, helps your physical and mental health.

- **Exercise** - 20 - 30 minutes of walking or other “aerobic” exercise at least 3 times a week means healthy “endorphins” being released regularly. It’s also a great way to withstand and/or release stress. Remember to talk to your doctor first!
Behavioral Interventions for Depression

- **Structured activities** – Be sure to schedule activities consistently during the week whether it be volunteering, visits to museums, fishing or religious activities, etc.

- **Maintain social contacts** - Involving yourself with family and friends will help eliminate the feeling of isolation.

- **Sleep hygiene** - Go to bed at the same time every night. Before bed try and maintain a calm and quiet environment - do activities such as reading or taking a warm bath (and make sure to avoid caffeine and alcohol!)

Behavioral Interventions for Depression

- **Negative Thoughts** – Be aware of ruminations of negative thoughts and redirect them to positive ones. This takes dedication and perseverance!

- **Relaxation techniques** – Yoga, music, and visualization are important tools when trying to release stress and create positive energy.
Behavioral Interventions for Depression

• For “Care Facilities”:
  ▪ Know your resident!
  ▪ Utilize consistent staff, which assists in building relationships and trust.
  ▪ Administer “touch” and positive interactions.
  ▪ Remember issues of autonomy and choice. We “all” need to feel we “have control” over our environment.

Therapy and the Older Adult

• Life review/ reminiscing
• Psychotherapy
  • Cognitive Behavioral Therapy
  • Problem Solving Therapy
  • Insight Oriented Therapy
  • Family therapy
  • Psycho-educational approaches
• Religious/Spiritual needs
• Support groups
Behavioral Health Issues and Interventions

**Therapy and the Older Adult**

- For older adults, especially those who are in good physical health, combining psychotherapy with antidepressant medication appears to provide the most benefit.
- One study showed that about 80 percent of older adults with depression recovered with this kind of combined treatment and had lower recurrence rates than with psychotherapy or medication alone.


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**Depression, Suicide and Older Adults**

- NIMH - Older adults with depression are at risk for suicide. In fact, white men age 85 and older have the highest suicide rate in the United States.
- American Association of Suicidology - Suicide rates for elderly males are the highest risk at a rate of 29.0 per 100,000 (2010).
- White men over 85 (the old-old) were at the greatest risk of all age-gender-race groups. In 2010, the rates for these men was 47.33 per 100,000 - 2.37 times the current rate for men of all ages (19.94 per 100,000).

American Association of Suicidology
Behavioral Health Issues and Interventions

Depression, Suicide and Older Adults

- APA – 20% of Older Adults who committed suicide saw their physician within the prior 24 hours, 41% in the past week and 75% within the past month.

- The risk of depression in the elderly increases with other illnesses and when ability to function becomes limited. Hybels CF and Blazer DG. Epidemiology of late-life mental disorders. *Clinics in Geriatric Medicine*, 19(Nov. 2003):663-696.

- Associated with late-onset depression.

Risk Factors for Suicide Among Older Adults

- Differ from those for younger persons
- Higher prevalence of depression
- More physical illnesses
- Often visits a health-care provider before attempts
- More social isolation
- Higher male-to-female ratio
- Greater use of highly lethal methods
- Fewer attempts per completed suicide

Source: Aging and Mental Health and CDC
### Assessing Suicide Risk (SAD PERSONS)

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### Suicide Prevention Strategies

- Effective and appropriate clinical care for mental, physical and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
Suicide Prevention Strategies

• Support from ongoing medical and mental health care relationships

• Learned skills in problem solving, conflict resolution and nonviolent handling of disputes

• Cultural and religious beliefs that discourage suicide and support self preservation instincts

Older Adults who take their own lives are more likely to have suffered from a depressive illness than individuals who kill themselves at younger ages.
Family Caregiving and Depression

- It is a myth that most the elderly in the United States are cared for in nursing homes and health care institutions. Family and friends provide 80% of the long-term care of older adults in the United States.

  *National Alliance for Caregiving, 2009*

Incidence and Prevalence of Depression among Caregivers

- Family Caregiver Alliance 1997 – 58% of caregivers showed clinically significant depressive symptoms.

  - 1/3 family caregivers of individuals with dementia have symptoms of depression
    (Alzheimer’s Association, 2008; Yaffe and Newcomer, 2002)
Incidence and Prevalence of Depression among Caregivers

☑ 40 – 70 % of family caregivers have clinically significant symptoms of depression with 25% meeting the diagnostic criteria for major depression.


Caregiving and Depression

➢ Family caregivers face a range of health risks and serious illnesses themselves.
➢ Family caregivers experience high rates of depression, stress and other mental health problems.
➢ Elderly spousal caregivers experiencing mental or emotional strain have a 63% higher risk of dying than non-caregivers.

Family Caregiver Alliance 2007
National Policy Statement
Incidence and Prevalence of Depression among Caregivers

- 61 percent of family caregivers of individuals with Alzheimer’s and other dementias rated the emotional stress of caregiving as high or very high.

- 33 percent report symptoms of depression.

Alzheimer’s Association (2012) Alzheimer’s Disease Facts and Figures

Depression among Caregivers

- Care recipient’s behavior is an overwhelming predictor of caregiver depression.

(Shultz and Colleagues 1995)
Depression and Dementia

• Up to 40% of individuals with Dementia also suffer from depression.

• Symptoms can include:
  - Apathy - loss of interest
  - Increased irritability
  - Weight loss - refusal to eat
  - Social withdrawal
  - Crying
  - Sudden deterioration in skills

(Alzheimer's Association)

Depression and the “Nursing Home”

• Occurrence 10 times higher than those elderly residing in the community (Rovner)
• Thakur and Blazer (2008) up to 35% of nursing home residents are affected by significant depressive symptoms
• Associated with distress, disability and poor adjustment to the facility (Rovner)
• Most common cause of weight loss in long term care (Katz)
In older persons, anxiety rarely occurs in the absence of depression.

Anxiety
Anxiety in Older Adults

- Affects as many as 10 – 20% older adults, though it is often under diagnosed.
- Some argue that anxiety disorders in older adults are “different”.
- Most common behavioral health problem for women, second most common behavioral health problem for men after substance abuse.
- Co-morbidity with physical problems make diagnosis difficult.

Geriatric Mental Health Foundation

Anxiety in Older Adults

- Causes of Anxiety Disorders:
  - Stress or trauma, complicated grief, caffeine, medications, medical or psychiatric illness, a family history of anxiety disorders, a neurodegenerative disorder.

Geriatric Mental Health Foundation

- Medically ill older adults have an higher incidence of anxiety disorders.
Anxiety and Older Adults

✓ High level of co-morbidity of anxiety and depression
  ▪ 50% of clinically depressed older adults suffer from co-morbid anxiety
  ▪ 25% of those with anxiety suffer from major depression

Anxiety

▪ Symptoms
  • Cognitive – nervousness, worry, apprehension, fearfulness, irritability
  • Behavioral – hyperkineses, pressured speech, exaggerated startle response
  • Physical – muscle tension, chest tightness, palpitations, hyperventilation, parasthesias, sweating, urinary frequency
“Organic Anxiety”

✓ Anxiety associated with illness or medications
  ▪ Common presentation
  ▪ Maybe co-morbid as psychiatric illness with common medical illness
    • Cardiac
    • Respiratory
    • Endocrine disorders
    • Neurological disorders

Anxiety

✓ Common Medical Disorders that can produce anxiety symptoms –
  ▪ Endocrine disorders – hyper- and hypo-thyroidism, hypoglycemia, menopause
  ▪ Cardiovascular disorders – Congestive Heart Failure (CHF) Pulmonary Embolism, Angina, Arrhythmias
  ▪ Pulmonary conditions – Chronic Obstructive Pulmonary Disease (COPD), Pneumonia
  ▪ Neurological disorders – Parkinson’s disease
Anxiety

✓ Common medications/substances that can produce anxiety symptoms –
  ▪ Stimulants – caffeine, Theophylline, ephedrine or pseudoephedrine
  ▪ Steroids
  ▪ Thyroid preparation
  ▪ Anticholinergic medications
  ▪ Antidepressants (first 1-3 weeks of treatment)
  ▪ Alcohol

Anxiety Association with Dementia

✓ Anxiety occurs commonly with Dementia
  ▪ Depression and anxiety early to middle stages
  ▪ Anxiety/agitation in moderate to late stages
    • Frequently with motor restlessness and inappropriate behavior
✓ Need to identify “triggers” –
  ▪ Environmental stimuli
  ▪ Medications
  ▪ Inability to communicate
Behavioral Health Issues and Interventions

**Anxiety**

- Universal human experience
- Catastrophic reaction?
- Emotionally based physical symptoms
- Question the cause of anxiety
  - Environmental issues
  - Developmental / Psychosocial issues
  - Anxiety Disorders
  - Organic Anxiety Disorders

**Assessment Scales**

- Hamilton Anxiety Rating Scale
- Zung Self-Rating Anxiety Scale
- Anxiety Disorders Interview Schedule
- Yale-Brown Obsessive-Compulsive Scale

➢ Have not been validated for this population
Assessment Scales

- Self Report Measures:
  - Beck Anxiety Inventory
  - Penn State Worry Questionnaire
  - Adult Manifest Anxiety Scale- Elderly
  - Short Anxiety Screening Test

Interventions for Anxiety

- Cognitive Behavioral Therapy
  - Education
  - Self Monitoring
  - Relaxation training
  - Exposure and Response Prevention
  - Cognitive Restructuring
### Interventions for Anxiety cont.

- Problem solving skills training
- Sleep hygiene
- Other therapies – Interpersonal therapy, Family therapy, Supportive therapy,

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### Interventions for Anxiety

- CALM Study: (Controlling Anxiety in Later-life Medical Patients)
  - Recognizing anxiety
  - Learning to relax
  - Getting to sleep
  - Solving problems
  - Accepting the inevitable

  (Wetherell et al, 2005)
Interventions for Anxiety

✓ CALM Study: (Controlling Anxiety in Later-life Medical Patients)
  ▪ Controlling worry
  ▪ Increasing your pleasure
  ▪ Challenging your thoughts
  ▪ Facing your fears
  ▪ Coping with pain
  ▪ Asserting yourself
  ▪ Managing your time
  ▪ Maintaining your progress

(Wetherell et al, 2005)

Sleep Hygiene

• Maintain regular sleep-wake cycle and restrict naps
• Avoid caffeine after 12 PM
• Daily exercise during morning hours
• Move evening meal to an earlier time
• Take a hot bath before bedtime
• Have a small bedtime snack
• Meditation or relaxation exercises at bedtime
• Keep bedroom quiet and dark
• No smoking
• Limit liquids in the evening hours.
Therapy for Anxiety Disorders

- A study by Stanley and Novy demonstrated after 14 weeks of treatment for anxiety that 50% of individuals receiving Cognitive Behavioral Group therapy and 77% of individuals receiving Supportive Psychotherapy showed significant improvements and maintained those improvements for 6 months.

- Cognitive-Behavioral Interventions consisted of Cognitive Interventions and Relaxation techniques


Behavioral Interventions for Anxiety

- Consistency
- Structured routines
- Relaxation techniques
- Exercise
- Life review/ Reminiscing
- Psychotherapy
- Medications
Anti-anxiety Medication

- Common Uses
  - Situational Anxiety
  - Panic Disorder
  - Insomnia
  - Behavioral and Psychological Symptoms of Dementia
    - Anxiety
    - Acute Agitation
    - Sleep Disturbance

Other Psychiatric Disorders

- Mood Disorders with Psychosis
- Bipolar disorder
- Schizophrenia / Late-Onset Schizophrenia
- Personality Disorders
- Adjustment Disorders
Dementia

- Irreversible chronic brain failure.
- Loss of mental abilities.
- Involves memory, reasoning, learning and judgment.
- All patients with dementia have deficits, but how they are experienced depends on their personality, style of coping and their reaction to the environment.
**Dementia – DSM 5**

- The term dementia is eliminated.
- Replaced with “major” or “minor” neurocognitive disorder.
- The definition focuses on the decline as opposed to deficit.
- Old definition required memory impairment, which is not always the first symptom.
- The presence of a “neurocognitive” disorder needs to be established, and then it is determined whether it is minor or major.

**Minor Neurocognitive Disorder – DSM 5**

- Modest cognitive decline from a previous level of functioning based on the concerns of the individual, knowledgeable informant or the clinician;
- Decline in neurocognitive performance in the range of one or two standard deviations below appropriate norms.
- The cognitive deficits are insufficient to interfere with independence (IADL’s), but more complex tasks require compensatory strategies or accommodation.
- The cognitive deficits do not occur in the context of a delirium.
- The cognitive deficits are not attributable to another mental disorder.
## Major Neurocognitive Disorder – DSM 5

- There is evidence of a substantial cognitive decline from a previous level of performance in one or more of the domains based on the concerns of the individual, a knowledgeable informant, or the clinician;

- Decline in neurocognitive performance typically involving test performance in the range of two or more standard deviations below appropriate norms on formal testing or equivalent clinical evaluation.

## Major Neurocognitive Disorder – DSM 5 Cont.

- The cognitive deficits are sufficient to interfere with independence requiring minimal assistance with instrumental activities of daily living.

- The cognitive deficits do not occur in the context of a delirium.

- The cognitive deficits are not attributable to another mental disorder.
Changes in DSM 5

“The DSM IV terminology required the presence of memory impairment; often memory impairment is not always the first domain affected in dementia or neurocognitive disorders.”

Causes of Dementia

- Alzheimer’s Disease
- Multi-Infarct or Vascular Dementia - strokes, mini-strokes, TIAs
- Lewy Body Disease
- Pick’s Disease
- Jacob-Creutzfeldt Disease
- Parkinson’s Disease
- Substance abuse
Neuropsychiatric or Behavioral and Psychological Symptoms of Dementia

- Symptoms of disturbed perception, thought content, mood or behavior that frequently occur in persons with dementia
- BPSD are treatable
- BPSD can result in:
  - Suffering
  - Premature institutionalization
  - Increased costs of care
  - Loss of quality of life for the person and caregivers

Finkel et al 1996

Neuropsychiatric or Behavioral and Psychological Symptoms of Dementia

- Hallucinations (usually visual)
- Delusions
  - People are stealing things
  - Abandonment
  - This is not my house
  - You are not my spouse
  - Infidelity
Behavioral Health Issues and Interventions

Neuropsychiatric or Behavioral and Psychological Symptoms of Dementia

- Misidentifications
  - People are in the house
  - People are not who they are
  - Talk to self in the mirror as if another person
  - Events on television

- Depressed Mood
- Anxiety
- Apathy
  - Decreased social Interaction
  - Decreased facial expression
  - Decreased initiative
  - Decreased emotional responsiveness
Neuropsychiatric or Behavioral and Psychological Symptoms of Dementia

- Wandering
  - Checking
  - Attempts to leave
  - Aimless walking
  - Night-time walking
  - Trailing
  - Excessive activity

- Verbal Agitation
  - Negativism
  - Constant requests for attention
  - Verbal bossiness
  - Complaining
  - Relevant interruptions
  - Irrelevant interruptions
  - Repetitive sentences
Neuropsychiatric or Behavioral and Psychological Symptoms of Dementia

- Verbal Aggression
  - Screaming
  - Cursing
  - Temper Outbursts

- Physical Agitation
  - General restlessness
  - Repetitive mannerisms
  - Pacing
  - Trying to get to a different place
  - Handling things inappropriately
  - Hiding things
  - Inappropriate dressing or undressing
Neuropsychiatric or Behavioral and Psychological Symptoms of Dementia

- Physical Aggression
  - Hitting
  - Pushing
  - Scratching
  - Grabbing things
  - Grabbing people
  - Kicking and biting

- Disinhibition
  - Poor Insight and Judgment
  - Emotionally Labile
  - Euphoria
  - Impulsive
  - Intrusiveness
  - Sexual Disinhibition
Delirium

• Delirium is a sudden, severe confusional state with rapid changes in brain function that occur with physical or mental illness

• Fluctuating level of consciousness

• Reversible/ treatable
Delirium  DSM 5

1. Disturbance in attention (reduced ability to direct, focus, sustain and shift attention) and orientation to the environment.

2. Disturbance develops over a short period of time (hours to few days) and represents an acute change from baseline; not attributable to another neurocognitive disorder and tends to fluctuate in severity throughout the day.

3. A change in an additional cognitive domain such as memory deficit, disorientation or language disturbance, or perceptual disturbance that is not better accounted for by a pre-existing, established or evolving other neurocognitive disorder; and

4. Disturbance in #1 and #3 must not occur in the context of a severely reduced level of arousal, such as a coma.
Risk Factors for Delirium

- Pre-existing cognitive problems
- Advanced age
- Hospitalization
- Multiple medical conditions
- Depression
- Use of multiple medications, especially those with anticholinergic properties
- General anesthesia
- Visual problems
- Male gender
- Abnormal serum sodium

Delirium

- Symptoms:
  - Changes in alertness
  - Changes in feeling (sensation) and perception
  - Changes in level of consciousness or awareness
  - Changes in movement
  - Changes in sleep patterns, drowsiness
  - Confusion (disorientation)
Delirium

- Symptoms:
  - Decrease in short-term memory and recall
  - Disrupted or wandering attention
  - Disorganized thinking
  - Emotional or personality changes
  - Incontinence
  - Psychomotor restlessness

Delirium

✓ Causes:
- Medications
- Infections
- Metabolic/ endocrine
- Vitamin deficiency
- Dehydration
- Anesthesia
- Trauma
- Alcohol or sedative drug withdrawal
Behavioral Management is the key in taking care of anyone with a Dementia!

Communication

10 Keys of Communication

• Set a positive mood for interaction
• Get the person’s attention
• State your message clearly
• Ask simple, answerable questions
• Listen with your ears, eyes and heart

Fact Sheet: Caregiver’s Guide to Understanding Dementia Behaviors, Family Caregiver Alliance
Communication

10 Keys of Communication

- Break down activities into a series of steps
- When the going gets tough, distract and redirect
- Respond with affection and reassurance
- Remember the good old days
- Maintain your sense of humor

Fact Sheet: Caregiver’s Guide to Understanding Dementia Behaviors, Family Caregiver Alliance

Handling Troubling Behaviors

- Check with the doctor first!
- We cannot change the person
  - Try to accommodate the behavior, not control the behavior.
  - Remember that we can change our behavior or the physical environment.

Fact Sheet: Caregiver’s Guide to Understanding Dementia Behaviors, Family Caregiver Alliance
Handling Troubling Behaviors (Cont.)

- Behavior has purpose.
- Behavior is triggered.
- What works today may not work tomorrow.
- Get support from others!

Fact Sheet: Caregiver’s Guide to Understanding Dementia Behaviors, Family Caregiver Alliance

Three Steps in Identifying Causes of Behaviors

1. Identify and examine the behavior:
   - Could it be related to medication or illness?
   - What was the behavior? Could it be considered harmful?
   - What happened before the behavior?
   - What was the trigger?
   - What happened immediately after the behavior occurred? How did individuals react?

Alzheimer’s Association – “How to respond when dementia causes unpredictable behaviors.”
### Three Steps in Identifying Causes of Behaviors (Cont.)

2. Explore potential solutions:
   - What are the individual’s needs? Are they being met?
   - Can adapting the surroundings comfort the person?
   - How can you change your reaction or your approach to the behavior? Are you responding in a calm and supportive way?

   *Alzheimer’s Association* – “How to respond when dementia causes unpredictable behaviors.”

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### Three Steps in Identifying Causes of Behaviors (Cont.)

3. Explore different responses:
   - Did your new response help?
   - Do you need to re-evaluate for other potential causes and solutions?
   - What could you do differently?

   *Alzheimer’s Association* – “How to respond when dementia causes unpredictable behaviors.”
Remember Behaviors may be related to:

- Physical discomfort – illness or medication
- Overstimulation – loud noises or a “busy” environment
- Unfamiliar surroundings – new places or the inability to recognize home
- Complicated tasks – difficulty with activities or chores or even simple requests
- Frustrating interactions – inability to communicate effectively

Alzheimer’s Association – “How to respond when dementia causes unpredictable behaviors.”

Behaviors are a form of communication!

Understanding, flexibility, and creativity are the keys to effective behavior management!
The Case for Individualized Care

Assessment Scales

- Montreal Cognitive Assessment - MOCA
- St. Louis University Mental Status Examination - SLUMS
- Mini-Mental Status Examination MMSE- (Folstein - Copyrighted)
- Clock Drawing
- Blessed Dementia Scale
Assessment Scales

- BEHAVE-AD: Behavioral Pathology in Alzheimer’s Rating Scale
- Cornell Scale for Depression in Dementia

Resources

Multidisciplinary Approach

- History and Physical
- Laboratory tests - CBC with Differential, Thyroid studies, B12, Folate, Chemistry Profile, RPR, UA, Sedimentation Rate
- Psychiatric Assessment
- Psychological testing
- Evaluation of functional abilities
- Social factors

Older adults with mental illness are at increased risk, compared with younger adults, for receiving inadequate and inappropriate care
Multidisciplinary Needs

✓ Social needs for both caregivers and patients.
✓ Cognitive difficulties and behavioral manifestations
✓ Psychiatric symptoms
✓ Complicated medical needs
✓ Changing communication and ADL needs
✓ Normal age related changes may cause potential iatrogenic illness

Behavioral Health Needs of Older Adults

• Multidisciplinary approach
• Consumer input
• Stakeholder-generated principles – CSP/CASSP
• Culturally competent
• All levels of interagency collaboration
• Toward the aim of dispelling stigma
• Integrated at the community level
• Continuum of care from prevention to treatment

SAMHSA Strategic plan Substance Abuse and Mental Health Issues facing Older Adults 2001 - 2006
Resources

- Alzheimer’s Association – www.alz.org
- ADEAR (NIA) – adear@alzheimers.org
- Family Caregiver Alliance – www.caregiver.org
- Geriatric Mental Health Foundation – www.gmhfonline.org

Resources

- Suicide Prevention Network USA – http://www.ncsp.org/spanusa.html
- Pennsylvania Behavioral Health and Aging Coalition - www.olderpa.org