Caring for People with Problem Behaviours

A basic, practical text for nurses, health workers and others who are learning to manage difficult behaviours

2nd Edition, *including a chapter on dementia*

Bernadette Keane and Carolyn Dixon

Ausmed Publications

Caring for People with Problem Behaviours

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A self-instructional learning–teaching package by
Bernadette Keane and Carolyn Dixon

SECOND EDITION

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PREFACE TO THE SECOND EDITION

The intention of the second edition of any book is to keep to the stated aim as expressed in the introduction to the first edition and to update and improve the content. To this end, where appropriate, the chapter references have been updated in this edition.

With regard to the content, apart from some fine tuning, the major changes and additions are as follows:

1. In chapter 4, “The person with aggressive behaviours”, the section headed “Restraint in residential aged care settings” has been further developed and expanded. This new material includes an overview of policy guidelines for the restraint of clients in aged care residential facilities. Mention is also made of ethical and legal considerations and the notion of “reasonable risk”.
2. Chapter 6, which was titled “The person who has difficulty co-operating” has been converted to a chapter titled “The person who has a mental illness”. Within this content there is a special emphasis on the recognition and care of people who present with psychotic disorders or marked personality problems.
3. Chapter 7 is new and is titled “The elderly person who is confused”. When the first edition was written, a decision was made to omit the behavioural problems associated with confusion because the guiding model for the book, namely the Solution-focused Behavioural Change Model, requires a collaborative approach and therefore is unsuitable for confused people. We now feel this omission limited the scope of the book hence this new chapter which provides helpful guidelines and practical suggestions for the care of confused people.

Finally, as before, highlighted words in the text are included in the glossary and pre and post test questions and answers have been prepared to cover the new chapters 6 and 7.

INTRODUCTION

Caring for People with Problem Behaviours aims to assist nurses and other health workers and carers to learn practical approaches to people who present with difficult behaviours. In fact this book will be of assistance to any workers whose jobs require them to deal with people.

The book is simply written and talks directly to you, the reader. It focuses on the way people think, feel and behave and how these activities can lead to problems. It provides written exercises to help you, the reader, to know yourself and your clients better so that you can work more effectively with those who need your help.

In particular, this book offers a Solution-focused Behavioural Change Model that can be used to develop strategies to solve the problems that difficult behaviours can cause. In recognition of the increasing numbers of aged people in care, some of the illustrative examples are derived from behaviours seen in people who are elderly.

Throughout this book the term “client” is used to refer to those in your care who are patients, clients, residents, elderly people in their own homes etc. Important words have been highlighted and the glossary towards the back of the book explains their meanings.

Each of the seven chapters in this book includes:
- learning objectives;
- chapter references;
- instructional material;
- learning activities; and
- post-activity explanations that serve as answer guides.

With regard to the learning activities, our advice here and at the top of each activity (as a reminder) is to photocopy the page(s) on which the learning activity appears and complete the activity on the photocopy. This allows you to tackle a learning activity more than once for practice and reinforcement.

One of the most interesting features in the book is the test that has been included immediately after this introduction to enable you to gauge your current knowledge about the planned management of behavioural problems. Our advice is to take the test without checking the answers. If you find the pre test difficult, do not be deterred, as all of the information and concepts are explained during the course of the text. When you have finished the book, take the test again, check the answers, then compare your two tests to see just what you have learned about caring for people with problem behaviours.

We are confident that the information presented here and the skills that you can develop through the use and reuse of this book will help you, whatever your role in caring for clients, to experience fewer interpersonal difficulties and to share more enjoyable relationships.

PRE TEST

INSTRUCTIONS

Read each question carefully and then select the most appropriate answer by placing a tick in the box.

NB *Do not write in this textbook. Photocopy the pages and complete the pre test on the photocopy.*

Multiple-choice questions

1. An accepting attitude is important for the development of a helpful relationship. Acceptance means. . .

☐ (a) clients should be able to behave as they like
☐ (b) carers should accept the fact that clients cannot help the way they behave
☐ (c) difficult client behaviours should always be seen as expressions of problems
☐ (d) carers should regard difficult behaviour as a reflection of moral weakness

2. When talking to a client for the first time, the carer should realise that:

☐ (a) hostile behaviour from the client indicates the carer's initial approach was inadequate
☐ (b) the client's case history should be discussed fully with the family before talking with the client
☐ (c) the client's physical appearance provides accurate cues as to whether or not the client will be receptive to the carer
☐ (d) the client and the carer are strangers to each other, and will need time to develop a relationship

3. You notice Mrs G. pacing up and down anxiously. Select the best response from the following options.

☐ (a) "Let's go and get you some tablets to help you to relax."
☐ (b) "Go and sit down and try to relax."
☐ (c) "You seem bothered by something. Would it help to talk to me about it?"
☐ (d) "It can't be all that bad. Come and help me sort out the linen."

4. A client with paranoid feelings confides in you — "They are out to get me, even my doctor is in with them". Select the best response.

☐ (a) "I can understand that you feel worried, but it doesn't seem to me that it is so. You're quite safe here."
☐ (b) "You're letting your imagination run away with you."
☐ (c) "Yes, and the sooner the better. We might get some peace then."
☐ (d) "You feel that way because you're ill."

5. Below are a number of strategies that can be used when a client exhibits difficult behaviours:

(i) engage in solution-focused problem solving
(ii) ignore the behaviours
(iii) warn the client of the consequences
(iv) blame the client for being difficult

Choose the best strategy or combination of strategies to use.

It is best to use:

☐ (a) (i), (ii) and (iv)
☐ (b) (ii) and (iii)
☐ (c) (i) and (iii)
☐ (d) (i) only

6. Below are a number of strategies that carers can use to help prevent suicide in clients who are thinking of taking their lives:
- (i) reassure them of their ability to tolerate the stress being experienced in their present situation
- (ii) assess their strengths and past experiences in coping with stress
- (iii) avoid any mention of suicidal ideas
- (iv) mobilise resources to assist them with personal responsibilities

Choose the combination of strategies that is the best to use.

It is best to use:

- ☐ (a) (ii) and (iii)
- ☐ (b) (i), (ii) and (iii)
- ☐ (c) (i), (ii) and (iv)
- ☐ (d) (ii) and (iv)

7. Which of the following interventions would be helpful when caring for a person suffering from schizophrenia?
- (i) leave the person to get on with their life as much as possible without interfering
- (ii) maintain an attitude of calm acceptance and friendly encouragement
- (iii) understand that even though the person may show little emotion, they do experience feelings, such as sadness, and respond accordingly
- (iv) promote co-operative working relationships with psychiatric services in order to provide better coordinated care

Choose the combination of strategies that is best to use.

It is best to use:

- ☐ (a) (i) and (ii)
- ☐ (b) (i), (ii) and (iii)
- ☐ (c) (ii), (iii) and (iv)
- ☐ (d) all of the above

8. Possible causes of organic brain disorders are:
- (i) arteriosclerosis
- (ii) some forms of AIDS
- (iii) head trauma
- (iv) skin cancer

Choose the correct answer.

- ☐ (a) (i), (ii) and (iv)
- ☐ (b) (ii), (iii) and (iv)
- ☐ (c) (i), (ii) and (iii)
- ☐ (d) all of the above

9. The permanent impairment of brain functions which occurs in chronic organic disorders produces defects in:
- (i) memory
- (ii) orientation
- (iii) judgement
- (iv) comprehension

Choose the correct answer.

- ☐ (a) (i), (ii) and (iv)
- ☐ (b) (ii), (iii) and (iv)
- ☐ (c) (i), (ii) and (iii)
- ☐ (d) all of the above

10. Orientation can best be understood as:
- (a) a realistic awareness of place, time, circumstances and relationships with others
- (b) a tendency to behave at a fairly concrete level of understanding of the world
- (c) recognition of what is happening to oneself, including the probable causes and the likely outcomes
- (d) the ability to correctly interpret facts and their logical connections

True or false statements

T F

☐ ☐ **11.** Reassurance means keeping the environment clean, tidy and well organised.

☐ ☐ **12.** Feelings have as much influence on our lives as facts do.

☐ ☐ **13.** Personality development is likely to be impaired if parents frequently withhold affection from their children.

☐ ☐ **14.** Psychological needs are less important as we grow older.

☐ ☐ **15.** The use of defence mechanisms is valuable as a protection against overwhelming levels of anxiety.

☐ ☐ **16.** The goal of empathy is genuine understanding of another human being.

☐ ☐ **17.** When dealing with a verbally aggressive client the aim is to prevent this hostility from escalating into physical violence.

☐ ☐ **18.** Only some behaviours have meaning.

☐ ☐ **19.** The best way to deal with manipulative behaviour is to threaten the person.

☐ ☐ **20.** When depressed people don't feel like talking the carer should leave the room.

☐ ☐ **21.** Carers should encourage clients to be as independent as possible.

☐ ☐ **22.** All people who are sad are depressed.

☐ ☐ **23.** Active listening means spending a lot of time with clients and their families.

☐ ☐ **24.** Holistic care means physical, emotional and behavioural care activities.

☐ ☐ **25.** People who threaten suicide never carry out their threats.

☐ ☐ **26.** Early detection and treatment can improve the life of people with schizophrenia.

☐ ☐ **27.** Dementia is a form of brain disorder.

☐ ☐ **28.** Symptoms of delirium include confusion, thirst, an excited mood and risk-taking behaviour.

☐ ☐ **29.** The primary symptom of dementia is memory loss.

☐ ☐ **30.** There is no cure for Alzheimer's disease at present.

☐ ☐ **31.** Drugs taken for high blood pressure can cause symptoms that look like dementia.

☐ ☐ **32.** Stuttering is an inevitable part of the dementing process.

Chapter one

UNDERSTANDING HUMAN BEHAVIOUR

LEARNING OBJECTIVES

At the conclusion of this chapter you should be able to:

- understand some key concepts about human behaviour
- appreciate the need to understand more about psychology as a basis for understanding problem behaviours
- identify the difference between mental health and mental illness

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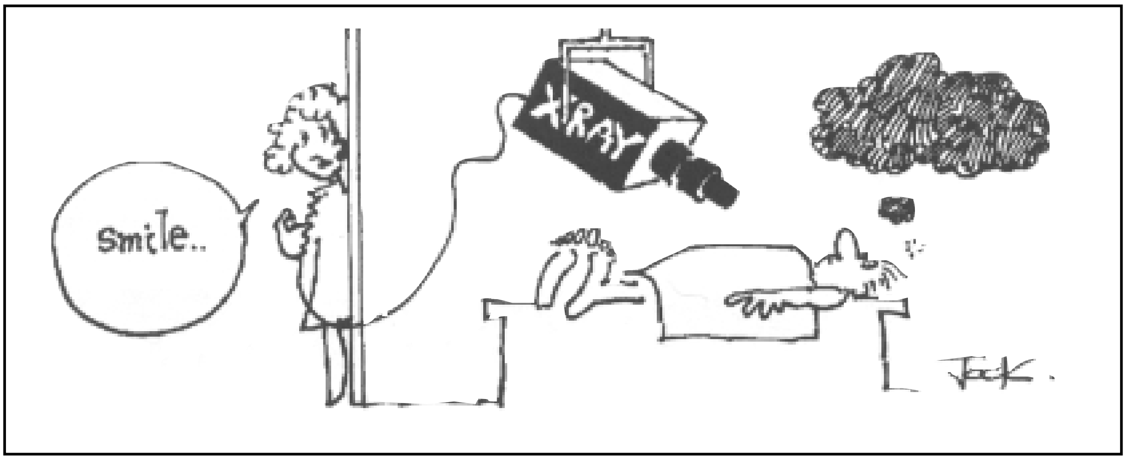
INTRODUCTION

Most people are curious about how human beings express their needs, what motivates them, and how they respond to their surroundings. When people are healthy they tend to cope reasonably well, even if they have problems. In other circumstances, such as being admitted to hospital, people worry about their family responsibilities, their finances and security of employment, their diagnosis and its outcome. Such ruminations often leave clients in emotional turmoil.



Emotions in disarray are not like a broken arm; there is no x-ray that can show exactly what is wrong. Instead, as carers, you have to rely on your understanding of the mind and its workings to assess what is going on. Your assessment capabilities will emerge from:

- your **insight**, derived from life experiences;
- your levels of self-awareness and self-esteem;
- your use of assessment tools if you have health care training; and
- your knowledge of psychology.

Clients who are diagnosed with physical illnesses will also have mental sets that influence how they respond to their illness and to the carers who deal with them either in a health agency or in their own homes. Clients who enter hospital for emergency care tend to have more difficulty than those with planned admissions, e.g. for elective surgery, because they have not had time to adjust to the dislocation that hospitalisation causes in their lives. Elderly people who are admitted to nursing homes have to give up many of their preferred routines and activities. As a result they experience varying degrees of grief and loss at separation from their previous lifestyle (McCracken 1992).

KNOWLEDGE OF PSYCHOLOGY

Psychology is the study of how human beings behave, feel and think. Psychology explores people's motivation, personality traits, patterns of emotional response and behaviours, both normal and abnormal. The study of psychology, for instance, helps you to understand that a client's response to a current disability is never due solely to the presenting illness. All past experiences with illness or other dangers, whether similar or not, tend to contribute to each succeeding experience (Byrne and Byrne 1992). It is in this way that each client builds up their own characteristic way of responding to illness and to the anxiety that illness causes.

All clients have **fantasies** about what will happen to them in hospital or in a nursing home. Some of these imaginings are based on **unconscious** perceptions and some are **conscious** perceptions. Internal sources as well as external sources are equally important considerations when trying to explain behaviour.

All behaviour has meaning

According to Hase and Douglas (1986) the five broad areas of psychological functioning can be identified as:

- feelings and emotional behaviour;
- interpersonal behaviour;
- activities of daily living;
- intellectual activity; and
- physical functioning.

Feelings and emotional behaviour are responses to our perceptions of reality and meaning, e.g. tears when we feel sad, laughter when we feel happy or frustration when we experience conflict.

Interpersonal behaviour involves interacting with other people, either individually or in groups. These interactions can range from very simple relationships with minimal verbal, physical and emotional contact, to very complex relationships such as those in the family.

Activities of daily living are a range of behaviours that people engage in on a day-by-day basis, e.g. nutrition, exercise, recreation, sleep and sexual fulfilment.

Intellectual activity refers to the ability to make decisions and to think rationally. Sometimes this is called “cognitive functioning” meaning the capability to comprehend and interpret ideas. Abstract thinking, problem solving, the ability to plan, adaptability, insight, learning and memory are examples of intellectual activities.

Physical functioning is the ability of the body as a physiological entity to operate as a properly functioning unit. The central nervous system is made up of the brain and the spinal cord which act in harmony to coordinate (or balance) all parts of the body, e.g. hormones and communication pathways. Psychology is very interested in the link between the mind and the body and the impact each has on the other.

Learning Activity 1.1
FIVE ASPECTS OF PSYCHOLOGICAL FUNCTIONING

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

To check that you now understand the five broad areas of psychological functioning, try to define the following terms without looking back at the text.

Feelings and emotional behaviour

Interpersonal behaviour

Activities of daily living

Intellectual activity

Physical functioning

Now check your answers against the text.

KNOWLEDGE OF HUMAN BEHAVIOUR

Needs

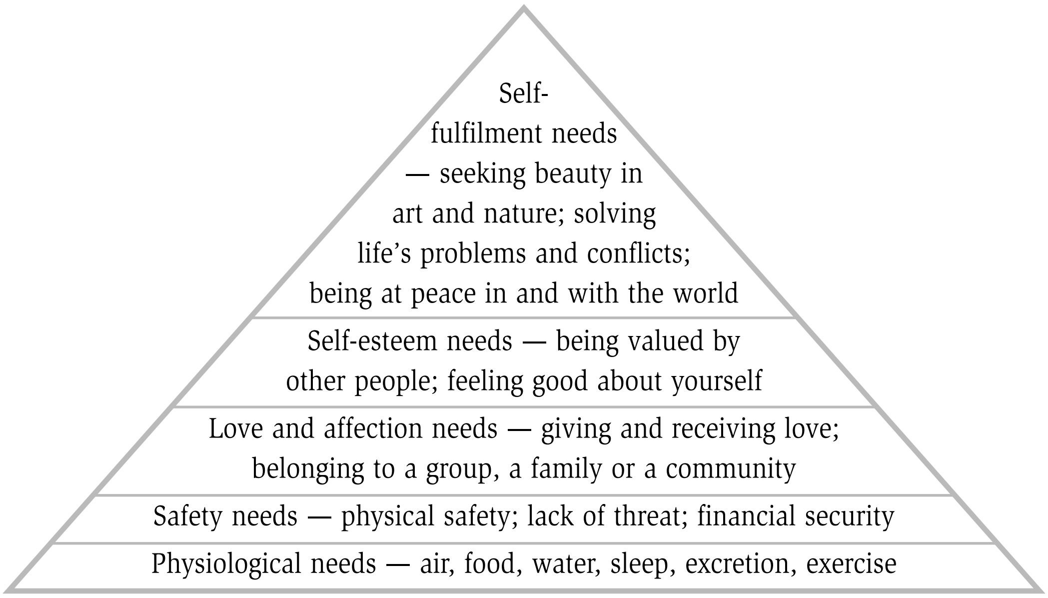
All human beings have certain needs that must be satisfied if we are to survive and to live safe and happy lives. A baby is born with a number of basic physiological needs that must be satisfied if the baby is to survive. Most of the baby's needs are taken care of in a self-regulatory manner, e.g. the need for oxygen is satisfied by the reflex mechanism of breathing. Hunger and thirst are needs that cannot be met automatically so the baby learns quickly how to behave in order for these needs to be met.

Human behaviour is
all the actions we take
in our efforts to meet our needs

As we grow into childhood and then adulthood the behaviours we develop to meet our needs become more complex. We begin to understand the emotions we experience, we learn to think and we build up certain attitudes.

A theorist named Abraham Maslow (1968) suggested that human needs form a hierarchy. Maslow's hierarchy consists of five levels.

Figure 1.1 Maslow's hierarchy of human needs



Physiological and safety needs are basic needs; love and self esteem are "higher" needs; self-fulfilment needs (at the highest level) are about developing your potential in the world. The needs found in the lower levels are more insistent, or exert more pressure to be satisfied immediately, than do those needs found in higher levels. For example, people who live in situations where their physical safety is threatened are not conscious, generally, of their need for self-fulfilment through seeking beauty in art and nature.

It is important to understand that, unless a person's basic needs are met, that person will not be able to proceed to satisfy the needs of a higher level. Often, as carers, you will need to assist clients to meet their physiological and safety needs, thus enabling them to try to satisfy their higher emotional needs.

Emotions

Feelings arise from complex physiological responses to our efforts to meet our needs. From the time we are born we exercise emotional responses, e.g. the baby's emotional responses to hunger are distress, crying and frustration, as compared with the emotions of contentment and pleasure during and after being fed. At the same time, feelings of security and being loved are developing between the mother and the baby.

Feelings are expressions of emotions

Adults can usually satisfy their basic needs themselves but they may require help from others to satisfy higher-level needs. For example, imagine being alone all day — no-one phones, no-one calls in to see you. You feel lonely and sad. Then, out of the blue, a friend drops in. You go out and meet other friends. Now you feel happy and excited. For the moment, your love and affection needs are satisfied. Loneliness, sadness, happiness and excitement are all emotions. Your **mood** (sometimes called **affect**) relates directly to the types and levels of emotions that you experience.

Thinking

Thinking is the joining of ideas. It includes imagining, creating new ideas, remembering, making connections between thoughts, and solving problems. Thinking develops as the infant's language grows. In mentally healthy people, thoughts and emotions work in harmony with each other. We use our thinking abilities to plan actions to satisfy our needs. Remember when you were feeling lonely because nobody had been in contact with you? One way to satisfy your need for contact would be to phone a friend or go and call on someone. Then you would be using a particular behaviour, based on problem-solving thinking patterns, to satisfy your need.

Attitudes

Attitudes are predispositions to think in certain ways. They are built up over time through many experiences of responding to particular situations. For example, a carer may approach elderly people with an attitude of open friendliness and informality because the carer has discovered that friendliness is a good attitude to have — most people respond in a similar friendly way. This works well until the carer encounters an elderly person who finds this friendliness and informality to be overfamiliar and is offended. Not everyone has the same attitude. In new situations (or with new people) attitudes need to be checked to establish whether the people involved share the same attitude.

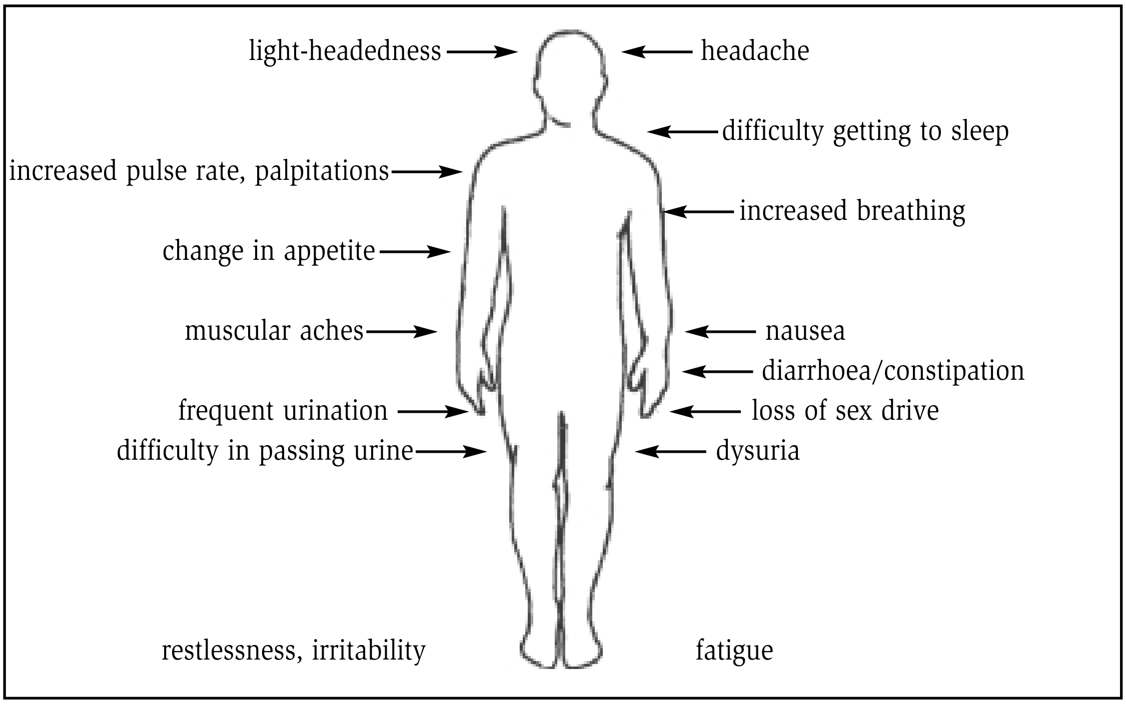
Intelligence

Intelligence is the capacity for understanding. Intelligence influences talking, memory, creativity and the development of new ideas. Intelligence develops from a combination of our inherited abilities, our learned behaviour and our daily interactions — especially within our family but also with our world in general.

ANXIETY

Just like the other feelings we have discussed, **anxiety** is a mental and physical response that we have to internal and external events. We experience anxiety in a number of ways such as a feeling of “being nervous”, a feeling of tension and apprehension. All is “not right”, something unpleasant is about to happen. Anxiety has physical as well as emotional expressions.

Figure 1.2 Some physical signs of anxiety



Anxiety can range from mild discomfort to a crippling disorder. It is part of everyday life for all human beings. Different cultures have different preferred ways of expressing anxiety, for example, in some cultures anxiety should never be shown in public; in other cultures, public displays are essential to obtain social support.

Anxiety motivates or gives energy to much of our behaviour

It is unlikely that you would get out of bed early on a cold, frosty morning and go to work at a job as difficult as caring for the sick and the elderly without the stimulus of anxiety — anxiety about losing your job, about the need to support yourself and your family, about the care of your clients, about your ambitions and plans. Anxiety can motivate change and therefore promote personal growth and development. For some people, however, high levels of anxiety are disabling.

From early childhood we all learn different ways of managing anxiety. These individual ways of handling feelings, our patterns of coping, become part of our personality.

Defence mechanisms

One way in which we all manage anxiety is by using **defence mechanisms.** Usually our defence mechanisms are unconscious, that is, we are unaware that we are using them. Common unconscious defence mechanisms are defined in Table 1.1. As you read through them, see if you can substitute examples from your own experience for the examples that have been given.

Table 1.1 Unconscious defence mechanisms

	Definition	Example
Repression	Painful and unacceptable thoughts and feeling are removed from consciousness	The person who has been abused as a child often doesn't remember
Suppression	Unwanted feelings and thoughts are put out of the mind	A young woman pushes out of consciousness thoughts of a disastrous date
Regression	The adoption of an earlier stage of development at times of stress	A toddler behaves like a baby when a new baby comes along
Sublimation	Desires that are thwarted or not acceptable are directed into socially approved behaviour	Strong maternal feelings are directed into caring for sick people
Displacement	Feelings and thoughts are directed from an unacceptable to a more acceptable, less powerful object	A client is rude to a carer after the doctor failed to leave time to answer questions
Projection	Attributing unacceptable thoughts and feelings to another person	A seriously ill person who cannot contemplate thoughts of death accuses medical staff of disliking them and not treating them adequately
Rationalisation	Indulgence in excuses for or explanations about behaviour which produces discomfort or guilt	Poor quality nursing care is "justified" by referring to budget cuts
Reaction formation	Behaving in a manner contrary to threatening thoughts and feelings	The anxious manager becomes a petty tyrant
Undoing	An action that is the opposite of the unacceptable behaviour is taken to "compensate"	A gift is used to "undo" an argument

Some defence mechanisms have a good outcome. For instance, as we can see from the example given in Table 1.1, sublimation of the need to “mother” may be the reason people enter the “caring professions” such as any one of the many health occupations. They express their need to care for others by being health workers.

Other defence mechanisms have poor outcomes, for instance, projection, because it consists of accusations and blaming. The health care worker, anxious about the quality of her work and unable to handle criticism, accuses the supervisor of “not liking her” and of being “against her”.

Carers must be alert to recognise that difficult client behaviour may really be a defence mechanism and not personal criticism.

Conscious coping devices

The more conscious techniques that we all use for managing feelings of anxiety or everyday stress are called coping devices. Talking with a friend, jogging, listening to music or drinking alcohol are a few such activities that help us cope. As a carer, one of your roles is, where possible, to facilitate your client’s coping device choices. A very lonely patient in hospital may ask to watch the midnight movie on television. Instead of simply saying “No”, a nurse should see how this request can be accommodated because it is obviously the patient’s preferred way of coping with loneliness. Quite often clients are compliant and unquestioning as a coping device to keep anxiety at bay.

Other commonly used coping devices include smoking, swearing, chewing fingernails, making jokes and pursuing hobbies.

Anxiety and the environment

The use of unconscious defence mechanisms and conscious coping devices is very much influenced by current events and circumstances in a person’s life. Stressful and distressing events increase anxiety and the use of anxiety-reducing mechanisms. Supportive and affirming circumstances reduce the need to allay anxiety.

Learning Activity 1.2

WAYS OF MANAGING ANXIETY

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Using information from Table 1.1 and knowledge of the conscious coping devices that you use when you are anxious, consider a person you have cared for recently who exhibited anxiety. Identify and describe any defence mechanisms or coping devices used by your client and by yourself during your interactions with this anxious client.

Defence mechanisms

Client

Carer

Coping devices

Client

Carer

This learning activity is designed to increase your understanding of the behaviour of people. Describe how this exercise has been of assistance to you.

PERSONALITY

Very early in this chapter we established that carers need to have some knowledge of psychology in order to better understand their clients. Knowledge of psychology includes some understanding of personality.

Personality is all the enduring characteristics that make a person uniquely themselves. Personality comprises the physical, mental, emotional, spiritual and social aspects of one's behaviour and the way in which these aspects relate to form an integrated whole person.

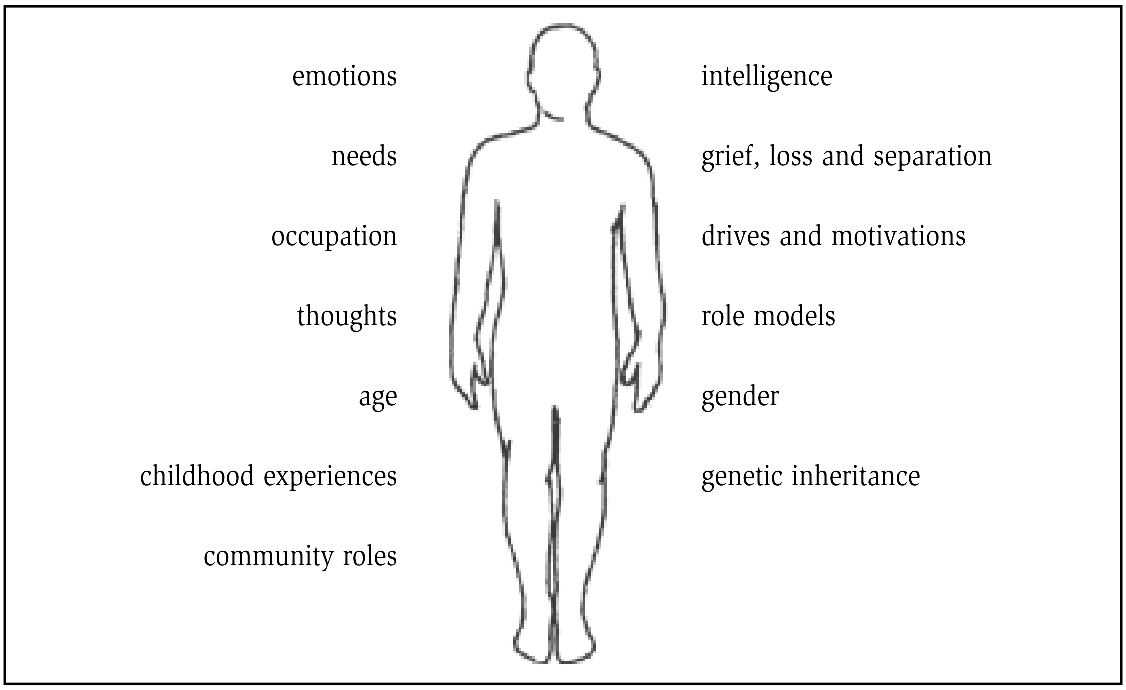


Figure 1.3 Influences on the personality

Personality development

There are many theories describing how the personality develops. The following ideas are drawn from these different theories.

The importance of the very early relationships between the infant and the caregiver (usually the mother) in creating a bond of trust that allows subsequent human interaction In your roles as health workers and carers you will find yourself caring for children and adults who vary widely in their ability to trust strangers and to cope with the dependency that often accompanies illness and infirmity. This varying ability often reflects earlier experiences.

The role of modelling or copying of behaviour by the child, that is, young children adopt the behaviours of the adults in their world even when this behaviour is not the most effective
In our health worker/carer role we often learn by using experienced senior colleagues as role models.

The value of a positive family atmosphere and childhood experiences in promoting self-esteem and allowing the child to develop more fully than one would in an atmosphere that is negative or fearful Messages need to be conveyed to children that they are worthwhile and loved even when they make mistakes or have failures.

The ability to cope with loss and to grieve The ability of the infant to cope with increasing separation from the mother will reflect significantly on the development of a positive self-concept. Sometimes the loss of a parent or sibling is not resolved and this becomes a permanent "scar" on the personality.

The need for the child to pass through and learn from different stages of childhood This idea is dramatically illustrated by adolescence. The pleasant, co-operative child of 10 or 11 years becomes the rude, rebellious teenager of 13. Adolescence is the stage of personality development that sees individuality dominating as the young person breaks away from parents and family and becomes a separate, socially recognised person. During adolescence the duties of adult life are learned. This may be completing secondary education or, in other cultures, learning to hunt or farm or collect food.

Adolescence is also the stage in which adult sexuality emerges. The human body changes from its juvenile form to that of the adult sexually mature form. Adult sexual behaviour is influenced by the way society defines male and female behaviour. This behaviour is called "gender roles" or "masculinity and femininity". Sexuality is a central part of our personality and often an area of life associated with feelings of insecurity.

The integration of innate characteristics inherited from parents with each person's responses to the many experiences of life make up each person's unique personality This accounts for why no two human beings are alike, and why each person's needs and aspirations differ.

Learning Activity 1.3

PERSONALITY SELF-AWARENESS

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

You might now like to reflect on your own personality. What significant events or people have contributed to the development of your unique personality characteristics or traits? We have provided a couple of ideas to get you started.

Influencing circumstance	***Personality trait***
1 Being the eldest child in a large family	*1 Bossy, organising*
2	*2*
3	*3*
4	*4*

Reflection: Have your dominant personality characteristics been with you since childhood?
How much has your work as a carer influenced whom you are?

ROLES

Roles are particular clusters of behaviour that society or the community assigns to different individuals or groups. Society expects us to behave differently from one situation to another or to undertake different responsibilities in different situations.

Certain behaviours go with certain roles

In times past, womanly behaviour was thought of as being kind, caring, nurturing and non-confronting. Women cared for and brought up children, and worked in service occupations such as nursing, teaching, office work and shop assisting. Manly behaviour was thought of as aggressive, brave and commanding. Men should not cry very often. Men worked in heavy jobs in manufacturing or ran businesses or were lawyers or surgeons.

Such strictly defined roles are being challenged by our society. These days it is not unusual for fathers to care for small children and for some pilots to be women. Men become nurses, women become surgeons.

In our own lives we play many different roles. We have all been someone's child, we may also be someone's parent or sibling. When we take a job we add a professional role to our personal or family roles. Most people also hold community roles. So any one of you may be mother or father, health worker, secretary of the playgroup, treasurer of the cricket club and so on. All of these roles could be called formal roles, because each has a "name" and there are expectations of how you will behave when you are filling that role.

We also fulfil roles according to our skills or attitudes in different social settings. We all know someone who "always listen to others' troubles" and someone who is "always the life of the party". These roles might be called informal roles. They are not roles that have "names" as such, but they are roles into which we fit and in which we are recognised because of our special skills.

We gain much of our self-esteem from the roles we fill whether they are our formal or our informal roles.

As we have seen, certain behaviours go with certain roles. These patterns of behaviour guide both our actions and the expectations of those around us, allowing group activity to occur more smoothly than if everyone "started from scratch" each time.

In our society, as people grow older, they lose many of their roles — professional, community, social and even family. We give very low status to elderly people, partly because they no longer perform the roles they once did. Loss of roles, together with other losses such as physical disability, economic impoverishment and the death of friends or spouse, reduces the feelings of worth and value that elderly people have about themselves. Consequently elderly clients can experience great anxiety. As carers you need to be sensitive to this situation and to understand that some difficult behaviours can be a direct result of this anxiety.

Sometimes our various roles can come into conflict. For example, a woman whose elderly mother is terminally ill may not be able to concentrate on her work — her daughter (family) role is in conflict with her professional role. A male member of staff who is the “boss” at home might think he can give orders to his female colleagues at work — his family role is also in conflict with his professional role.

We begin to learn when we are young just how we should behave in our various roles, and we keep on learning throughout our lives. The motivation or urge to be accepted by other people is very strong. We feel very anxious and uncomfortable if we think we “do not fit in”. Therefore, in a whole variety of different social settings, we learn quickly the different behaviours expected of us so that we can reduce anxiety and feel comfortable.

The sick role

In order to understand the issues that arise when clients do not co-operate with carers we need to consider the different roles of “carer” and “client”.

Health workers and carers learn their skills in both formal and informal ways. Information and skills are acquired in structured ways in schools and colleges as well as “on the job”. Not only do carers perform particular duties, but they behave in the way that is expected of carers. Some aspects of being a carer, such as attitudes and values, are learnt less formally — in the family, on the job and in social settings. Gradually, students in the health professions make the transition to qualified carers by behaving in certain ways and by performing duties as expected by those around them — both clients and other carers.

Being sick or dependent can be thought of as a role. Workers in the health care profession indicate to people in their care how those people should behave. In an institution such as a hospital or nursing home, patients or residents learn by watching other patients or residents. “Sick role” behaviour includes:

- accepting illness and following instructions of doctors and other carers;
- trying hard to get well;
- letting others take care of you; and
- letting go of usual responsibilities at work or at home.

Many people find the dependency of the sick role very difficult. This may be the source of some behavioural difficulties that arise when people become ill or disabled. Other people may abandon all responsibility and become dependent on carers.


I THINK YOU'RE HAVING DIFFICULTY ADAPTING TO THE SICK ROLE...
PEGS
JACK

Learning Activity 1.4
PLAYING THE ROLE

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Think of two clients with whom you work at present. Using the headings provided, make notes about aspects of the behaviour of your clients which indicate that they are behaving in ways they believe that people receiving care "should" behave.

Client A

Actions, e.g. eager to present little gifts to carers

Appearance

Ways of speaking

Anything else?

Client B

Actions

Appearance

Ways of speaking

Anything else?

Now think of two of your colleagues. Make similar notes about behaviours of theirs that indicate that they are “performing” their carer roles.

Colleague A

Actions

____

____

Appearance, e.g. wearing particular clothing (uniform) and badges to indicate whom they are when they visit a client at home

____

____

Ways of speaking

____

____

Anything else?

____

____

Colleague B

Actions

____

____

Appearance

____

____

Ways of speaking

____

____

Anything else?

____

____

As we have said already, role behaviour is one of the ways that social life is made manageable. If we had to start at the beginning every time, working out independently in each situation how to behave, the interactions of people would be very slow and awkward. Role behaviour allows smoother social interactions.

Deviancy

Sometimes a person's behaviour varies significantly from that which is acceptable in our community. Examples of deviant behaviour are excessive drinking or drug taking and destructive actions such as stealing, lying or criminal conduct. In some cases such behaviour may be the result of mental illness.

Labelling can reinforce deviancy. Labelling occurs when members of the community place on a person their idea of that person, for example, calling a person a "schizo", a "crim", or a "junkie". It then becomes very difficult for a person to break away from this stereotype. They come to believe the label placed upon them and may act accordingly. People, often including family and friends, do not see the person as a total person, only as the label. When the person acts as expected by the label this confirms labelling. When the person acts otherwise this is ignored as it does not fit in with the label. As carers you must be particularly sensitive to labelling and not fall into the trap of labelling clients negatively when they present with difficult behaviours.

MENTAL HEALTH AND MENTAL ILLNESS

Usually we don't think about mental health until we come across someone who is said to have a "mental illness". Then we realise that people who are "mentally healthy" are those who seem to be "normal" and "well adjusted" though it is debatable as to what is normal.

One definition states that those who are mentally healthy possess the attributes of mature, balanced persons. According to Jasmin and Trygstad (1979) these attributes include a firm grasp of reality; a value system; a sense of self; and the ability to care for others, to work productively and to cope with stress.

Mental illness may be defined as maladaptive **psychosocial** responses to anxiety or as thought impairments that interfere with or inhibit a person's ability to meet human needs comfortably or effectively and to function within a culture. In other words mental illness is caused by problems in living set in motion by anxiety or malfunctioning processes of the mind. Mental illness responses include emotional pain, distorted thinking and abnormal behaviour. As Table 1.2 shows, between mental health and mental illness there is a grey area where difficulties need to be acknowledged.

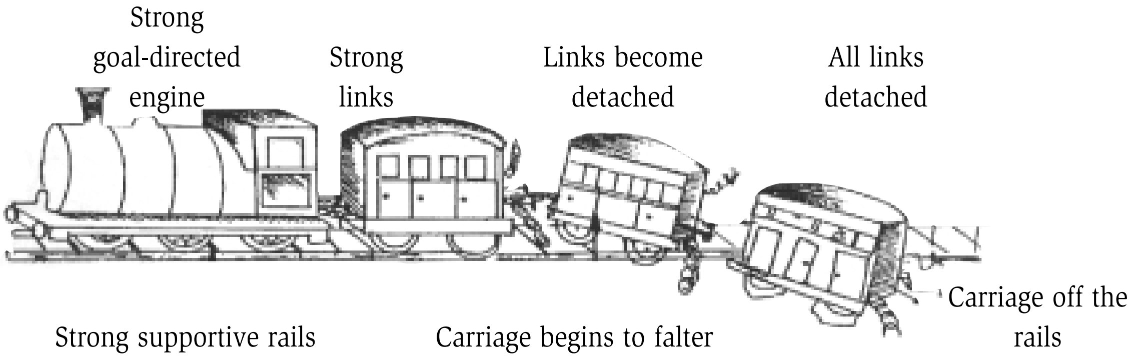
Table 1.2 The shades of mental health

Normal	Grey area	Abnormal
People who are mentally healthy can handle the ups and downs of life without becoming greatly disturbed when things go wrong. A mentally healthy person can deal with changing relationships — if things do not turn out well, the mentally healthy person is disappointed but not devastated.	Many people (even all of us, at some time) become nervous, overexcited, and downhearted or behave in ways that indicate to others that they are "out of balance". Such behaviours are not quite normal but neither are they abnormal. They do not persist.	**The person with a mental illness has ways of thinking, feeling and behaving that are a concern for that person and/or for others. The person may even be out of touch with reality. The abnormality becomes very obvious when it interferes with personal and working life.**

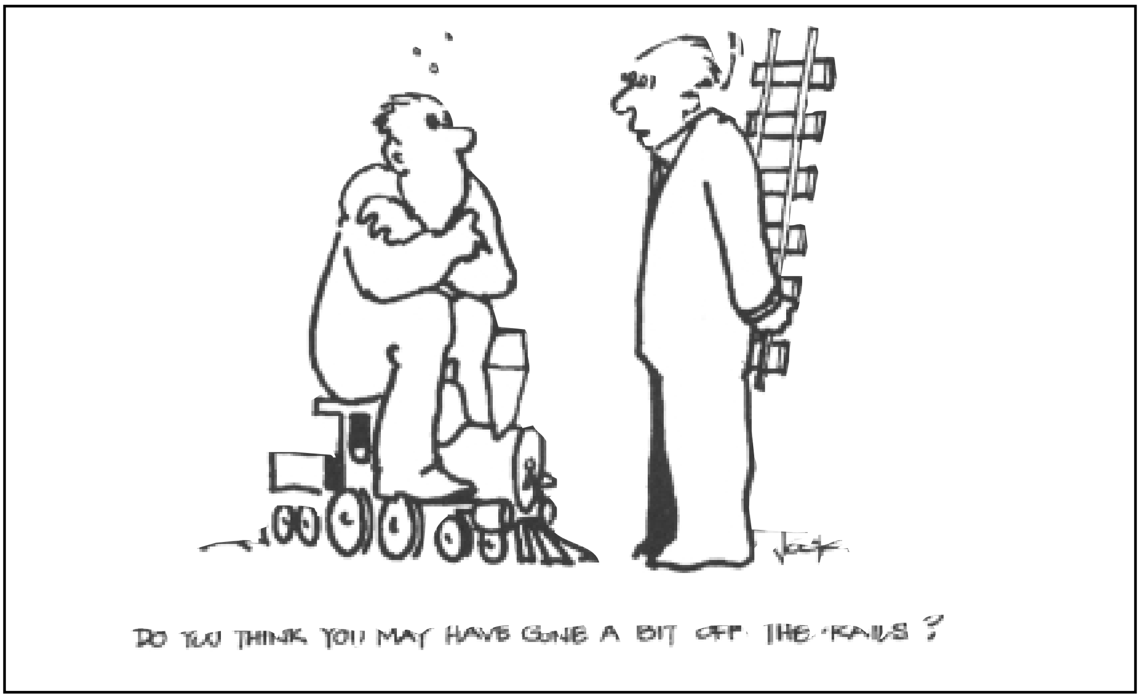
In your interactions with clients you will meet those who have dipped into the "grey area". They are not mentally ill nor are they 100 per cent well mentally; they are very stressed emotionally and they behave accordingly.

It may be useful to compare our mental health with a train.

Figure 1.4 The "mental health train"



Just as the train has an engine so the body has a mental "engine", residing mainly in the brain but very much linked to the body. This is the co-ordinating, goal-directed part of us. There are strong links between the mentally normal part of our beings and the first carriage, which represents the "grey area" into which we sometimes stray with short outbursts of disturbed behaviour or thinking. The strong links between the "grey" carriage and the engine get shaken about whenever the train shunts, just as, if our lives get jolted about and we may even feel we are going backwards, we may stray into the grey area between mental health and mental illness. Further back in the train are overloaded carriages representing what happens when people become mentally ill. These carriages have become separated from the rest of the train so the engine (or co-ordinating brain) can no longer control them. One of them has rolled off the sturdy, supportive rails that carry the train forward when things are going well. When the brain is not in control of the body and behaviours are unacceptable we often talk about people "going off the rails".



The unconscious mind

The renowned **psychiatrist,** Sigmund Freud (1856–1939), devised psychological theories about the conscious and unconscious world of human beings. It seems our inner thoughts, instincts and motivations are constantly trying to keep the balance between internal and external reality. Freud pointed out that only 20 per cent of the way people communicate and interpret their reality is conscious; the remaining 80 per cent arises from the unconscious.

Therefore when clients are asked how they are feeling, the answers they give are always incomplete because the unconscious part of the brain is not taken into account. What is happening there, in terms of unmet needs, repressed anger and internal conflicts, is not available to conscious understanding, yet it has great power to influence behaviour and emotions. The more you understand about how human beings behave, feel and think, the more you will be able to make educated guesses about what is going on in the unconscious mind.

Mental illness/psychiatric illness

Because of the interrelationship between mind and body it is often difficult to differentiate between physical and mental illness (the terms “mental illness” and “psychiatric illness” are synonymous). In mental illness there may be a disturbance of the person’s personality, evidenced by the behaviour produced, that may prevent the person from functioning normally and that interferes with their interpersonal relationships. Sometimes the mentally ill person can appear to behave quite normally on casual acquaintance, and it is only when you get to know the person well that their behaviour may appear unusual, that is, deviating markedly from the normal pattern. Others who are mentally disturbed will behave in clearly dysfunctional or bizarre ways which make it evident to carers that the behaviour is “mad”. These days such people are said to have a psychiatric or mental illness. This is not the same as **intellectual disability.** Stigma is still attached to both psychiatric illness and intellectual disability.

Psychiatric illness affects the inner life of those who experience it as well as impacting on relationships with others and the ability to live in harmony with the community. The emergence of treatments such as **psychotherapy** and the major tranquilliser drugs has meant that sometimes the person with a mental illness can be cured, or else their symptoms may be controlled sufficiently so that they can take their place in society (see chapter 6).

Nurses who work with people who have mental illnesses are called “psychiatric nurses”. Psychiatric nursing is a patient-care speciality that deals with promoting mental health and the use of therapeutic nursing interventions for those affected by mental illness.

CONCLUSION

In order to understand problem behaviours, you need a basic understanding of the sources and influences that shape human behaviour. Such an understanding includes knowledge about needs, emotions, thoughts, attitudes and the influence of personality growth and development on behaviours and emotions.

Personality is that part of the person that is most representative of them; it not only makes one person different from another but it makes them actually whom they are. Personality consists of the most typical and characteristic aspect of a person, e.g. Joe has an aggressive personality, Marina is a timid person, Aaron is a suspicious person.

The question of who is mentally well and who is mentally unwell is a perplexing one. Usually mentally healthy people are thought to be those who:

- are in harmony with themselves and their environment;
- comply reasonably well with community expectations and the culture to which they belong;
- can reason, make appropriate decisions, problem solve and adapt to changing situations;
- are able to cope with stress so that it doesn’t overwhelm them; and
- have the capacity to develop close, loving relationships.

On the other hand people are said to be mentally ill when they do not conform to what their society decides are “normal” ways of behaving and responding to the world around them. In order to work out who is so unwell as to need psychiatric treatment, a referral to a psychiatric health worker might be needed. However, it needs to be emphasised that not all people who present with difficult and challenging behaviours are psychiatrically ill.

CHAPTER SUMMARY

There are some clients who are difficult because of their maladaptive personality traits and others whose behavioural difficulties are caused by the circumstances in which they find themselves. There may be little difference in the way that they are being difficult or in how much self-control they have. If you understand that a person is abusive because of anger as a result of recent experiences, or because of using the unconscious defence mechanism of projection, then you are more likely to react to the behaviour in a way that is helpful to the client and, ultimately, to yourself.

There are a number of ways of looking at a client who presents with difficult behaviour. Most obviously it is easy to label them as “difficult clients”. However, it may be things in the environment, e.g. noise levels, or attitudes of the staff working with the clients, that are really causing the problems.

The key to an understanding of problem behaviours is an understanding of normal human behaviour. Also important is the role of anxiety and the way in which people use defence mechanisms to handle anxiety. Social roles (such as the sick role), gender, labelling and deviancy are other considerations.

In the next chapter we will deal with the central role of **communication** in the effective management of problem behaviours (Nelson-Jones 1991). Succeeding chapters will provide a detailed overview of ways to care for clients with anxiety, depression and aggression as well as clients who are mentally ill and elderly clients who are confused.

Chapter two

COMMUNICATION AND PROBLEM SOLVING

LEARNING OBJECTIVES

At the conclusion of this chapter you should be able to:

- describe communication elements that contribute to the establishment of helpful relationships
- use the Solution-focused Behavioural Change Model when dealing with difficult behaviours
- understand how to assess social, emotional and behavioural aspects of clients
- incorporate appropriate psychosocial and mental status elements into assessment procedures

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INTRODUCTION

As a carer you are faced with the challenge of delivering holistic care. Holistic means paying attention to the physical, emotional and behavioural aspects of those in your care — you need to take care of the whole person. Some clients develop emotional and behavioural problems together with a physical disability. Others have a past history of psychiatric illness that may or may not re-emerge, along with a current physical problem.

The carer–client relationship, no matter how brief, has the capacity to be a rewarding or a negative experience. Effective communication is the crucial building block of all interpersonal relationships. Communication is a process of discovering and conveying meaning; it is a process of moving toward one's life purpose; it is the way we are known by others and come to know them; and it is one way we learn about ourselves.

In order to communicate well, you must have a knowledge of the communication process and an ability to analyse it. You need an understanding of environmental and cultural components of communication as a framework for purposeful interaction with others.

When communication goes awry, people feel devalued and misunderstood and sometimes they become alienated, bitter, lonely and frustrated.

Through effective carer–client communication there is a chance that clients will become aware of their behavioural problems. Such insight is a good basis for effective problem solving.

Problem solving is a beneficial activity when you are seeking improved outcomes and resolutions. Instead of accepting immediate and impulsive answers to difficulties, you make use of an appropriate problem-solving framework to arrive at a more objective position.

Essentially all problem solving consists of a four-stage construct of assessing, planning, implementing and evaluating.

COMMUNICATING EFFECTIVELY

The first step in effective communication is to establish that the client can hear and understand your communications. Barriers to communication include:

Difficulties in understanding

For older people generally, but for some younger people as well, the most obvious reason for difficulties in understanding will be ***hearing loss.*** Many people are reluctant to admit the loss of physical abilities, such as hearing, and try to cover up this deficit.

The next most obvious reason is ***language difficulties.*** A person who does not speak or understand English well will need an interpreter or bilingual carers. When people are aged or under stress they often lose their "second" language(s) and revert to their childhood or "first" language. It is most important for you as the carer to check regularly that the people in your care actually understand what you are saying to them. In doing this, be careful not to ask closed questions such as “Did you hear me?” or “Do you understand?” to which clients can readily say “Yes”. Rather, after you have told your client what you are proposing to do with/for them, ask them to repeat what you have said. You will soon discover whether they can understand you.

Difficulties in understanding may also be caused by ***cultural differences*** aside from language. For example, the role of a client undergoing health care may vary from one culture to another. You, as a carer, may expect that clients will do all they can to care for themselves. You probably consider this to be an important part of rehabilitation and you probably value the attitude that every person should be as independent as possible. However, you may have a client who comes from a culture where the role of the client in health care is to be very passive and to be cared for, and the role of the carer is to do all.

These roles may be further complicated by different cultural expectations of the behaviour of men and women. Some men expect carers to be young women who will do everything for them while they are in health care and brand the carers as “lazy” and “not doing their job” if this does not happen. Meanwhile the carers become very frustrated because the clients “are doing nothing to help themselves”. Some women, particularly older women, may be very reluctant to co-operate with requests from male carers working in roles that have traditionally been regarded as female roles. Such women are seeing the carers as men rather than as carers.

Difficulties in comprehension may also be caused by an inability to understand due to some ***brain dysfunction.*** The person may have suffered a stroke or have Alzheimer’s disease (see chapter 7). If a person is unable to understand verbal communication she or he may respond to nonverbal communication such as touch; he or she may not accompany you when asked but may come when taken gently by the arm. Following a stroke a person may not be able to talk but may be able to write a little or point to a communication board.

Poor communication skills on the part of the carer or the client may also lead to difficulties in understanding. As carers you all require the ability to communicate well. You must take time to check that your clients understand what you are asking of them. Don’t use technical words or health jargon. The complexity of your language should vary according to the different verbal abilities of your clients. The time you spend developing caring relationships will result in improved communication as you and your client(s) get to know and understand each other better.

Clients often feel that carers don’t spend enough time talking to them. Sometimes carers feel guilty if they chat to clients in case their colleagues think they are being lazy, while other carers talk only to clients whose company they enjoy. In fact, effective communication is a most important part of the caring process. The aim is for carers to establish a helping relationship with clients and their families/friends.

Learning Activity 2.1
ESTABLISHING A HELPING RELATIONSHIP

NB Do not write in this textbook.
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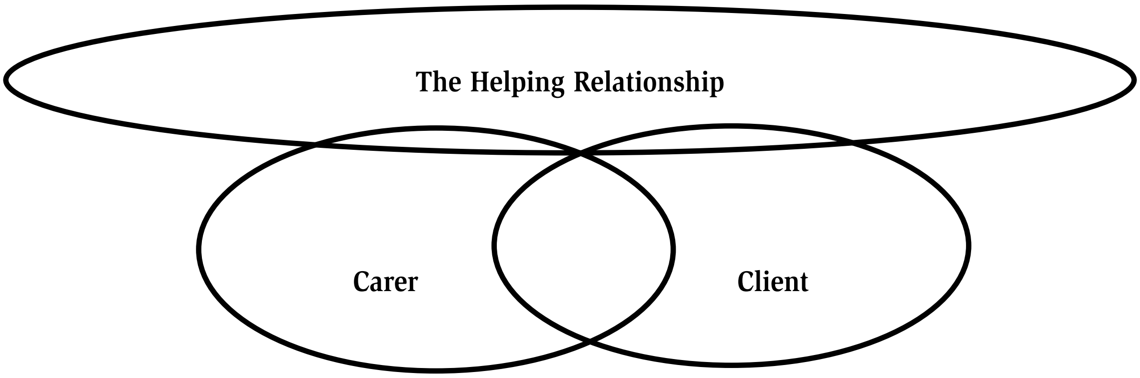
From your work experience, list what you think are key factors that have promoted the establishment of helping relationships between, on the one hand, you as the carer and, on the other hand, your clients and their families/friends.

Key factors in a helpful communication process include self-awareness, listening and attending, responding empathetically, genuineness and respect, and questioning techniques. When forming relationships with clients, the carer's role is projected in statements such as: "I want to work with you to help you manage your health better". A helping relationship is one in which the carer and the client work harmoniously toward a shared goal in health, health maintenance or rehabilitation.

Figure 2.1 The helping relationship



Self-awareness

Increasing your self-awareness is a major basis for communicating effectively. A heightened awareness of self develops through self-reflection and experience. Most of us pay comparatively little attention to our outer and inner worlds. Awareness of the external world comes to us through our senses, that is the sensations and experiences we receive by hearing, seeing, touching, smelling and tasting. Awareness of the world of inner experience, the experience of what is going on within our bodies, comes to us through physical sensations. Awareness of the world within our minds comes to us through the images and ideas we carry around with us in our thoughts, in our fantasies of what the world is like. Stereotypes, explanations, comparisons and categories, events selectively remembered with our own personal interpretations and our own anticipations of the future, all feed our fantasies (Smith 1992).

Carers and clients have various levels of awareness of these different worlds. Feelings and responses (both yours and those of your clients) need to be acknowledged, accepted, managed and appropriately expressed. It is understandable that, as you talk with clients, feelings will be triggered off in you. This is quite normal. However it is possible that if these feelings are not identified, not owned, they will seriously limit your effectiveness as a helper. For example, a carer, abused as a child by a grandfather, might feel revulsion whenever asked to work with old men. Another carer might find all clients named Glen attractive and easy to care for because a favourite cousin has the same name.

Learning Activity 2.2
KNOWING YOURSELF

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Make a list of your personal strengths and limitations. Examples of strengths might be a friendly disposition, conscientiousness, loyalty, tolerance, coping well with crises, a sense of humour. Examples of limitations might be lack of assertiveness, always putting off decisions, being hypercritical, poor study skills, being unsociable. Make sure you think of others to put in your list. On your list indicate which are your three greatest strengths and your three most significant limitations.

My strengths	***My limitations***

My three greatest strengths are	My three most serious limitations are
1.	*1.*
2.	*2.*
3.	*3.*

Listening and attending

When clients speak with you they expect that you will not only listen to them, that is, attend to their verbal cues, but that you will also watch for **nonverbal communication** and you will let them know that you understand what they are saying. Listening carefully and then reflecting back to the client what you have heard is a kind of oil that lubricates the entire communication process.

If you are to convey to the client that you are comprehending what is being said, you must first pay attention to what is being communicated. Knowing how to pay attention to others and how to listen carefully are essential communication skills.

Poor listening and poor attending result in poor communication

When **active listening** occurs, you take on the responsibility of not merely absorbing words that are spoken to you, but trying actively to grasp the facts and feelings in what you hear. This is by far the highest and most effective level of listening. If you try to see things from the other person's point of view then real communication can take place. Not only are you attentive to the words being spoken but you also try to get inside the mind of the client so that you can understand her or his concerns. In doing so, you suspend your own thoughts and feelings and give attention solely to listening (Nelson-Jones 1992).

As well as being disposed to listening actively, you need to establish clearly that you are available to help. There are many nonverbal clues you can give a client that will indicate that you really are concentrating and trying to help. One writer, Knapp (1980), talks about the SOLER system. The letters S-O-L-E-R are reminders of five basic things you need to do with your body to let your client know that you are involved.

S = face the client SQUARELY
    This is the basic posture of involvement. If you face the person squarely, you say by your posture, "I'm available to communicate with you".
O = adopt an OPEN posture
    An open posture, especially with open arms, signals that you are open to the person and to what they have to say. It is a nondefensive position.
L = LEAN towards the other person
    This is another sign of being fully present, available and involved.
E = Maintain good EYE contact
    As you speak with the person, spend much of the time looking directly (without staring), but bear in mind that there are some cultures for whom direct eye contact is not appropriate.
R = Try to be RELAXED
    If you are really involved with the person and wanting to communicate, you need to practise the balance of being interested and being relaxed at the same time.

Empathy, genuineness and respect

For the most effective communication you need to sustain a positive attitude towards your clients, that is, you must respond to them with **empathy,** you must be genuine in your dealings with them and you must have respect for them. One writer, Rogers (1980), says the ideal attitude is one of unconditional positive regard, consisting of three elements:

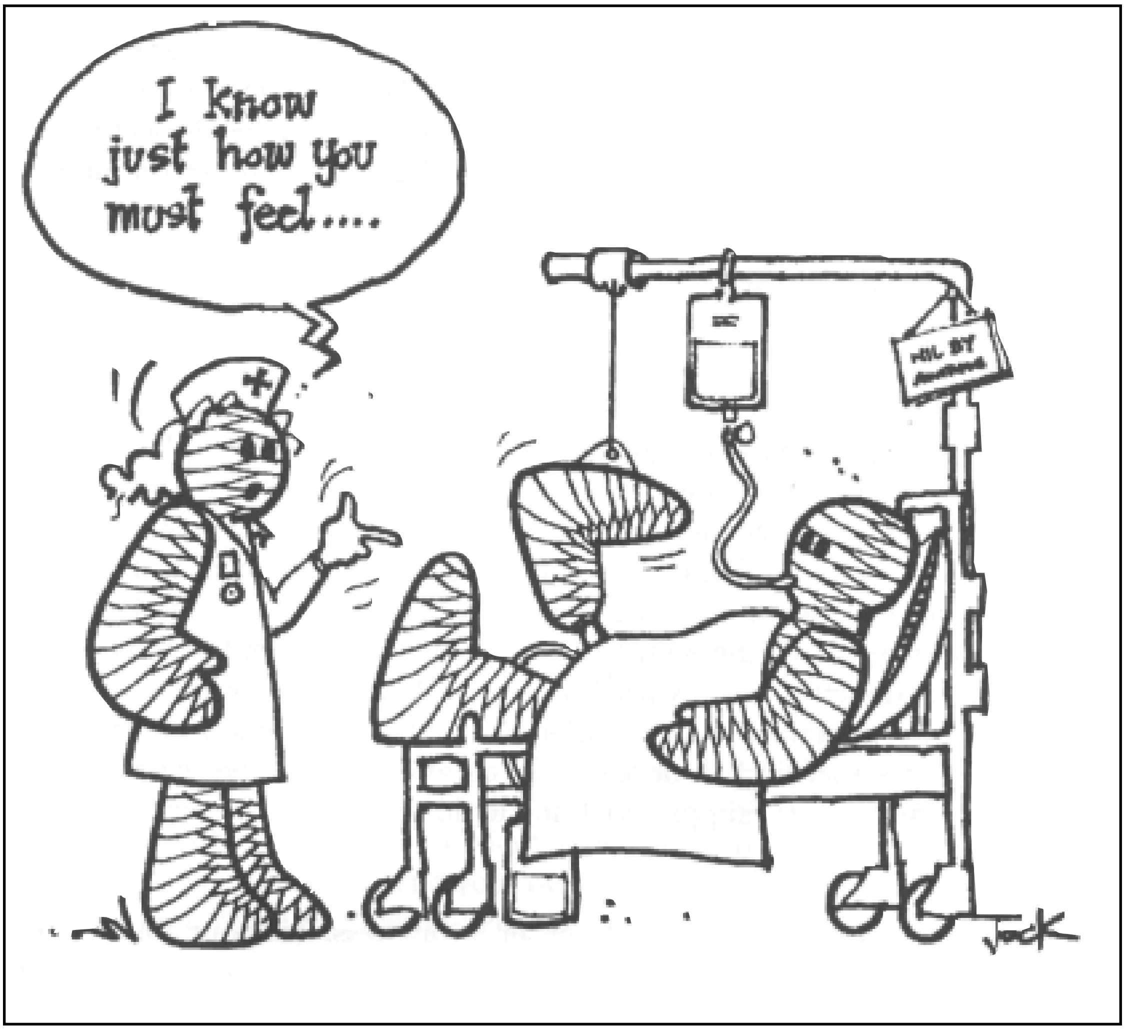
i) being nonjudgemental;
ii) being empathetic; and
iii) being genuine.

Being nonjudgemental means putting your biases and prejudices aside and moving toward acceptance of clients as unique and important people. Empathy is the ability to perceive accurately the current feelings of another person and to understand the meaning of those feelings to them. Your responses to a client can help to establish empathy. For instance, remarks such as “It seems as if you are very discouraged with your treatment” or “It sounds as if you are quite worried about whether you made the right decision” prompt your client to respond to you. If you say directly: “I know just how you feel” your client cannot be sure you truly understand their feelings. After all, you’re not the one who has had an operation or uses a wheelchair or has meals on wheels to call every day. Using informed reassurance is a supportive thing to do and it conveys empathy to your client.

Being genuine is a valuable extension of self-awareness. It is your ability to be yourself when communicating with your clients, to be direct and honest within a range of helping relationships. Genuineness is free of manipulation or deceit. The process of becoming an effective health care worker involves acquiring therapeutic attitudes and discarding unhelpful attitudes.

In summary, what Rogers calls unconditional positive regard is an approach to clients that values them as persons to be respected, regardless of their behaviours. Examples of specific behaviours that show respect include:

- addressing clients in a warm, accepting manner, using the name by which they prefer to be known;
- promoting clients’ rights to hold opinions that differ from your own;
- avoiding being patronising and using jargon; and
- encouraging clients’ capacities for positive action.



Use of questions

When communicating with clients you need a good questioning technique. If you ask too many questions, for instance, you may frighten your client. The three main types of questions to remember and use appropriately are:

- open-ended questions;
- closed questions; and
- leading questions.

Open-ended questions allow your client to give an extended response, e.g. “How are you since we last spoke together?” Closed questions usually elicit a restricted “Yes” or “No”, e.g. “Are you still in pain?” Leading questions have a directive value inserted that leads the answer, e.g. “You like it when I sit down to talk with you, don’t you?” Ideally, mainly open-ended questions should be used. However, for focused inquiries, closed questions are appropriate and if a client is shy or suffers from confusion, then leading questions may be the most appropriate to help them make a response that you can build on.

Learning Activity 2.3

TYPES OF QUESTIONS

NB Do not write in this textbook.
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For each of the categories just discussed, write two questions you might ask a client.

Open-ended questions

Closed questions

Leading questions

Assuming that a readmission to hospital is the topic being discussed with your client, here are some examples of the questions that might be asked:

Open-ended question: "What happened that caused you to be back in hospital?"
Closed question: "Were you readmitted because of your irritable bowel problems?"
Leading question: "I don't think you were coping at home, were you? Tell me about it."

Have you noticed that some questions are both closed and leading?

Questioning is necessary at times to encourage, to prompt and to help clients explore problem situations or feelings when they fail to do so spontaneously. The questions asked should be expressed clearly and simply. Ask only one question at a time, e.g. "What have you been doing since we last met?" is one question but "What have you been doing since we last met? Is your diabetes playing up again?" is a two-part question made up of an open-ended question and a closed question (Purtilo 1990).

Communication and you

Due to technological advances and rapid social change, health care is a complex process that demands coherent and competent communicators to assure clients the best possible care. Your role as a health care worker will develop as you demonstrate high-quality communication skills, both when speaking and in writing, as you monitor and document client care.

Effective communication skills apply equally to written communication. Being nonblaming and empathetic in written communication can be very effective in developing positive attitudes within health care teams.

Your ability to use effective verbal, nonverbal and written communication can help you as you progress through all levels of your health care stream. Remember to listen, observe and exchange information, and you will have little difficulty in demonstrating your competency and establishing your credibility as a health worker. As a carer, you cannot help people with difficult behaviours unless you have absorbed the foundation skills of effective communication. Coherent and competent communication, both written and spoken, will also help minimise the chance of malpractice litigation.

WHEN EFFECTIVE COMMUNICATION IS INADEQUATE — STRATEGIES TO DEAL WITH PROBLEMS

How do you come to the position of deciding that you are dealing with a problem and that the problem you have is a behavioural problem? All people requiring care have difficulties. The difficulties may be physical illness or disability, psychological or personality stresses, or social disruption caused by isolation from their social network. When people need residential care, either acute or longer term, combinations of these factors are usually operating.

A few of your clients will have unsatisfactory patterns of response to stress. Even when carers are skilled communicators, these unsatisfactory responses persist and cause difficulties for those with whom the person has daily contact. Additional skills will be needed to provide good-quality care for these clients. Problem behaviours may be present at the first contact (e.g. the person who is angry when you first meet) or may emerge during the initial weeks of providing care (e.g. the person whose anxieties are never reassured). The initial assessment of the client, including the **psychosocial and mental health assessment,** may provide clues to the existence of problems and to possible causes, but problems often creep up on carers — the crotchety old man who gradually becomes the subject of complaints by the staff or the sweet and gentle woman who evolves as the person who divides the staff and is the subject of arguments.

It is important to declare that a problem behaviour exists so that actions can be taken to minimise it or manage it. Usually the declaration is based on evidence from those involved in the person's care — despite their best efforts they are having difficulty providing care for this person and the difficult area is the client's behaviour. Generally the staff will find that, although they approach the client using strategies that are successful with other clients, in this case their efforts are unsuccessful. The situation may involve one or many carers and a plan must be developed to seek solutions to the problem behaviour, keeping in mind that sometimes only a partial solution will be achieved and sometimes the problem behaviour remains stubbornly unresolved.

Problem behaviours that are not responsive to interpersonal approaches (such as in the case of brain damage) can still become more manageable for the health care team when the team uses problem-solving strategies that focus on the team's ability to continue to provide care even in difficult situations.

Learning Activity 2.4
SOLVING A PROBLEM OF YOUR OWN — 1

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Think of a problem that you have been having for some time — it may be in your personal or working life.

Write down the problem specifically — that means be accurate, not vague — and list the ways you have been trying to solve this problem.

The problem

____

____

____

____

____

Now write down some possible solutions to your problem

Possible solution 1

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____

____

____

Possible solution 2

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____

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____

Possible solution 3

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Try to identify the process you used to reach these solutions.
We will refer back to this learning activity when you have finished reading this chapter.

Solving problems

Within the general framework of "problem solving" there are a number of variations or models based on different ways of understanding human behaviour. Many of you will be familiar with the nursing process (Davies and Janosik 1996). This is a form of solving problems. There are a great many variations of the nursing process but they all have a general format that matches a problem-solving process that can be used by anyone.

Assessment

The carer makes an assessment of the person including physical, emotional, social, spiritual and behavioural aspects of their life.

Goals

From the assessment, goals of care are developed. These goals identify the needs of the person for care, for treatment and for support. If the person receiving care is able to help develop the goals then he or she should be included.

Actions (or implementation)

These are the actions that the carers take to achieve the goals. These actions include physical care, specific treatments, emotional support and family involvement.

Evaluation

Actions are assessed regularly to see if they are meeting the goals. Depending on the results of these assessments new actions may need to be developed as the person's condition alters. It may be found that new goals also need to be developed to meet new circumstances. Problem-solving evaluation requires regular monitoring and reassessment activities.

This assessment, planning (goals), implementation (actions) and evaluation problem-solving sequence is a dynamic process. In this context, dynamic means that the process is not static. The evaluation stage will always point to whether new actions need to be set in place.

Notice how this model focuses on developing goals to solve problems, i.e. unmet needs. This model is a problem-oriented approach. The following model encourages readers to approach problems with an attitude that is solution-focused.

Solution-focused problem solving

Molnar and de Shazer (1987) and Walter and Peller (1993) have proposed a model that has been found particularly useful when caring for clients with problem behaviours. In this book it is called the Solution-focused Behavioural Change Model and all readers are recommended to try it. The Model has three important characteristics: it is solution focused, it is nonblaming and it externalises the problem.

The first characteristic means that there is a focus on the desired solution to a problem not on how the problem arose. The Model promotes solutions called "win-win" solutions. This means that all people involved can feel satisfied with the solution, no-one is made to feel wrong.

The nonblaming characteristic of the model means that the aim is to remove the difficulties, not to blame the client or anyone else for causing the problem.

The third important feature, externalising the problem (White 1989), means that the problem is the behaviour or actions of the person, not the person themselves. The problem is “extra” to the person, not an intrinsic part of their personhood.

Nonblaming and externalisation also incorporate the notion that people do not choose to develop difficult behaviours. The difficult behaviour develops in response to earlier traumatic experiences or it is composed of ingrained maladaptive learned behaviours or it is the result of ineffective ways of dealing with stress and relating to others. The Model assumes that if people with difficult behaviours were able to choose, they would choose to get along better with others.

There are some people for whom the Solution-focused Behavioural Change Model will not work because they are not competent. For example, clients with dementia cannot participate and people with severe brain damage cannot enter into an agreement to change their behaviour. Clients must be not only able but also willing to participate in finding a solution to problem behaviours.

It is still possible to use solution-focused problem solving with these clients but the strategies will all be carer strategies. For example, in the case of dementia clients in residential settings, taking all clients to the toilet after meals will promote continence.

Learning Activity 2.5

HOW DOES IT FEEL?

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Think about some problems that you have experienced in life and the different ways people have tried to solve these problems.

When "blaming" was involved, what emotions did you feel?

When a "win-win" solution was found, how did you feel?

Which situations promoted more pleasant feelings?

THE STAGES OF THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

When you come across a case of problem behaviour, before you can start developing a solution, you need to identify all the people who will support the process, that is, those who wish the problem to be replaced with a situation in which everyone is satisfied — a win-win situation. You need to identify these supporters because they will be the people who will take action. Once the supporters are identified you can proceed with the following process.

Name the problem

The name given to the problem should, where possible, be the client's name for the problem. The name needs to be short, specific and nonblaming. However, while it is important to express the problem briefly, it is even more important to be accurate. For example, naming the problem as "incontinence" does not identify the type of incontinence and other relevant characteristics, whereas "wetting the bed at night" expresses the problem very clearly.

Identifying the exact problem may require a period of regular observation — under what circumstances does this client's behaviour cause a problem? Who is present when the problem occurs?

Behaviours may be problems, for example, shouting or compulsive wandering. People themselves are not problems.

Name the solution

The solution should be a short, specific declaration of the desired outcome and it should be the outcome that the client desires. For example, if the problem is "incontinence" the solution might be "getting to the toilet in time". Again a period of observation will be needed to establish in what situations does desired behaviour occur. When is there no problem? Who or what is involved at times when the desired behaviour occurs? What are the changed circumstances?

Look for causes

It is important to note that the psychosocial and mental health assessment, completed as part of the initial client assessment, will be an important source of information when looking for causes of the problem. Look for causes in a nonblaming way; the aim is to understand, to find solutions not to find fault. The client should contribute their understanding of the problem and possible solutions. Family, friends and other people important to the client, such as the general practitioner, may be involved in the search to understand how this problem arose and how it might be solved. The opinion of everyone involved is valuable and may contain clues to the solution. An understanding of human psychology will assist in developing a broader range of insights (see chapter 1).

Develop and implement strategies

Problems are solved only when people are ready to solve them. Recognition of the benefits of having a solution, in contrast to continuing to suffer the behaviour, will motivate some people to act.

The best outcomes are achieved when the person with the problem behaviour engages willingly in a solution-focused process, so ask the person with the problem behaviour would they like to have the solution and are they ready to help try and achieve the desired outcome.

Consider all possible strategies to achieve the solution. Do not eliminate any ideas without consideration — actions that don't seem reasonable at first may turn out to be the best solutions. If the first strategy used is not successful attempt another. Never give up.

Reward success

It is very important to give vigorous praise for episodes of the desired behaviour. We all have a tendency to focus on difficulties and to pass over achievements. Thus we lose the opportunity to reinforce the good things that happen. Making a big fuss about a success makes people feel valued and motivates further success. When the solution is achieved and there is a successful resolution to the problem, there needs to be acknowledgement of this accomplishment.

THE MODEL IN PRACTICE — A CASE STUDY

Let us look at an example of using the Solution-focused Behavioural Change Model. This is a case study of the kind of problem that could occur in any residential care environment.

One morning, Rob, the hostel manager, heard a disturbance in one of the bathrooms. A resident was shouting at a staff member. Rob found the resident, who was clearly upset, shouting at Kim, one of the personal care attendants. Kim was as upset as the resident. Rob knew that Kim was very competent and was surprised that the resident was disturbed while in Kim's care. Rob calmed things down without allotting blame but there was obviously a problem to be solved.

How should the situation be analysed and the problem solved?

First, name the problem.

Rob discovered that this resident needed lots of reassurance about bathing because there had been a recent family tragedy. Rob also discovered that Kim had been late for the shift and had missed the hand-over at the start of the shift so had not been told of the family tragedy and that the resident felt insecure at bathtime. Further inquiries revealed that Kim was often late for the morning shift and frequently did not have time for a proper hand-over. Rob also discovered that Kim's lateness was resented by other staff members. It became obvious that the problem was not the behaviour of the resident. The problem was Kim's lateness.

Naming the solution to the problem was easy — Kim wanted always to be on time.

Rob then looked for the causes of the problem in a nonblaming way. Rob discovered that Kim arrived late only for the morning shift. Rob arranged a discussion with Kim. Sympathetic open-ended questions revealed that Kim was a single parent who was having trouble getting child care for the morning shift. This was affecting Kim in many ways — not only being late for work but also developing poor self-esteem as a parent.

So the cause of the problem was Kim's difficulties with child care.

Rob's next step was to develop and implement strategies to reach the solution that had been identified — to assist Kim to be on time. By now Rob knew just who was in favour of reaching the solution — Kim and the staff and the residents. Everyone was ready to help Kim arrive on time. Kim was aware that the lateness was causing a problem and had tried a number of strategies to be ready on time in the morning. Unfortunately none of Kim's strategies had worked.

Rob, Kim and the other staff discussed possible strategies. Together they found the best strategy to reach the solution. It was implemented forthwith. Arrangements were made for Kim to renegotiate the hours worked so that the child care that was available could be used. With the changed hours Kim always arrived in good time, was always there for the hand-over, was properly briefed about clients and ceased to annoy other staff.

Rob knew it was important to reward success. Until Kim was helped to focus on the problem and find a solution, Kim had been suffering self-blame for not managing better and for irritating the other staff. With life in better order, Kim's self-esteem as a parent improved and increased trust developed between Kim and the client who had originally come to Rob's attention. Kim's workmates were delighted and organised a special outing and afternoon tea for parent and child to honour the fact that Kim had not been late for a month.

Learning Activity 2.6
SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Think about one of your clients, past or present, who was/is persistently rude and abusive. In the space provided below, fill in the information required by the headings.

Name the problem

Name the solution

Look for causes

Develop and implement strategies

Reward success

Here is a brief illustrative summary of a hypothetical situation based on the learning activity.

Problem: Cranky and rude to carers
Solution: To replace rudeness and abuse with friendliness
Causes: Psychosocial and mental health assessment revealed poor social role models in family and friends, low self-esteem and low tolerance for frustration.
Strategies: No retaliation. Facilitate a behavioural change agreement in writing. Walk away, without comment, from rudeness and/or abuse. Reinforce politeness. Use trial and error. Maintain positive regard.
Reward: Praise for politeness. Arrange a special treat that matches the client's interests and preferences.

ADVOCACY AND MEDIATION

Speaking up on behalf of vulnerable people, e.g. clients who are disturbed or ill, and/or calling in an outsider to mediate on behalf of a client's interest where there is a debate over acceptable behaviours are two important social justice elements. At any stage of the Solution-focused Behavioural Change Model, advocating in the client's best interests or setting up a mediation encounter might be called for. Both approaches ensure that the client is not being "steam rolled" into a behavioural change program against their wishes and without their side of the story being heard. Carers will find it very useful to call on advocacy/mediation strategies as required by the personalities involved and by the circumstances.

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT

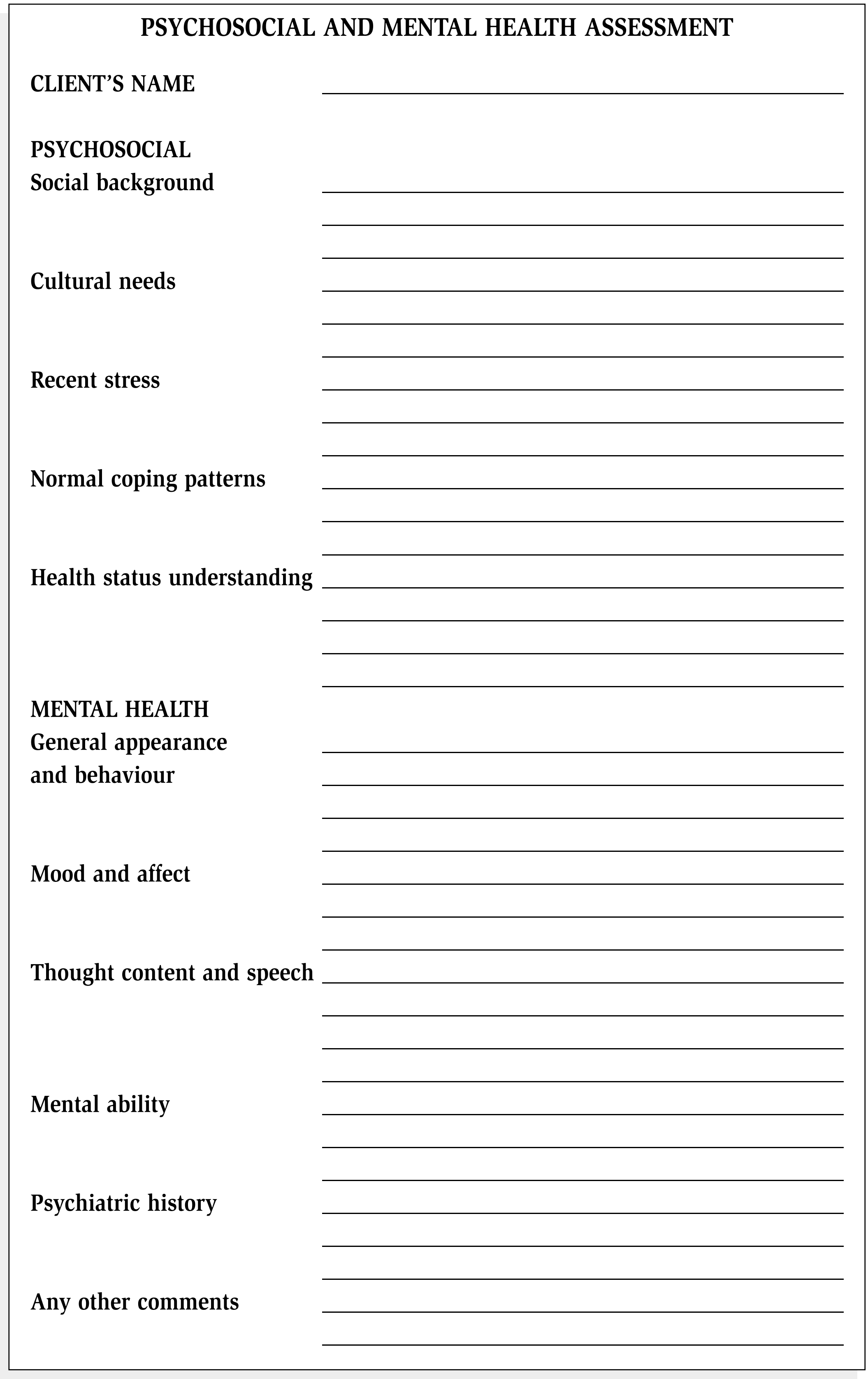
In order to be of assistance to your clients, it is essential for you to try to understand them as people. The key to high-quality care planning is a detailed assessment of your client so that you can plan your health care interventions. This assessment should be performed formally by a health care professional. Don't forget, however, that, as a carer, you are probably constantly performing informal assessments of your clients just as all of us, in our daily lives, frequently make informal assessments — physical, psychosocial and mental — of the people we meet in our work life and our private life.

For a holistic health assessment to be valid and useful it must include psychological and social details as well as information on the person's physical condition. Using basic **psychosocial and mental health assessment** items as part of the assessment format, you can gather facts about the emotional, behavioural, thinking and social aspects of your client. This purposeful gathering of information about your client's current or potential behavioural status is compiled from the client's records; from detailed physical, psychosocial and mental examinations; and by interviewing the client, family members, other caregivers and health professionals who have been involved with the client. Reassessment of presenting or emerging problems can be done as required, and provides the dual opportunities of working on the problem(s) and developing the carer–client relationship.

Psychosocial and mental health assessments

The aim of a psychosocial and mental health assessment is to identify the nonphysical functioning of the client with regard to their social history, their level of stress, their cultural needs, their normal coping patterns and their understanding of their condition. In the interests of being concise, holistic and practical, psychosocial and mental health assessment items of the type shown on the next two pages can be incorporated into an assessment document which also addresses the physical dimensions. A separate document is not required. The psychosocial and mental health assessment samples presented in this book are intended to be used as part of — and not apart from — the physical assessment that contains assessment details pertaining to the client's level of physical wellbeing. All three assessments — the physical, the psychosocial and the mental health — should be part of the same assessment format or document.

Figure 2.2 Psychosocial and mental health assessment format



PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT

CLIENT'S NAME

PSYCHOSOCIAL

Social background

Cultural needs

Recent stress

Normal coping patterns

Health status understanding

MENTAL HEALTH

General appearance and behaviour

Mood and affect

Thought content and speech

Mental ability

Psychiatric history

Any other comments

Social background includes brief information about a client's family and lifestyle and the availability of supportive people. Social needs relate to the interactions and interconnections a person has with other people, e.g. communication patterns, a sense of belonging and being loved/valued by others.

Cultural needs are those ethnic values, attitudes and beliefs that influence lifestyle choices and developmental opportunities, e.g. food preferences, family structure etc.

Recent stress is an assessment of the current levels of stress, including major stressors, e.g. the loss of a companion animal.

Normal coping patterns refers to inquiries about how a person usually responds to difficult events in their life, e.g. despondently, courageously, indifferently.

Health status understanding is the extent to which the person has knowledge of their health/illness situation, and responses to any existing dysfunction, e.g. fear of dying because a malignancy has been identified.

General appearance and behaviour includes observations of physical appearance, dress, mannerisms, posture, facial expression, eye contact and level of anxiety.

Mood and affect refers to what the person says about how they feel and also what you observe from their facial expression and body language. It is also important to note whether their feelings are in keeping with what is happening to them.

Thought content and speech includes any distinct features such as rapid, slow or slurred speech, and unusual thought patterns such as suicidal ideas or other preoccupations. Thought content also relates to whether thinking is logical or disjointed or irrational.

Mental ability is an assessment of the person's memory for both recent and past events and their orientation to time and to place and to person. Do they know where they are, who you are and what is happening to them? It also includes their level of intellectual functioning.

Psychiatric history refers to any history of treatment for a mental problem or illness and any services currently involved.

Any other comments is a useful part of the psychosocial and mental health assessment procedure. It enables the person to mention psychosocial issues of concern which may otherwise be overlooked.

Learning Activity 2.7
ASSESSING YOUR CLIENT

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Using this format, make a psychosocial and mental health assessment of one of your clients.

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT

Client's name ____________________________________
(use initials only to preserve confidentiality)

Psychosocial

Social background

Cultural needs

Recent stress

Normal coping pattern

Health status understanding

Mental health

General appearance and behaviour

Mood and affect

Thought content and speech

Mental ability

Psychiatric history

Any other comments

In summary, a client assessment consists of a physical assessment and a psychosocial and mental health assessment.

It is the psychosocial and mental health assessment that is of particular importance for assessing behavioural problems. Only problem behaviours require the use of the Solution-focused Behavioural Change Model.

Learning Activity 2.8
SOLVING A PROBLEM OF YOUR OWN — 2

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Look back at Learning Activity 2.4. Using the outline below, take the problem you identified in 2.4 and apply to it the Solution-focused Behavioural Change Model that has been demonstrated in this chapter.

Name the problem

Name the solution

Look for causes

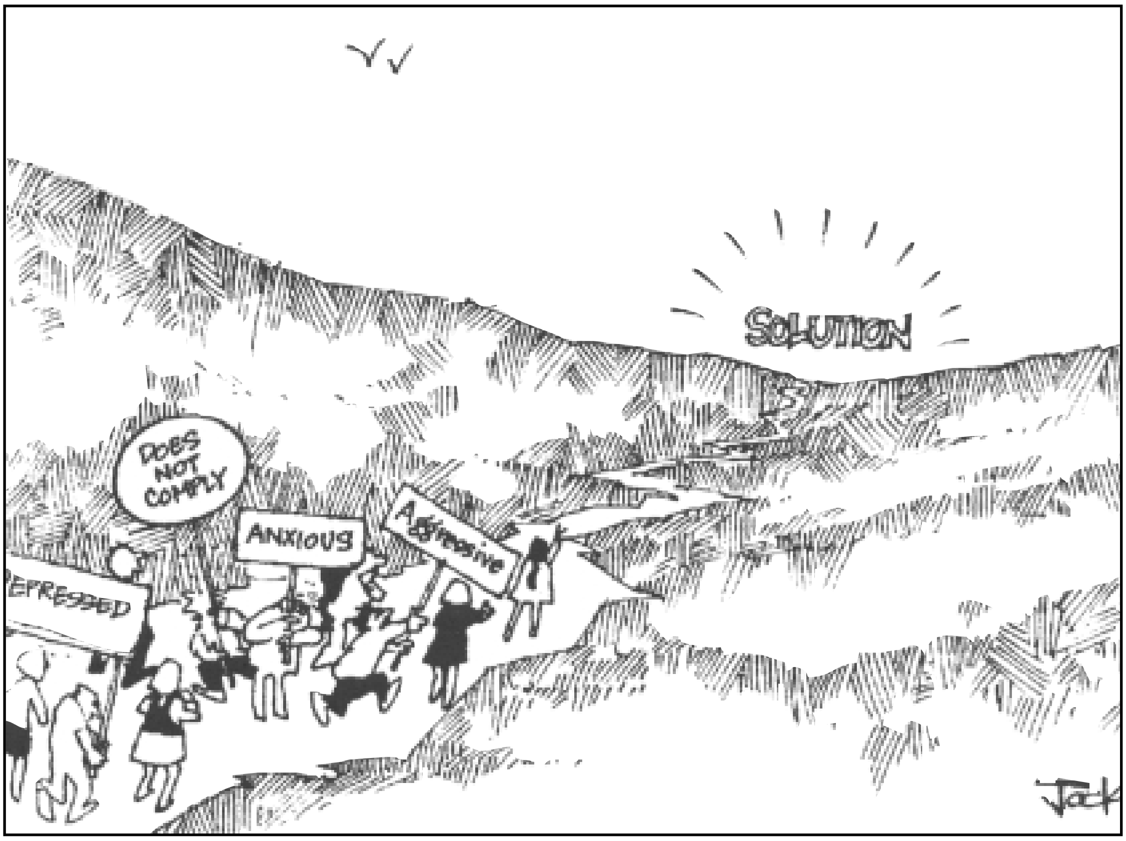
Develop and implement strategies

Reward success

Do you now have a different solution to your problem from what you had at the end of Learning Activity 2.4? Write down your feelings about going through each of the learning activities.

How I felt about Learning Activity 2.4

How I felt about Learning Activity 2.8



CONCLUSION

An important part of your day-to-day work is to interact with clients. When you are skilled in these interactions clients will have a greater understanding of what is expected of them and what is happening to them so they will be better able to co-operate. This is especially so when you encounter clients with problem behaviours. An unskilled communicator can provoke difficult behaviour in otherwise reasonable clients. The more positive you are about the relationship, the more rewarding you will find interacting with clients. Difficult people are often so because they are discontented, frustrated and defensive.

CHAPTER SUMMARY

Foundation skills in effective communicating are essential, being particularly indispensable when clients present with difficult behaviours. You need to be a competent communicator in order to interview and assess clients (if these activities are part of your role), to persuade them to trust you and co-operate with you in their care.

Carers respond to clients’ needs and demands in accordance with the message they receive concerning their clients’ desires, the abilities they have to cope with clients’ needs and their evaluation of the urgency of the needs. Sometimes clients do not meet the expectations of carers. At other times carers do not meet the expectations of clients. In both of these instances problems are likely to arise because of differing perceptions.

The skill of problem solving is essential when you work in health care. In order to identify problems and their causes you need to take an objective view. This means you need to know what may cause people to behave in ways that challenge health care staff and others in the clients' environments. You will benefit from using a problem-solving model which will help you to approach problems in a structured, effective way. As a carer, your expectations and ability to predict human behaviour forms an integral part of problem solving.

Finally, you need to be clear when it is necessary to recommend that a client with problem behaviours be referred to another service. Be aware of the correct referral procedure. Sometimes you may be empowered to make direct referrals and in other circumstances your supervisor/ senior health worker is required to make the referral decisions. Knowledge of services/networks and matching them to the presenting problem is important.

Presented in this chapter is a Solution-focused Behavioural Change Model, a special problem-solving model for use when you encounter problem behaviours. This solution-focused format is an approach to behavioural change which emphasises the need for carers to follow identification of the problem with activities that promote the emergence of purposeful opportunities for helping the client to develop solutions. When success is achieved this is marked with a reward that aligns with the client's wishes and preferences.

Description of the Model is followed by a reminder that any assessment or reassessment is not valid unless appropriate psychosocial and mental health questions are included.

Chapter three

THE PERSON WHO IS ANXIOUS

LEARNING OBJECTIVES

At the conclusion of this chapter you should be able to:

- recognise the physical, emotional and behavioural impacts of anxiety
- appreciate how your own anxiety can impact on others
- understand the undesirable effects of high levels of anxiety
- value and use the Solution-focused Behavioural Change Model when planning interventions with people who are very anxious

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INTRODUCTION

As we saw in chapter 1, the experience of anxiety is normal and essential to our life and growth. Any demand or threat made upon us, either conscious or unconscious, causes our body to make a nonspecific response called anxiety. We call these demands or threats upon us stress. Stress means the strain that arises as a result of conflict. Whenever the essential needs of a person are threatened, there you will find stress. It is an inescapable part of life and is greatly influenced by a person's own perceptions and interpretations. Normally our body puts into operation mechanisms to restore us to a balanced state as soon as possible after the stress that caused the anxiety has occurred. We all vary as to how much anxiety a particular stressful event (or stressor) will cause us. A major result of chronic, intense anxiety is disease.

As a health worker or carer you are expected to assess anxiety in your clients by observing emotional expressions and bodily responses and actions and by noting which events or stressors result in severe anxiety reactions. You should also examine the factors that may influence the number and frequency of anxious responses to stress.

The best way to help clients relieve their anxiety is to help them identify the typical responses they have to anxiety, and the level of stress they can tolerate. Then you can help them to alter their lives to reduce the stress and to change the level of anxiety they experience. Learning new responses to stress may involve changes in lifestyle.

WHAT IS ANXIETY?

Anxiety is a normal emotion, a feeling state common to all human beings. We feel it as "tension" or apprehension. Anxiety arises from the unconscious part of our mind and is triggered by fear of loss — loss of love, loss of self-esteem, loss of physical capabilities (and encroachment of frailty), loss of social worth or value in the eyes of others.

Childhood is a time of successive anxieties as the child learns to master each stage of childhood and move on to the next. In order for the child to grow and develop fully, the anxieties of childhood need to be dealt with in a generally secure and loving environment. Children who do not feel they can rely on receiving love and acceptance will not manage each psychological stage completely and will be left with persistent feelings of anxiety. As an adult, higher levels of anxiety will develop whenever these people feel stressed, such as at times of illness and hospitalisation.

Small to moderate amounts of anxiety are appropriate in different situations. For example, we would all be mildly anxious if asked to provide blood and urine samples to be tested for diabetes. If the test results suggested that we had diabetes our anxiety would increase. If we were found to be completely well, then the experience of anxiety about the possibility of diabetes may motivate us to make a change in our lifestyle, such as changing to a low-sugar diet.

Anxiety can motivate positive behavioural change

Anxiety and the environment

Anxiety is a response, both physical and emotional, that allows us to deal with situations we find threatening. It puts the body “on alert”. Anxiety is essential to our survival. It is the overuse, or misuse, of anxiety that causes problems. The environment in which we normally operate or in which we may find ourselves temporarily can increase the stress upon us and raise our level of anxiety. The situation is usually worse for clients because of their impaired health status. Illness and disability increase anxiety so your clients are very likely to be anxious.

Physical environment

Physical events that affect a client can cause stress. Such events can include noise; excessive heat or cold; physical discomfort; lack of pain relief; medical, nursing or other health care procedures. Threatening physical environments — for example, a scary fun-fair ride — obviously cause anxiety. Some people become anxious about riding in lifts because they find them claustrophobic.

Emotional climate

Emotional stress arises from fear of the unknown, fear of an illness and its future consequences, lack of adequate explanation about treatment procedures and lack of opportunity to express the feelings that these situations provoke. Therefore staff attitudes are a primary influence on the levels of anxiety experienced by the people in their care. Bossy carers, rigid routines, inflexible and conflicting explanations all contribute to increasing levels of stress for clients and thus increasing levels of anxiety.

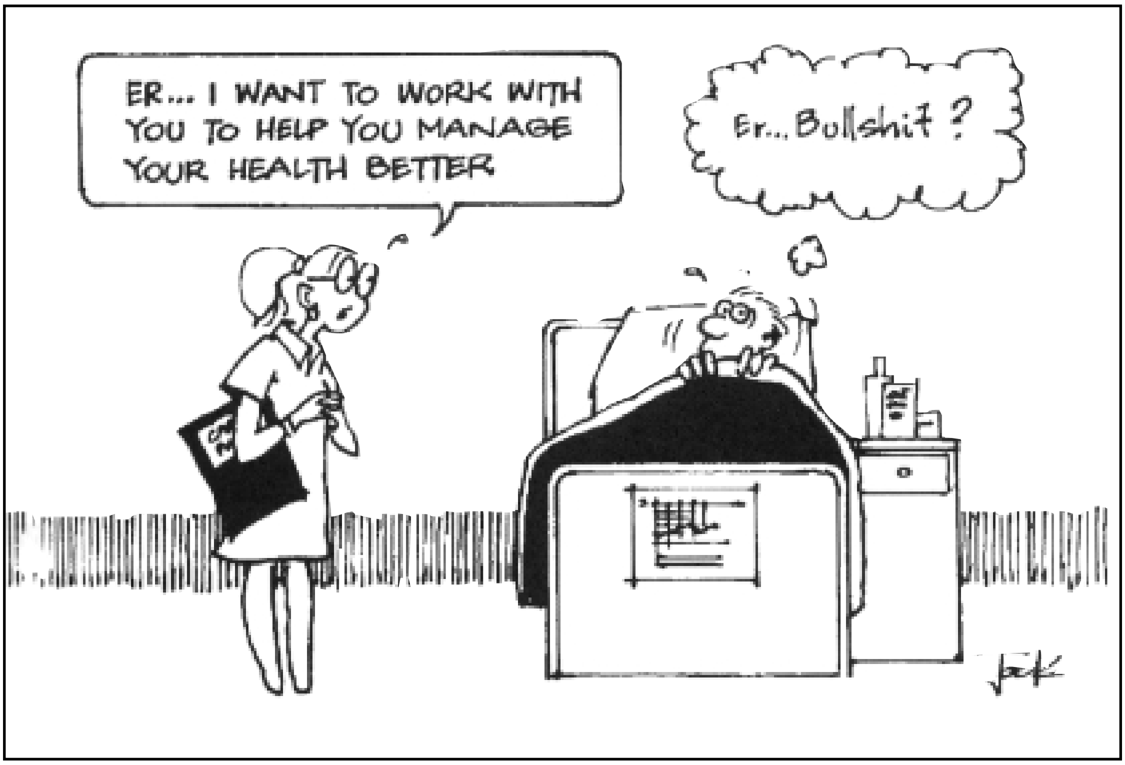
Other behaviours by a carer (or carers) that contribute to high levels of anxiety for clients include failing to respect privacy, ignoring confidentiality, labelling some clients as “difficult”, having “favourites” amongst clients, carer relationships with high levels of conflict, and communication patterns that “make people wrong”.

Similarly, the relationship of senior to junior carers can provoke anxiety in less experienced staff. Anxiety is infectious: anxious carers will have anxious clients.

The role of health workers and carers is to create a physical and emotional environment in which carers and clients can interact in ways that lower anxiety and the need to use anxiety-reducing defences. A low-anxiety setting will be pleasant and clean. The friendly, calm carers will give clear explanation; will allow time for clients to talk and express their feelings; and will take account of clients’ feelings and wishes when planning their care or working around them.

Anxiety and the carer

All of you, as health workers and carers, have experienced anxiety yourselves so you bring to your dealings with anxious clients a personal comprehension of how it feels, emotionally and physically, to be anxious. Even so, it is by no means easy to tolerate evidence of stress in people who are very anxious. You need to understand that the degree of anxiety is heavily conditioned by thoughts and perceptions. Quite short conversations with clients or relatives show that their concept of illness and treatment is a mixture of objective knowledge and fantasy (Menzies-Lyth 1992). You may find that you will unconsciously associate clients and relatives as being people under stress. This can increase your own anxiety and difficulty in handling them. You need to be aware that defence mechanisms are operating in you as well as in your clients and their families.



Learning Activity 3.1
ANXIETY SELF-AWARENESS

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Think back over the past 24 hours. Think of three situations that you knew were going to occur and about which you had been anxious. Record the details on the chart below. Remembering your state of mind before the situations, give each of them an "anxiety grading" — low, medium or high. For example, you may have known that you had an appointment with your supervisor but you did not know what it was about. How anxious would you have been about that appointment?

Time	Description of situation	"Anxiety grading"	Reason for anxiety
Situation 1			
Situation 2			
Situation 3			

Reflect on how you felt after each of the three situations had passed. Were the situations as difficult as you had anticipated? Were you as anxious as you expected to be? Many people find this kind of self-awareness thinking difficult — indeed it may increase your anxiety!

To be effective as a carer you must be sufficiently free of anxiety to be able to channel your resources into quality care activities. Learning Activity 3.1 is designed to help you develop an increased understanding of the circumstances that cause you high levels of anxiety. You may also have noticed that, in the three activities, you performed better (i.e. were less anxious) than you had expected. This is because most of the things we fear do not actually happen. This is called anticipatory anxiety.

One of the problems with anxiety is carers' uneasiness with the emotions clients talk about and display. Most carers are fearful when clients reveal their anxious feelings and fantasies (Keane 1978).

What can you do about your own anxieties so that they will not add to the client's difficulties? For one thing you can identify the kinds of clients who make you anxious. Are they men or women, the rich or the poor, the passive or the aggressive? If this self-scrutiny turns up a specific pattern, the next step might well be to explore strategies for reducing your response to such an anxiety-producing pattern.

Recognising anxiety

Besides being alert to suspecting all clients of being anxious, you must learn how to see through anxiety's many disguises. One common disguise is a change of name. The client says, "I feel nervous, tense, faint, scared, fidgety, worried, on edge, restless." Clients use hundreds of words for anxiety and unaware carers believe that clients who use these words are not anxious, just a little tense, nervous or upset. Quite the contrary is true. Anxiety includes nervousness, tension, feeling faint and so on.

As mentioned already in chapter 1, perhaps the most common disguise is anxiety's appearance as a bodily symptom or sign. This disguise will, understandably, cause problems for those carers who are more at ease with physical complaints than with **psychosomatic** ones and may lead to anxiety being overlooked.

Sample statements that are used by clients include: "I'm short of breath.", "I've got indigestion.", "I feel cramps.", "I'm dizzy". It is the doctor's responsibility to check and see whether these symptoms have a physical cause. Having excluded this, carers need to accept that the client's physical symptoms are ways of expressing and showing anxiety. It is a normal response to the threat of illness and concerns about treatment.

Anxiety also hides behind other emotions. Clients who are unaccountably irritable, or openly nasty, or who produce irritation and anger in others, may be reacting to their current anxiety-producing situation. Some clients, if given a chance, will openly admit this is how they react when they are tense or frightened. Others will deny it. Still others will freeze up and withdraw or become overtalkative (Keane 1978). How to determine that anxiety is the cause of these behaviours is not always clear. The clue often comes from some feeling towards the client which warns the carer that all is not well.

Surprisingly some clients defend themselves against anxiety by exaggerating it or exhibiting it. They tell others persistently how anxious and worried they are and what they're anxious and worried about. Others, when fearful of health workers, defend themselves by attacking not the carer in person but the image of the carer. They pepper carers with cynical, sarcastic or biting comments about the stupidity of health workers; repeat horror stories about the health care system; and tell crude jokes. A more subtle attack on the image of the carer consists in making the carer a friend rather than a health worker, in getting the carer to treat them as a friend rather than as a client. Such overtures may indicate, in psychological terms, that the client is fearful and anxious to deny the possibility of physical illness.

Clients with very high levels of anxiety sometimes present with somatic symptoms, **phobias, compulsions** and free-floating anxiety (see Table 3.1). In chapter 1, Figure 1.2 indicates some physical signs of anxiety. Table 3.1 includes physical signs as well as behavioural and emotional signs (Haber et al. 1997).

Table 3.1 Warning signs of anxiety

Physical signs	tension in the body skin rashes loose bowel motions loss of appetite frequency of urination pupils dilated sweaty	stomach ache palpitations "butterflies in the stomach" increase in breathing rate weakness of the muscles headache
Behavioural signs	ritualistic behaviour family conflict seeking attention listlessness seeking medical help tics (ritual body movements) difficulty sleeping	not ever feeling reassured feeling of fatigue generally feeling unwell seeking support and reassurance increased "checking" behaviour restlessness/pacing avoidance of social situations
Emotional signs	tearful feeling of "losing my mind" indecisive remorseful stressed	hypersensitivity to criticism unhappy excessive use of defence mechanisms irritable dissatisfied with self and others

CARING INTERVENTIONS

The nature of the experience of being admitted to a “foreign” environment such as a hospital, with its own routines and expectations, is, of itself, anxiety-provoking. Add to this the threat posed by the reason the client has been admitted to a hospital/nursing home, e.g. a trauma or illness or increasing frailty, and you can appreciate why clients admitted to health agencies are anxious. A client who is being cared for at home may be swamped with anticipatory anxiety about what might happen next.

Often carers have difficulty in responding to the needs of anxious clients because these types of clients frequently possess annoying characteristics. They may be bossy, demanding, argumentative, irritable, resentful and/or complaining. These are some of the ways clients show that they are anxious. When these messages are misinterpreted clients feel rejected, further compounding their discomfort. Acknowledging the presence of high levels of anxiety in clients is important, otherwise a vicious circle ensues; carers become more exasperated and the client’s behaviour worsens (Wilson-Burnett 1979).

When you recognise the existence of anxiety, you can make decisions regarding the care of the anxious client. In order to provide clients with holistic care you need to develop the skill of talking with anxious people. The fundamentals of effective communication have been covered in chapter 2. Once you have established empathy with your clients it needs to be nurtured and sustained.

As we saw in chapter 2 also, in all health care interventions, assessment is the key to providing high-quality care for your clients. The sources of your knowledge about clients are themselves, their family and friends, the medical history (past and present), the health care plan and your own observations and knowledge. Let’s look at what is required for a successful assessment interview.

Learning Activity 3.2
THE ASSESSMENT INTERVIEW

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

What are important considerations when conducting an assessment interview?

Write your ideas next to the headings listed below.

Venue

Positioning arrangements

Questioning techniques

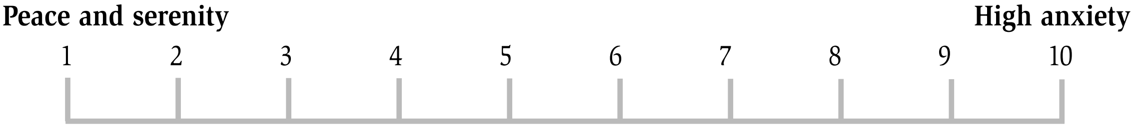
Observations

Besides a private venue with positioning based on the SOLER model outlined in chapter 2, there are communication considerations such as using mostly open-ended questions. Observations would include the client's appearance and responses during the assessment and it is important to look for nonverbal as well as verbal cues. When you work with a non-English-speaking client always use an interpreter but you must speak directly with the client, not to the interpreter, and listen for the translated answer before asking another question. If the matters to be translated are intimate or sensitive issues, you should use an accredited medical interpreter.

The questions asked should focus on the conflicts and frustrations in the client's life, for instance levels of job satisfaction and/or family relationships. Use mainly open-ended questions, e.g. "You say you feel anxious. What do you think is causing this?", because they allow the client to choose the response. Look back at chapter 2 for information on types of questions.

One useful technique for assessing anxiety involves marking the client's state on a rating scale such as the one shown below.

Figure 3.1 Anxiety rating scale



You can say to the client, "Think of a scale from 1 to 10. The 1 represents feelings of peace and serenity. The 10 represents high levels of stress and agitation. At the moment, where on the scale would you rate yourself?" The client's response can be a trigger for discussion of how the client is feeling.

Communicating with anxious clients

Clients often feel carers don't spend enough time talking to them. For talking to be of benefit it must have the aim of finding out about the client's strengths and weaknesses, their life experiences and their reactions to them. Talking with clients about their unexpressed — or even unrecognised — stresses and conflicts is a powerful way of reducing anxiety because ideas that are allowed to float around unspoken are tremendously threatening as they have no boundaries, no limits.

There are three important questions you should be trying to find answers to when you are talking with clients who are anxious:

1. What do they see as the threat?
2. What do they think is the source of the threat?
3. What accounts for the helplessness of the person feeling the danger?

Being prepared to listen is important. A major aim of spending time with the client is to encourage the client to talk, to be with them, to listen. Don't hammer them with questions without giving them a chance to think about the answers. You should say just enough to keep the person talking. Some will need prompting, others will speak freely or in a rambling fashion (and you might have to provide some gentle guidance). There is no need for you to feel you have to give advice, or to make elaborate interpretations for the benefit of the client. Even when you feel clients have peculiar explanations for their worries, don't be overly quick to set them right. Successful outcomes are more likely if you behave like a cheerful human being who is sincerely interested in the doings of other human beings.

The essential ingredient when listening is a willingness to concentrate on the task of understanding the client's communication, particularly the emotional implications and undercurrents. You should try to be nonjudgemental, respectful and accepting. As the listening carer you have to be careful not to interfere or interrupt. Maybe this is the first opportunity a carer has given this client to be heard, to become self-aware through talking about the anxiety to a genuinely concerned listener. Studies show a high percentage of clients worry because they have not been properly informed about their health status.

People become anxious
when they feel they are being denied
participation in decisions regarding their wellbeing

You can play a major role in reducing anxiety by providing informed reassurances and, more importantly, by getting in touch with the client's feelings. You achieve this by making "feeling" statements such as "It sounds as though you're angry about that". The aim of your communication with the client is to provide information in nontechnical language, to simplify the concepts and to convey empathy.

Learning Activity 3.3
THE AMPUTEE

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Imagine that, while you are helping an amputee client to dress, the client comments in an agitated tone, “My leg has a bad spot on it like the other one did before I lost it. I’m afraid that they’ll take this one too.”

On the lines below list the feelings you think the client may be experiencing and what immediate response you would make that conveys empathy.

Feelings

Your immediate response

Some of the feelings being experienced by this client might include powerlessness, unworthiness, unhappiness, apprehension and pessimism. Responses that would have a good chance of conveying empathy could include: “Would you like to tell me how that feels for you?” or saying, as you gently touch the client’s arm in a supportive way, “I’m trying to understand how that must feel for you”.

The key to empathy is to gain the client’s trust by getting in touch with the client’s feelings. Once trust has been established successfully it is important that you behave in a competent and confident manner so the trust can be sustained. After that it is appropriate to move on to tangible suggestions as to what you might do for the client. In the case of the amputee, for example, the next empathetic question might be, “Would you like me to request your surgeon to have a look at the bad spot tomorrow?”

Specific anxiety-reducing activities

Having assessed that your client is in fact experiencing anxiety, what else can be done to alleviate the problem? Complete alleviation is not the goal. Too little anxiety reduces motivation levels. Just sufficient relief is required for the client to regain a balanced, realistic perspective.

Let’s look at some techniques that you can use in addition to effective communication. Learning how to use these individually or in combinations can be invaluable for client stress management.

Therapeutic touch

Touch is a significant form of nonverbal communication. To gently take the hand of a client who is struggling with emotion conveys the feeling that somehow the problem is shared. At the very least the client realises that you are not insensitive to his/her state of mind.

Progressive relaxation

The procedure is simple. The client flexes and then relaxes the major muscle groups of the body, going in a systematic way from one group to the next. Some methods start at the top of the body and move down; others work from the feet up. The result is the same, however, and leads to profound relaxation of the large muscles of the body. Often a tape-recorded guide, e.g. Hutchinson and Keane (1993), allows the client to practise the exercises in the prescribed way and may combine progressive relaxation with **guided imagery techniques**.

Meditation

Meditation is an ancient method of reducing anxiety by bringing the body into harmony with itself and its surroundings. It is useful to focus on certain aspects of meditation particularly sitting quietly, repeating a set word or phrase to keep other thoughts from entering consciousness, and remaining deeply relaxed but awake (Miller, Ross and Cohen 1985).

Interpersonal relationships

You can reduce clients’ anxieties by building a strong interpersonal relationship with them. But remember that the relationship must be a client–carer relationship not a friendship in the true sense of the word. Your part in such an interpersonal relationship should be to listen actively to what the client is saying, to view clients with unconditional positive regard, to convey empathy by focusing on the client's feelings and to repeat information (perhaps many times) about treatment and other things that impact on the client's welfare.

Low-stress environment

Factors that will promote stress reduction include attention to the provision of:

- friendly, relaxed staff;
- flexible routines;
- aromatherapy oils to be used for fragrance and relaxation;
- noise control; and
- a homely atmosphere.

Anxiety and caring for children

The children's ward in a hospital is a situation in which anxiety reduction is essential. The children may be too young to understand verbal communication, so you should be careful to create a physically cheerful and child-centred place that will provide the reassurance that you cannot provide verbally. Murals on the walls, toys and time for play, opportunities for parents to be included in the child's care, informal uniforms and lots of physical contact will contribute to reducing anxiety and aiding children's recovery.

CASE STUDY

Here is an illustration of how the Solution-focused Behavioural Change Model was used to solve a problem of anxious behaviour.

Mrs Ivy Campbell, 77 years old, had been a widow for six years. She still lived in the family home although it was increasingly difficult for her to manage a large suburban house. She had two daughters, both married with children.

For about twelve months she had been experiencing difficulty in leaving her home. She worried about what might happen when she was out — that she might be robbed, that the house might burn down if she had left the gas on, that she might not have locked the door, or that she might meet someone she did not like while she was out.

At home she spent much of her time cleaning — she did washing each day and cleaned windows, floors and so on, whether they were dirty or not. Her daughters tried to persuade Mrs Campbell to come and live near them, but she always refused. She began discouraging visitors. She made frequent visits to her general practitioner with numerous complaints, but had difficulty complying with treatments because she experienced many side effects from medication.

She was admitted to hospital with a fractured femur following a fall in her kitchen. Progress in the acute hospital was very slow so she was sent to a rehabilitation hospital for remobilisation. The notes from the general hospital described her as "a worrier" who could "help herself more if she tried".
On transfer Mrs Campbell was found to be very fearful of her new surroundings. She regaled the staff

repeatedly with descriptions of the difficulties she had experienced while in the acute hospital — her aches and pains, her digestion problems, and other physical complaints. Mealtimes were very difficult because Mrs Campbell rejected much of the food provided.

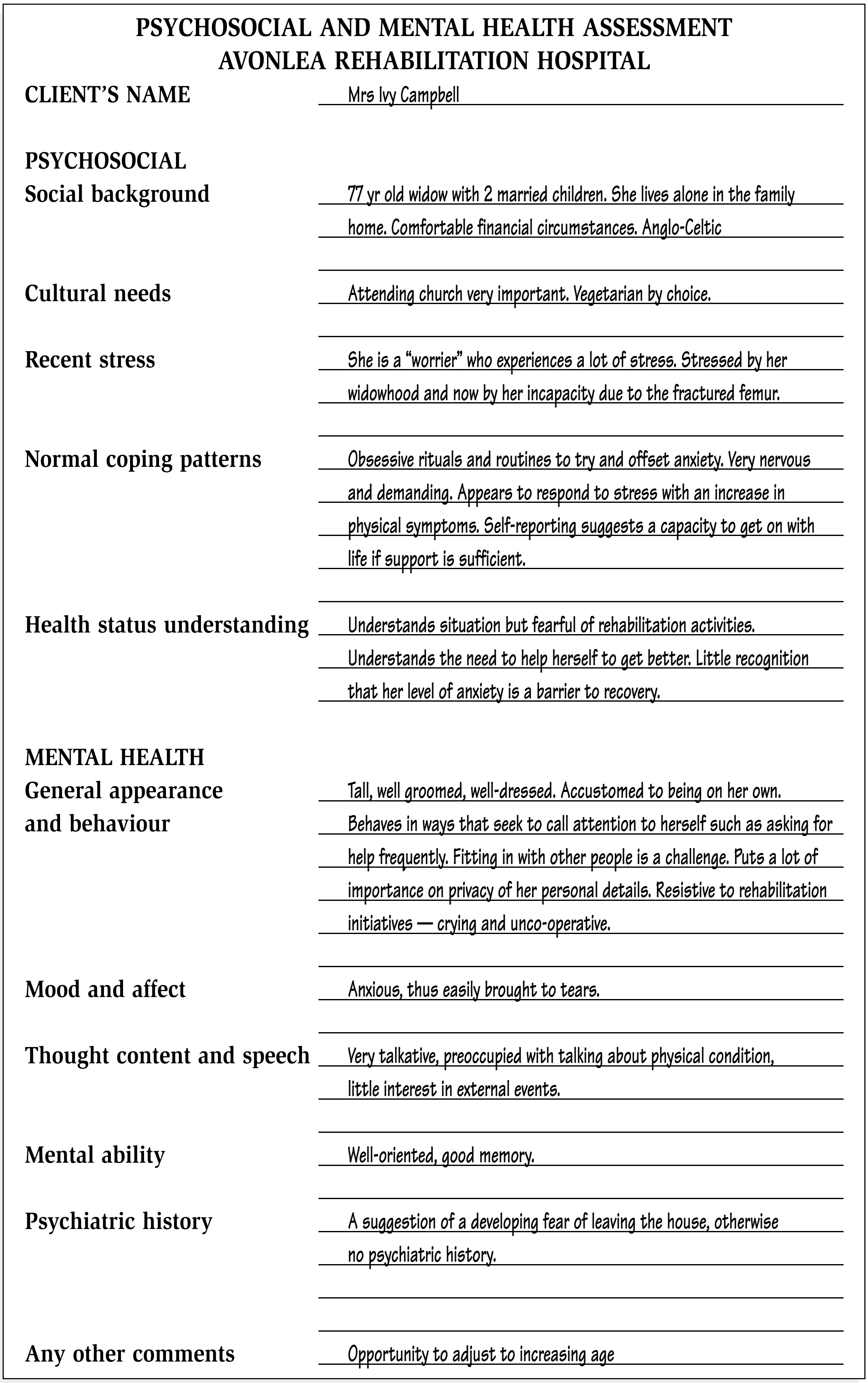
Her daughters and some of the grandchildren visited at weekends. A neighbour also visited.

The staff experienced most difficulty when attempting to mobilise Mrs Campbell. She cried out at each attempt and appeared terrified of putting any weight on her injured leg. She was beginning to attract the label "difficult" so a thorough reassessment was essential to establish the sources of her behavioural problems and to indicate directions for problem solving.

The reassessment reviewed the psychosocial and mental health assessment that had been part of the initial assessment. Additional information was collected from Mrs Campbell, her family, her general practitioner and her neighbour. Mrs Campbell was also observed during the daily ward routine to identify her difficulties and her strengths. During this period of observation the care staff used empathetic conversation to encourage Mrs Campbell to talk about how she felt, for example, "It must be difficult to think about not being able to be independent". The staff also used touch as a means to communicate. They did not engage in blame and they attempted to encourage Mrs Campbell to think of solutions to her own problems. At times Mrs Campbell cried, particularly when she reflected on her current circumstances.

Following the review assessment, staff used the Solution-focused Behavioural Change Model to assist Mrs Campbell to modify her behaviour.

Figure 3.2 Psychosocial and mental health assessment: Mrs Ivy Campbell



PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT
AVONLEA REHABILITATION HOSPITAL

CLIENT'S NAME Mrs Ivy Campbell

PSYCHOSOCIAL

Social background 77 yr old widow with 2 married children. She lives alone in the family home. Comfortable financial circumstances. Anglo-Celtic

Cultural needs Attending church very important. Vegetarian by choice.

Recent stress She is a "worrier" who experiences a lot of stress. Stressed by her widowhood and now by her incapacity due to the fractured femur.

Normal coping patterns Obsessive rituals and routines to try and offset anxiety. Very nervous and demanding. Appears to respond to stress with an increase in physical symptoms. Self-reporting suggests a capacity to get on with life if support is sufficient.

Health status understanding Understands situation but fearful of rehabilitation activities. Understands the need to help herself to get better. Little recognition that her level of anxiety is a barrier to recovery.

MENTAL HEALTH

General appearance and behaviour Tall, well groomed, well-dressed. Accustomed to being on her own. Behaves in ways that seek to call attention to herself such as asking for help frequently. Fitting in with other people is a challenge. Puts a lot of importance on privacy of her personal details. Resistive to rehabilitation initiatives — crying and unco-operative.

Mood and affect Anxious, thus easily brought to tears.

Thought content and speech Very talkative, preoccupied with talking about physical condition, little interest in external events.

Mental ability Well-oriented, good memory.

Psychiatric history A suggestion of a developing fear of leaving the house, otherwise no psychiatric history.

Any other comments Opportunity to adjust to increasing age

USING THE SOLUTION-FOCUSED BEHAVIORAL CHANGE MODEL

Name the problem

Following the assessment Mrs Campbell's problem was identified as "being very worried and fearful about the future". She also stated, "What I want is to be independent."

Name the solution

The task for Mrs Campbell and her carers was to overcome fear and worry and to replace it with maximum physical and emotional independence.

Look for causes

Causes were identified as follows:

- loss of mobility due to the injury
- physical and social losses due to ageing
- widowhood, with consequent loss of the "wife" role and personal companionship
- a developing habit of not leaving home
- a lifelong pattern of high levels of anxiety made worse by the above factors

Develop and implement strategies

It was decided that the most effective strategy was to create an environment that would reduce anxiety, and to introduce rehabilitation activities at which Mrs Campbell would succeed.

In the short time they had known Mrs Campbell, her carers had observed that her anxiety levels increased whenever attempts were made to place limits on her behaviour. For example, attempts to insist that she walk without assistance resulted in her crying out loudly and becoming emotionally distressed. So the carers decided that the most effective strategies would be those aimed at developing highly supportive relationships with her.

Three simple techniques were used to assist Mrs Campbell to overcome her anxiety — communication, relaxation and building her self-esteem.

Communication

The most helpful communication establishes trust and promotes personal competence so the carers decided that, in all their dealings with Mrs Campbell, they would be aiming to overcome her fears and promote her bravery.

As Mrs Campbell put undue emphasis on variations in explanations of her condition and progress, it was agreed that all carers would be vigilant about clear, simple and consistent explanation that would, as far as possible, praise Mrs Campbell and raise her self-esteem. For example, "Your bone is healing well, you must have a very strong body to heal so well. We will ask the doctor to show you your x-rays so you can see for yourself." No unnecessary information was given that might provide any extra focus for anxiety.

Mrs Campbell was kept informed of daily procedures and communication with her provided positive reinforcement whenever possible: "We plan to help you walk at 2 p.m. We will do only what you feel able to today. Each step is a step nearer your independence. You are a very brave woman to be learning to walk again."

The carers planned to give attention and praise, to express warmth and concern, and to use touch whenever the opportunity arose. They encouraged Mrs Campbell to talk about her feelings and the happy times in her life, especially stories involving her grandchildren. Her complaints were dealt with calmly and she was asked to suggest solutions for herself, for example, seeing the dietitian to arrange meals that caused less gastric distress. Because judgements and negative remarks caused anxiety to re-emerge, the carers avoided them.

Relaxation

Mrs Campbell was taught a simple relaxation technique to use before mobilisation each day. A carer sat with her and they relaxed together before and after each session.

Self-esteem

It was found that Mrs Campbell was very proud of her ability to sew and her family were encouraged to bring her sewing to do. She was commended on her ability and, from time to time, carers who were interested in needlework or sewing asked her for advice.

The implementation of these strategies created a climate that reduced fears and encouraged confidence.

Reward success

Within one week of implementing the support plan at the rehabilitation hospital Mrs Campbell was walking alone using a frame.

Her daughters organised a special afternoon visit to a craft exhibition. Although it was a new place that might cause their mother stress they felt that her interest in craft would overcome her fears, and they were right. Mrs Campbell's pride and joy, her grandchildren, were also included in the afternoon visit.

YOUR OWN CASE STUDY

NB Do not write in this textbook.
Photocopy the pages and complete the case study on the photocopy.

These three pages have been prepared for you to write your own case study showing how the Solution-focused Behavioural Change Model can bring about a change in behaviour. Maybe you have been lucky enough to work somewhere that this kind of solution-focused problem-solving plan was used and you can simply write down what happened. But it is more likely that a problem arose that was solved in a different way or that was not solved at all. This is your chance to show that you understand solution-focused problem solving by showing how you would have gone about solving the problem.

Think of a client whom you have cared for who was anxious. Jot down a few notes about the person. Carefully fill in the psychosocial and mental health assessment format. Work out what the client's problem was and state it succinctly then continue through the Solution-focused Behavioural Change Model.

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT

*Client's initials*____
(use initials only to preserve confidentiality)

Background (i.e. reason for this assessment)

____

____

Psychosocial
Social background

____

____

____

Cultural needs

____

____

____

Recent stress

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____

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Normal coping patterns

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____
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Health status understanding

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Mental health

General appearance and behaviour

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Mood and affect

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Thought content and speech

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Mental ability

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Psychiatric history

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Any other comments

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USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

Name the solution

Look for causes

Develop and implement strategies

Reward success

CONCLUSION

It is important to remember that anxiety is most amenable to caring intervention and support. The role of the carer is not to extinguish anxiety; rather it is to create a climate that reduces anxiety to manageable levels. Some level of anxiety is necessary to create motivating tension and energy.

Clients with high levels of anxiety respond best to carers with well-developed communication skills who genuinely try to understand how the client is feeling and make a real effort to read the client's nonverbal cues as well as listening carefully to what the client is saying. In time, with support and stress-reducing interventions, most clients become less agitated and the conflicts brought on by anxiety are reduced.

CHAPTER SUMMARY

In this chapter you have learned why carers may feel anxious in the presence of clients presenting with high levels of expressed anxiety. When carers are assessing a client's anxiety levels it is best to use mainly open-ended questions and to take into account conscious as well as unconscious sources of anxiety. It is important to recognise that anxiety has physical, emotional and behavioural aspects. Health care staff should work to establish an environment that deliberately reduces anxiety.

Care interventions include careful anxiety assessment, effective communication, the facilitation of interpersonal harmony, the control of environmental factors and the use of touch, relaxation and meditation techniques. There are, however, some people who experience unremitting levels of high anxiety which sometimes include painful and frightening panic attacks. Such people need to be referred to appropriate help for intensive psychotherapy and support.

Chapter four

THE PERSON WITH AGGRESSIVE BEHAVIOURS

LEARNING OBJECTIVES

At the conclusion of this chapter you should be able to:

- understand internal and external sources of anger and hostility
- recognise a range of overt and covert aggressive behaviours
- use strategies to prevent or intervene in aggressive outbursts
- appreciate how the Solution-focused Behavioural Change Model can help a client to change aggressive behaviour

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INTRODUCTION

Aggression and violence are increasing in health care settings so containing client aggression can be part of the role of every health worker and carer. As carers you will, on occasions, encounter physically or verbally aggressive outbursts from clients so you need to have a repertoire of skills to cope with such incidents. Aggressive outbursts have the potential to escalate from verbal abuse to physical violence and may place at risk the client with the aggressive behaviour, other clients, carers and property. Swift, appropriate decisions need to be made.

Anger, it should be remembered, is not a pathological event, nor is it unusual — everyone becomes angry at times. Basically anger is a protective device. It permits one to stick up for oneself. The anger that precedes aggression arises from frustrated needs and desires.

Anger is a normal emotion

Aggression is defined as an attack or harmful action. Its special meaning in psychology is a hostile or destructive mental attitude or behaviour. Aggression is one of a range of responses that people use to protect themselves from threats arising from internal and external causes.

As with anxiety, aggression grows out of our life history. A fundamental principle of human behaviour is that our responses to worrying situations are based on past experiences and past styles of reacting. For example, because of accumulated behaviour patterns, certain clients become angry when asked personal questions because they think it is prying. Some things make some clients angry, other things do not (Blumenteich 1993).

Aggression can range from suppressed hostility or angry verbal statements to physical assault against a person and/or the environment (Sullivan 1992). As carers, your aim is to prevent hostile feelings from deteriorating into dangerous actions.

THE SOCIAL CONTEXT

During the various stages of development a child learns to delay the need for satisfaction and to sublimate or suppress aggressive urges. The child is motivated to delay gratification of other needs by its very strong need for love. Parents temporarily withdraw love to encourage the child to develop self-control, to learn that aggressive outbursts will not be rewarded, e.g. “Mummy will read you a story when you stop yelling”. This process has been called “toddler taming” (Balson 1987).

Learning to control aggression may sometimes be incomplete or it may be based on fear of abuse and not on the fear of withdrawal of love. Some families encourage children, especially boys, to express aggression when they are angry and to demand instant satisfaction of their needs. In children this behaviour may be seen as amusing. Some children grow into adults who have great difficulty controlling feelings of aggression.

Adults with aggressive behaviour seldom have satisfactory and enjoyable personal lives. They have difficulty understanding how their aggression contributes to their unhappiness because, in their eyes, their aggression is always justified. As they see it, other people or circumstances cause them to become angry and frustrated, therefore they are entitled to become aggressive. Their aggression is righteous — other people are wrong, they are right. People who use aggressive behaviour rely on the use of intimidation or the threat of aggression to force others to do what they wish; they usually have poorly developed communication and problem-solving skills.

Aggression can be physical or verbal

Social psychology research has shown that, in some circumstances, external events can stimulate the level of aggression (Lippa 1994). Watching violent videos can increase the violent behaviour of vulnerable young men. Some people are susceptible to influence by crowd behaviour, such as football hooliganism, or by war situations. Other people who have experienced emotional deprivation or abuse may feel "the world is against them". This may lead to the use of aggression as a way of "paying back" society.

The expression of anger varies from one cultural background to another. For example, some Asian cultures consider it shameful to express open hostility in a social setting. Other cultures consider it shameful not to express anger. In these latter cultures anger is a sign that you are standing up for yourself and, consequently, for your ethnic origins. Thus it is important to understand people's cultural background in order to understand their behaviour.

You need to have an understanding of the personal and cultural background of people who are prone to aggression in order to develop appropriate strategies to assist them to express anger while reducing their need to use aggression.

RECOGNISING AGGRESSIVE BEHAVIOURS

The thinking of people with aggressive behaviours

People with aggressive behaviours need to learn to express and channel feelings of anger without being aggressive. Aggression often arises from faulty thinking. One researcher, Bowie (1989), believes that there are four common errors in the thinking of people with aggressive behaviour.

1. Rigid expectations

This is a tendency to see only one solution to a situation, only one way a current need can be met. If the desired outcome doesn't happen, then it's a "total disaster". For example, an elderly client wanted the "home help" to sit and chat but the home help had other clients to assist so made the suggestion that a volunteer visitor could be arranged. The elderly client became angry and abusive, refused the suggestion of a volunteer visitor and "sacked" the home help.

2. Faulty generalisations

This includes jumping to conclusions based on inadequate or faulty information. In the above example the elderly client not only did not understand the workload of the home help but also believed the small financial contribution paid actually made the home help an employee and therefore able to be dispensed with.

3. Faulty causes

This includes seeing only one cause of the problem and not considering that there may be others, e.g. blaming carers, and accusing them of not doing their job properly, when treatment is temporarily delayed. The actual cause could be an emergency taking priority.

4. Focusing on personalities not on issues

A person is attacked without consideration of events or issues involved. Instead of looking at the genuine issues involved, the person with aggressive behaviour uses a defence mechanism called projection to allocate blame to someone else. Sometimes staff may be the target of verbal aggression because of their age or because of their social or ethnic background, but not because of any fault in their performance.

Understanding the thinking of aggressive people may assist you as a carer to avoid an aggressive response, and indicate a way to discuss the issues — "I understand you feel angry that this has not happened. Let us look for solutions together".

Who is likely to be physically aggressive?

Research shows that certain people, particularly young men, are the most likely to exhibit aggressive behaviours. Common indicators are:

- a past history of violence
- a family history of involvement with the law
- abuse of alcohol and drugs
- an antisocial personality
- a habit of threatening aggression or suicide
- a psychiatric history, often nonspecific or paranoid (suspicious)
- organic brain disorders — aggression is often a feature of working with dementia sufferers
- abrupt discharge from a care institution with no follow-up care

It is important to note that people with mental illness, as a group, are not more likely to exhibit aggressive behaviours than other groups of people, unless they are also abusing drugs, including alcohol (Mullen 1997).

AGGRESSION AND THE HEALTH CARE ENVIRONMENT

Health workers are often responsible for providing care, in the least restrictive environment, while also attending to safety and other legal requirements. This means that people assessed as having poor impulse control need to be cared for in an environment that reduces stress and other triggers of aggression without reducing their rights to individual self-expression. Such people cannot be isolated in a single room and avoided because they may be frequently abusive. They must be cared for in a way that minimises their frustration and gives them frequent opportunity to have their concerns acknowledged. This does not mean that carers must accept aggressive behaviour; they also have rights to work in a safe environment, including both the physical and the emotional environment. Solutions need to be found that meet both client and carer needs. (For an example, see the case study in this chapter.)

Physical environment

Factors in the physical environment that can stimulate aggression include noise, overcrowding, heat, offensive odours and poor attention to safety issues.

Emotional climate

Factors that build up an emotional environment likely to stimulate aggression include:

- poor morale among carers and clients;
- poor communication skills
  (e.g. promoting "win-lose" relationships, giving conflicting messages);
- lack of opportunity to express emotions;
- rigid attitudes of carers and rigid routines;
- lack of opportunity for both carers and clients to participate in decision making;
- bossy, dominating behaviour by carers;
- carers having favourites among clients; and
- client frustration at being ignored frequently or made to wait.

Learning Activity 4.1
THE ENVIRONMENT AND AGGRESSION

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Think of your own work situation. Make a list of environmental factors that need to be put in place so as to minimise the risk of aggressive outbursts.

Environmental controls

Anti-aggression strategies include:

- reducing restrictive routines,
- extinguishing bossiness or other provocative behaviours among carers,
- ensuring the privacy rights of clients,
- responding promptly to clients' requests,
- monitoring safety precautions,
- having adequate work resources,
- providing varied and appropriate activities for clients, and
- establishing pleasant surroundings.

Health care staff create a predictable environment by being consistent. This requires good communication among the staff. One carer who does not co-operate is enough to sabotage the care plan. For confused clients persistent attempts at orienting them to the safety and caring aspect of their environment require a solid knowledge base and patience.

THE CARER AND AGGRESSION

Because you, as a carer, spend so much time with clients, you are likely to be exposed to aggression. Therefore carers need to understand how to cope when aggressive behaviour occurs. Some carers meet hostility with hostility, perhaps getting irritable or sharp-tongued. Others try to placate an angry client, going out of their way to be gentle and friendly or explaining that there is really no reason to feel suspicious. Still other carers ignore anger or irritation and carry on as if the client's angry mutterings, gestures and questions did not exist.

When one is provoked it is tempting to retaliate. A necessary technique for modifying aggressive behaviour in others is to make sure that your own behaviour is strictly under control. As carers, you need to monitor your own behaviour and to practise internal controls. One of the benefits of working in the health care field is attaining self-discipline, which prevents carers from responding negatively to open and sudden aggression.

It is also important to understand the way defence mechanisms work to protect people from overwhelming anxiety or anger. Clients often "take it out" on a carer when they are really angry with someone completely different. This defence mechanism is known as displacement.

CAUSES OF AGGRESSIVE INCIDENTS

Staff behaviour

Besides the environmental factors already discussed, health care staff must be careful not to behave in ways that may give rise to aggressive outbursts from clients. One writer, Vidovich (1991), believes that behaviours to avoid might include:

- inadequate leadership;
- prejudicial attitudes;
- poor limit setting;
- unnecessary withholding of information from clients;

- failure to explain properly care and management approaches being used;
- failure to ensure adequately the safety of clients; and
- disharmony among carers.

It is also essential not to delay the administration of medications that assist people to remain in control, that is, analgesics, tranquillisers or other prescribed medications. Delayed administration inhibits the beneficial effects of the treatment.

Client sources

It is extremely important for you to recognise risk factors in clients. Factors that may dispose clients to act aggressively are:

- abuse of drugs, including alcohol;
- a history of epilepsy;
- the onset of any disorder that irritates brain tissue, e.g. a brain tumour or meningitis;
- the presence of hallucinations (which are revealed as sensations of hearing, seeing, smelling, tasting and feeling);
- feelings of paranoia;
- feelings of entrapment and powerlessness;
- high levels of frustration;
- lack of impulse control;
- anxiety arising from conscious/unconscious conflicts;
- inadequate privacy;
- delusions of persecution; and
- use of inappropriate defence mechanisms, e.g. lying and projected hatred.

At the same time you should be monitoring the actions of your clients to ensure they are not ingesting nonprescribed alcohol or drugs.

Learning Activity 4.2
AGGRESSIVE INCIDENT MANAGEMENT

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Consider your daily work and identify a situation in which a client was verbally or physically aggressive towards you.

Describe the situation briefly

Describe your feelings at the time.

What do you think the client was trying to express or achieve?

Identify triggers to the situation

- *physical*

- *emotional*

Describe your behaviour (how you looked, the way you stood, your tone of voice and so on).

In reflecting upon this activity think particularly carefully about what you said when you were managing the client who was behaving aggressively. In handling such an incident it is important to acknowledge the client’s feelings (“You seem to be very upset.”). You should also give the client a choice so that she or he has the opportunity to behave more appropriately without “losing face”. So you would say something like, “You can wait quietly in the reception area and I will bring you a cup of tea or you can go for a walk and come back in 10 minutes when you are feeling better.” Always do what you can to assist the client, for example, “I have phoned to find out what has caused the delay and I know that the doctor will be here soon.”

How do you feel now about the incident you have described? What do you think you have learned from it? As already mentioned, it’s a good idea to photocopy these two pages and use them for other situations that might occur in your daily work.

CARING INTERVENTIONS

Communication

Recognising that some clients have levels of rage and frustration which are likely to get out of hand is only half the battle. The other half is to do something about it. Always try to talk to clients about their inner turmoil and angry feelings. Try to find out why a client is angry. Feel free to tell angry clients that they look angry or seem angry. If you suspect they are angry but you are not sure, ask whether something has upset them or ask them, with genuine interest, making sure they understand that you really want to know, “What has happened to upset you?” If the word “anger” seems too strong, which it often is, ease into their anger by saying empathetic things such as “You seem unhappy about something.”, “You look disappointed.”, “You look fit to be tied.”, “You look as if you want to say something.” Try to convey by your words and manner that clients’ getting angry, even with you, is not the end of the world. This does not mean that you make light of their anger. Treat it seriously, but not as a life-or-death issue.

It is common to find that anger covers or is a defence against anxiety. Realising this, you, the carer, can often suggest to a hostile client that they must be very anxious, and therefore bring the truer feeling to light, e.g. the client might say, “Yes, I’m anxious about my condition.”

Although it is not easy for a carer to sit calmly by and allow a client to say unkind things, to do so often pays great dividends, for hostility, when it has been vented, commonly provides a firm foundation of trust and co-operation. If you feel insulted by what a client says, use an appropriate “I” statement as a response, e.g. “I feel put down by that remark”. It is essential that you, the carer, remain in control so that client-centred, proactive interventions can be used instead of emotional, reactive ones.

The aim is always to help clients to talk about their rage and perhaps to find appropriate ways of dealing with it or defusing it. Sometimes a referral to another health professional, e.g. a **psychologist,** may be what is required. Some techniques used for managing aggressive incidents, e.g. setting limits or using chemical or physical restraint, activate unpleasant feelings because they strike at the basic values of freedom and dignity.

Specific strategies to manage aggressive incidents

An act of aggression can result in injuries. Violence must be reduced not only for the sake of the clients but also for the protection of the carers and the environments in which you all work. It is helpful to remove trigger events, such as unnecessarily denying clients’ wishes.

Prevention is always preferable to intervention

It is always better to try to prevent aggressive behaviour from occurring at all rather than to intervene once the behaviour has begun. The exception to this rule is where the cause of the aggression is organic. It is just not possible to predict the onset of aggressive actions arising from, for instance, episodes of epilepsy or other forms of cerebral irritation. Such episodes are spontaneous organic events and must be managed as they occur.

In order to handle threatening situations well, you need to learn how to make good decisions quickly. The best decisions will be those based on sound clinical knowledge, your own experience and your observation of how good role models perform.

The first task is to understand the feelings motivating the aggression (Smith 1994).

Fear When people feel under attack, or they perceive a threat to something or someone they value, they may respond aggressively.

Frustration Failure to have needs met or acknowledged can result in aggression.

Manipulation If a person attempts to force others to give or do something that person wants, it is called manipulation.

Intimidation The threat of aggression may be used to gain what is wanted by force.

The second task is to understand the stages involved in an aggressive incident (Bowie 1989).

There are five stages in an aggressive event (see Figure 4.1).

Stage one: triggering event This may be a situation that provokes fear or frustration in the person, e.g. a client loses a valued personal possession and is unable to have the loss taken seriously.

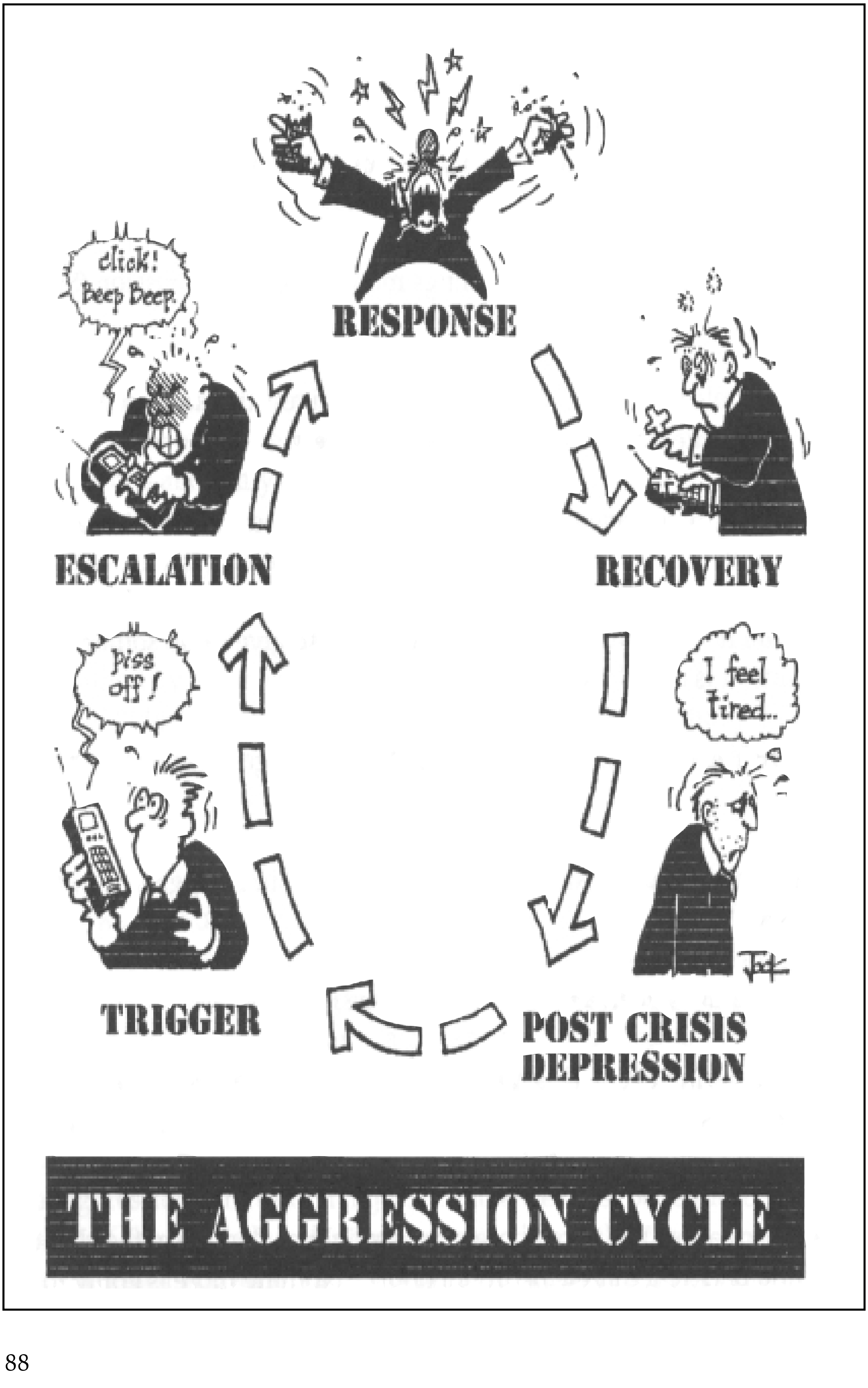
Stage two: escalation The person prepares for fight or flight, e.g. the client takes up a position of defence at the bedroom door — "Nothing more is going to be taken from here".

Stage three: crisis point A physically or verbally violent act occurs, e.g. the unsuspecting night carer attempts to get the client to go to bed and is slapped.

Stage four: recovery The body relaxes and the mind reduces its vigilance, the threat is over temporarily.

Stage five: post-crisis depression The person who has been aggressive often feels tired, depressed or guilty.

Figure 4.1 The aggression cycle



Crisis intervention

There are three phases to managing an aggressive incident — before, during and after the event. ***Before*** an incident you should be implementing preventive measures. ***During*** the incident you must use strategies that will not only assist the client to regain control but will also prevent injury to the client, to other people and to property. ***After*** the event you must discuss the incident with the client with the aim of preventing further episodes and to help the client deal with underlying issues.

Who? The best person to deal with a potentially aggressive situation is someone with whom the distressed client has a positive relationship. The person who is to manage the situation needs to feel reasonably confident.

Where? The best setting is to have as few onlookers as possible and to create as much calm as possible. Discreetly remove any superfluous items that could be used in an outburst.

When? The best time to deal with a crisis is before it becomes a crisis. It is vital for you to develop the ability to recognise when a potentially aggressive client is becoming stressed. Defuse the situation by dealing with their frustrations, making feeling statements, encouraging them to talk about their anxieties, and giving them choices and diversions.

Why? When you can prevent aggression you create a happier and healthier environment for carers, for other clients and particularly for people who have difficulty controlling their temper.

What? The essential element in dealing with a difficult situation is communication.

> First, ***body language:*** Have a relaxed nonthreatening stance, with your arms by your side. Both people should sit down if possible. Use plenty of eye contact but do not stare because staring is intimidating. (For clients of some cultures eye contact is not acceptable so you need to take clues from your client's usual behaviour.) If you are standing, stand side on, unless the client is being intimidating in which case you need to stand in a position from which control can be exerted. Always stand more than an arm's length away from a potentially aggressive person.
>
> Secondly, ***tone of voice:*** Be calm, pleasant, quiet and slow.
>
> Thirdly, ***content of what you say:***

- Acknowledge your client's feelings, e.g. "I know you are cross that you have had to wait."
- Acknowledge your client's issues, e.g. "It seems to you that other people are being attended to before you."
- Offer to assist, e.g. "I will ask how long you are going to have to wait."
- Offer a diversion, e.g. "I will get you a cup of tea while you wait and I will sit and talk with you."
- Offer a choice, e.g. "You can wait or you can come back at a time when you may not need to wait."

If the situation is not able to be defused then leaving the person alone may be the best action, e.g. "I would like to help you but I cannot work out what to do while you are shouting, so I will come back when you are able to speak quietly." Only when people are in danger of physical harm, or if serious property damage is likely, should you use physical intervention and actually restrain the person. Your place of employment should have a policy outlining the procedure to be used. This will vary with the setting — in a community setting the policy may require you to call the police; in a residential setting there may be a team of staff with specialist training who can restrain without harm to the client or themselves.

The physical restraint of people who are acutely ill is performed under a medical "duty of care". This means that medical staff have a responsibility to treat someone whose aggression is the result of illness such as head injury. Psychiatric medical staff have a similar responsibility to provide treatment to anyone whose aggression is a result of a mental illness. A little further on in this chapter you will find a more detailed discussion of the use of restraint with confused elderly people.

After care

After an incident there should be an opportunity for the carers involved to discuss the event, to express any distress they may be feeling (this is called debriefing) and to analyse the management of the event. Constructive discussions can result in further developing the skill of the carers, and in policies and procedures being adjusted, reducing the likelihood of future aggressive incidents.

At a noncrisis time you can discuss with your client who has shown aggressive behaviour the issues of replacing temper with more acceptable behaviour and learning other ways of expressing anger.

Restraint in residential aged care settings

It is of the utmost importance for carers and residents in aged care residential facilities that there be clear policies which govern if and when restraint may be applied. Restraint can be defined as any restriction of a resident's voluntary or involuntary actions for the purpose of preventing harm to self, others or property. Restraint may be perceived as necessary in order to prevent involuntary or unintended movement or uncontrolled action that may cause harm either to the client or to others (Health Department Victoria 1991).

Ethical considerations arise from the principles of duty of care and from ideas of social justice. Some of the precepts which should guide policy development include:

1. A resident's freedom of movement must not be restricted except where the safety of the resident or of others is at risk.

2. All restraint of residents should be based on the assessment and clinical decision-making skills of a medical practitioner or registered nurse. It is the resident's behaviour and its impact, as well as the method of restraint, which are to be assessed.

3. In a crisis situation carers should move to respond quickly to implement an agreed emergency restraint strategy which must be outlined in the procedure manual of the aged care facility.

4. Restraint should never be used merely as a convenience for carers nor as a punishment.

5. Ongoing restraint should be reviewed regularly.

6. All carers must be acquainted with the restraint protocol of the residential care facility and all new carers must be oriented accordingly.

7. Reasons for the restraint choice must be documented in the resident's clinical record.

Reasonable risk

Residents will, on occasions, decide to participate in activities which may involve a degree of risk. Risk taking is a normal part of everyday life and residents should not be deprived of this right unnecessarily. Quality of life involves a degree of risk therefore reasonable risk involves a balance between acceptable independence of movement and protection from possible harm, such as falls.

If you are a worker in an aged care facility, these are some of the questions you will need to consider:

- Is the resident's behaviour harmful or likely to be harmful to the resident?
- Is the resident's behaviour harmful or likely to be harmful to other residents?
- Is the resident's behaviour harmful or likely to be harmful to property?
- Does the situation involve unreasonable risk?
- What is the least restrictive form of restraint needed to restrain the resident in the presenting situation?
- Will a carer's action, or lack of action, constitute neglect?
- Is the assessment based on the individual's needs or is it an automatic, generalised response to the situation?
- Are nursing interventions adequate or does a medical practitioner need to be notified?

Types of restraint

1. Physical
2. Mechanical
3. Chemical

Physical restraint is the rare necessity for carers to physically confine a resident's movements by "hands-on" coercion. This form of restraint is required when there is a need for a spontaneous, crisis-intervention approach, in contrast to mechanical and chemical forms of restraint which are usually planned interventions.

Mechanical restraint is any mechanical device which inhibits the mobility of a resident, e.g.

chairs with fixed tables, beds with safety sides in place, abdominal lap belts, posy vests and "cocoon" bedding.

Chemical restraint is the use of drugs in the management of socially disruptive behaviours, e.g. sedative and psychotropic medications including diazepam and chlorpromazine.

Environmental security, for example high handles on doors and garden fences designed to contain "wanderers", can be used when appropriate. If a broad interpretation of the term "restraint" is used, then limit setting and the selective use of behaviour modification, e.g. time-out agreements, can be viewed as forms of restraint.

Restraint alternatives

Do not underestimate the positive benefits of creative options. Try some of these approaches:

- diversional/music/validation therapies;
- massage;
- a warm bath; or
- a warm drink (not forgetting to offer alcohol if it is not contraindicated).

Questionable forms of restraint

It is usually unacceptable to employ punitive methods, such as:

- applying restraining bandages or sheeting;
- removing the resident's call bell; or
- similar undignified activities.

Psychological intimidation, that is the threat of force or the threat of the withdrawal of privileges, should be prohibited.

Following the instigation of restraint on a resident, the incident should be recorded in the appropriate documents, e.g. a restraint form or an incident form.

Choose the least restrictive restraint to control the resident's unacceptable/dangerous behaviours, without leading to injury. In choosing a restraint you should bear in mind that preserving the resident's dignity is an important consideration.

A crucial question to ask when restraint has been applied is what were the positive and negative effects of restraint? Carers need to reflect on how the situation was handled or what may have been more effective actions. If appropriate, a post-restraint opportunity can be provided for the resident to vent feelings and for carers involved to convey follow-up assurances.

BEHAVIOURAL CHANGE PROGRAM

This specialised approach can be used with selected clients (see chapter 2 for those clients for whom the Solution-focused Behavioural Change Model is not appropriate). The use of a behavioural change approach for a client with aggressive behaviour requires that carers on all shifts receive education about the theory and the way in which it is to be applied in a particular instance. Carers often modify clients' behaviour without conscious intent. Acceptable behaviours, because they are not disruptive, are often not detected and rewarded. Unacceptable behaviours, on the other hand, may result in reinforcement through attention. Behavioural change, as an intended therapeutic intervention, is based on a belief that all behaviour is learned and therefore unacceptable behaviour can be modified or unlearned and replaced with the learning of more acceptable ways of behaving. To bring about behavioural change deliberately, carers must make conscious efforts to reward appropriate behaviours and not attend to inappropriate behaviours. Aggressive behaviours must be corrected with non-negative stimuli, i.e. punishments are never used (Miller 1990). In fact rewards should be incorporated into the agreement, e.g. carers giving lots of attention when the client behaves in a desirable manner.

One effective way to bring about positive change is to negotiate a behaviour change agreement with a difficult client. A behaviour change agreement should state the problem, the expectations of both client and carers and the agreement conditions that specify what will happen when the unacceptable behaviour occurs.

Learning Activity 4.3

BEHAVIOUR CHANGE AGREEMENT

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Think of a nonconfused client you have cared for who persistently met his or her needs in an unacceptably aggressive manner, then fill in the behaviour change agreement below.

BEHAVIOUR CHANGE AGREEMENT

Client's name ____
(use initials only to preserve confidentiality)

Unacceptable behaviour ____
____
____

Acceptable behaviour ____
____
____

Carers' expectations of client ____
____
____

Client's expectations of carers ____
____
____

Agreement conditions ____
____
____

Signatures

Client ______________________Carer(s) ______________________

It is advisable to choose to modify only one problem at a time. A completed behaviour change agreement appears in the following case study.

CASE STUDY

Here is an illustration of how the Solution-focused Behavioural Change Model was used to solve a problem of aggressive behaviour.

Mr Aldo Spano, a 70-year-old wiry, energetic, independent, Italian-born man, had been a widower for 10 years. Since the death of his wife he had lived alone in a large caravan on a corner of his son Tony's farm. Before his retirement he worked as a housepainter. He had an abiding passion for sport, particularly soccer.

Recently Mr Spano contracted influenza so for six weeks his grandson, Mario, went to his caravan twice a day to help with the housework and to bring prepared meals. One morning Mr Spano was wandering aimlessly about the kitchen in his pyjamas and he greeted Mario with, "Is that you Bennie? Is it time to go to Sydney?" Mr Spano was feverish to touch, had a harsh dry cough and seemed to have difficulty in breathing. Mario's parents responded quickly to his phone call; they put Mr Spano to bed and phoned for an ambulance.

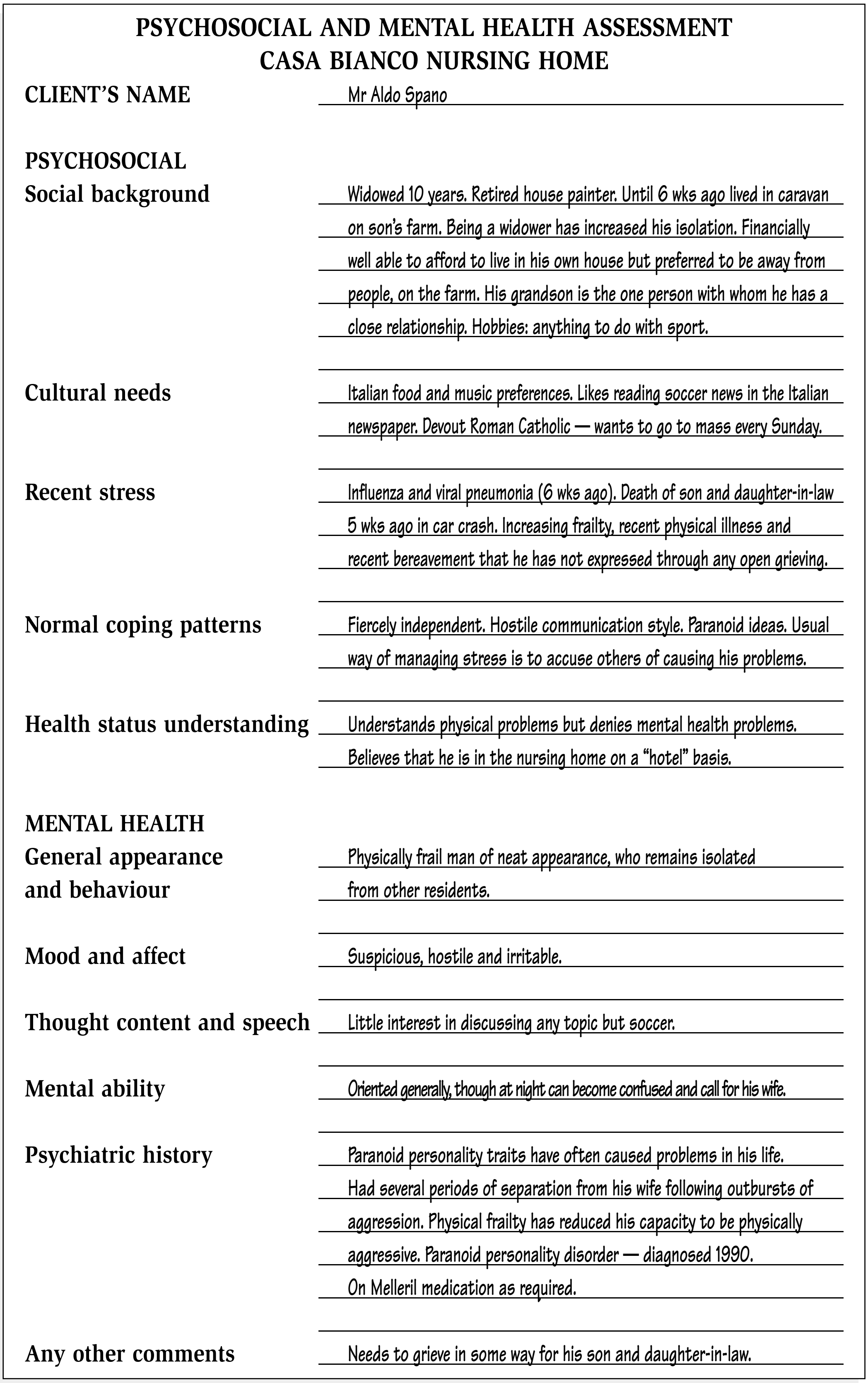
After initial laboratory tests and a chest x-ray Mr Spano was admitted to hospital with a diagnosis of viral pneumonia. He responded well to treatment, but on the fourth day of his hospitalisation a family tragedy occurred when Mario's parents, Tony and Sylvana, were killed in a motor car accident. Mr Spano remained in hospital for a further week and then was transferred to the Casa Bianco Nursing Home.

Mr Spano had a psychiatric history and had been diagnosed with paranoid personality disorder. As a result of this disorder he was constantly suspicious, territorial, rigid and set in his ways. He was mistrustful, convinced people were out to harm him. At one time he had even thought his son was the result of an affair between his wife and the family's doctor.

Mr Spano was on Melleril tablets. (The chemical name for this drug is thioridazine. It is medication that helps dampen down paranoid ideas.) He also required daily Liquifilm eyedrops to prevent dryness and, at times, medicated eyedrops to treat eye infections.

The main problem with Mr Spano was his verbal aggression. He frequently swore at the carers with such remarks as, "Piss off, you bastard. I don't want scum like you near me."

Figure 4.2 Psychosocial and mental health assessment: Mr Aldo Spano



PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT
CASA BIANCO NURSING HOME

CLIENT'S NAME	Mr Aldo Spano
PSYCHOSOCIAL	
Social background	Widowed 10 years. Retired house painter. Until 6 wks ago lived in caravan on son's farm. Being a widower has increased his isolation. Financially well able to afford to live in his own house but preferred to be away from people, on the farm. His grandson is the one person with whom he has a close relationship. Hobbies: anything to do with sport.
Cultural needs	Italian food and music preferences. Likes reading soccer news in the Italian newspaper. Devout Roman Catholic — wants to go to mass every Sunday.
Recent stress	Influenza and viral pneumonia (6 wks ago). Death of son and daughter-in-law 5 wks ago in car crash. Increasing frailty, recent physical illness and recent bereavement that he has not expressed through any open grieving.
Normal coping patterns	Fiercely independent. Hostile communication style. Paranoid ideas. Usual way of managing stress is to accuse others of causing his problems.
Health status understanding	Understands physical problems but denies mental health problems. Believes that he is in the nursing home on a "hotel" basis.
MENTAL HEALTH	
General appearance and behaviour	Physically frail man of neat appearance, who remains isolated from other residents.
Mood and affect	Suspicious, hostile and irritable.
Thought content and speech	Little interest in discussing any topic but soccer.
Mental ability	Oriented generally, though at night can become confused and call for his wife.
Psychiatric history	Paranoid personality traits have often caused problems in his life. Had several periods of separation from his wife following outbursts of aggression. Physical frailty has reduced his capacity to be physically aggressive. Paranoid personality disorder — diagnosed 1990. On Melleril medication as required.
Any other comments	Needs to grieve in some way for his son and daughter-in-law.

USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

Following a thorough assessment Mr Spano's unacceptable behaviour was identified as "persistent verbal abuse toward carers". His explanation was that he couldn't help himself because he had a "short fuse". When asked what "short fuse" meant, he said, "I've always had a bit of a temper."

Therefore, the problem was responding to stress with temper tantrums.

Name the solution

The solution was for Mr Spano to control his temper and be polite.

Look for causes

When asked where he got his temper from, Mr Spano replied, "My poppa was a very passionate man, especially when he couldn't get his own way."

From the psychosocial and mental health assessment the causes were deduced as being:

- poor impulse control as a result of learned behaviour;
- entrenched independence and dislike of having routines disrupted;
- misinterpretation of help as being threatening, because of his paranoid disorder;
- anger and grief at the loss of his family; and
- anger and grief at being admitted to a nursing home.

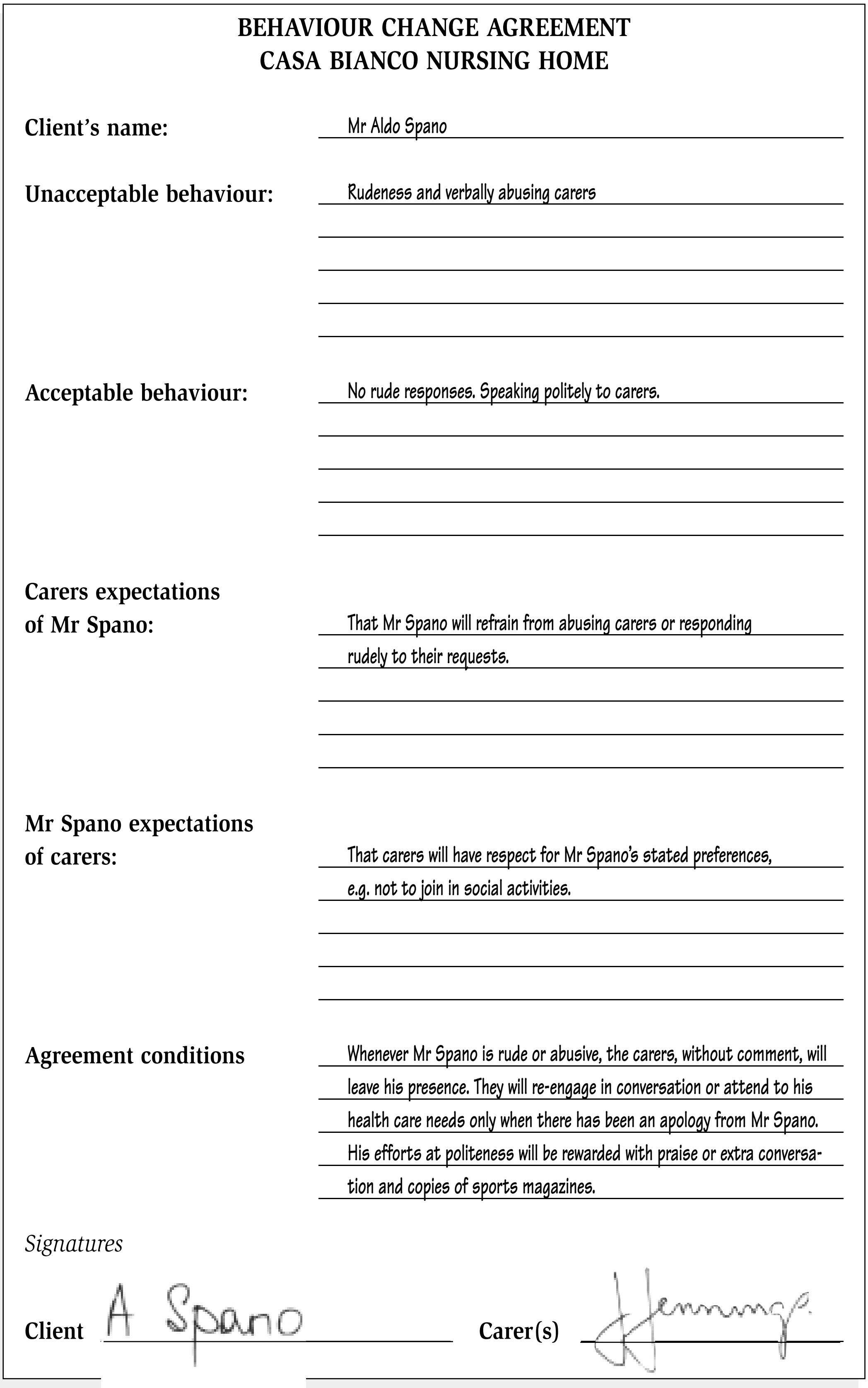
Develop and implement strategies

Carers needed to tell Mr Spano, in a nonconfronting way, using "I" statements, how they felt when they encountered his temper tantrums, e.g. "When you shout at me I feel very hurt because I'm trying to help you."

The next thing was to assess if he was ready to enter into an agreement with the carers to develop strategies to help him overcome his temper outbursts. One of the carers who had established rapport with Mr Spano was selected to make this approach. If Mr Spano was agreeable, then a behaviour change agreement would be drawn up, the aim of which was to get Mr Spano to cease being abusive toward carers and to replace temper outbursts with politeness.

Here is the agreement that was designed for this purpose:

Figure 4.3 Behaviour change agreement: Mr Aldo Spano



BEHAVIOUR CHANGE AGREEMENT
CASA BIANCO NURSING HOME

Client's name: Mr Aldo Spano

Unacceptable behaviour: Rudeness and verbally abusing carers

Acceptable behaviour: No rude responses. Speaking politely to carers.

Carers expectations of Mr Spano: That Mr Spano will refrain from abusing carers or responding rudely to their requests.

Mr Spano expectations of carers: That carers will have respect for Mr Spano's stated preferences, e.g. not to join in social activities.

Agreement conditions Whenever Mr Spano is rude or abusive, the carers, without comment, will leave his presence. They will re-engage in conversation or attend to his health care needs only when there has been an apology from Mr Spano. His efforts at politeness will be rewarded with praise or extra conversation and copies of sports magazines.

Signatures

Client A Spano **Carer(s)** Jennings

Strategies that helped Mr Spano keep to the agreement were:

- Carers took every opportunity to acknowledge his grief, e.g. encouraging him to talk about his lost loved ones and encouraging him to express his feelings appropriately.
- Mr Spano was encouraged to find his own self-regulated coping devices which, together with the support of the carers, helped him to say what was irritating him without resorting to losing his temper as a first choice.
- Carers always gave Mr Spano advance notice of their intended interventions and full explanations of any actions, so as to allay any suspicious thoughts he may have been experiencing.
- Whenever Mr Spano stated a problem or difficulty, without becoming angry and abusive, carers responded promptly to his request, thereby reinforcing that temper is unnecessary.
- Mr Spano was given complete decision-making responsibility to decide in which activities, if any, he would be involved.
- As his physical health improved, Mr Spano was agreeable to taking on responsibility for soccer pool entries for himself and another soccer enthusiast in the nursing home.

Reward success

Whenever Mr Spano acted politely towards carers, they made a great fuss of him, letting him know how happy they felt to be treated well. Eventually, he developed control of his behaviour and no more rudeness or abusiveness was forthcoming. The ultimate reward to acknowledge the success of the agreement was for the carers to organise an outing to the soccer finals for Mr Spano and his grandson.

YOUR OWN CASE STUDY

NB Do not write in this textbook.
Photocopy the pages and complete the case study on the photocopy.

These three pages have been prepared for you to write your own case study showing how the Solution-focused Behavioural Change Model can bring about a change in behaviour. Maybe you have been lucky enough to work somewhere that this kind of solution-focused problem-solving plan was used and you can simply write down what happened. But it is more likely that a problem arose that was solved in a different way or that was not solved at all. This is your chance to show that you understand solution-focused problem solving by showing how you would have gone about solving the problem.

Think of a client whom you have cared for who had aggressive behaviours. Jot down a few notes about the person. Carefully fill in the psychosocial and mental health assessment format. Work out what the client's problem was and state it succinctly then continue through the Solution-focused Behavioural Change Model.

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT

Client's name ____
(use initials only to preserve confidentiality)

Background (i.e. reason for this assessment)

____
____

Psychosocial
Social background

____
____
____

Cultural needs

____
____
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Recent stress

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Normal coping patterns

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Health status understanding

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Mental health

General appearance and behaviour

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Mood and affect

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Thought content and speech

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Mental ability

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Psychiatric history

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Any other comments

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USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

Name the solution

Look for causes

Develop and implement strategies

Reward success

CONCLUSION

In forming a general policy for managing aggression you must consider a number of factors to ensure a balanced and comprehensive approach:

- What training should carers request?
- What is the state/territory policy on restraint?
- What arrangements are made when a carer is physically assaulted?
- What are the client's rights?

Even so, we must recognise that, no matter how watertight the policy, how experienced the carers or what measures are taken to provide a safe environment, there will still, inescapably, be times when violence occurs.

Wrigley (1995) says, "Without written policies and procedures, both management and carers are in a legally vulnerable position." The aim when dealing with clients who are likely to become aggressive is to have in place a range of policies for intervention and a series of prevention strategies that can be employed when aggressive incidents emerge. Unconditional positive regard is focused on acknowledging clients' feelings of anger while not condoning verbal and physical aggression as an acceptable means of dealing with anger. The task of carers is to assist clients to express anger in constructive ways that do not threaten other people.

CHAPTER SUMMARY

Aggressive behaviours often occur with little warning and can escalate rapidly into a crisis event. This can force carers to choose the first alternative they think of, instead of contemplating the choice of alternatives (Antai-Ontong 1988).

Sometimes carers use the defence mechanisms of denial and avoidance by denying the importance of the danger and therefore their responsibility for doing something about it.

There are two types of anger, open anger and hidden anger. With openly expressed anger an aggressive act begins with a trigger or a stimulus that is usually a threat to the needs of the person who becomes angry. This trigger can be an internal or external provocation. The trigger is accompanied by observable clues, such as mild personal insults, swearing or yelling. These should alert you as the carer to the client's anger and heightened sense of arousal, preferably before a crisis situation occurs. At this stage recognising that a problem exists should result in your decision to intervene and manage the aggressive feelings before these are followed by aggressive actions.

Hidden anger occurs when clients experience but do not show anger. Strong feelings of hostility can play havoc with logical thinking and with reasonable behaviour, and as a result, will interfere with the carers' attempts to care for that client. Suppressed anger, if not addressed, can turn into rage. Often such rage is turned inward, especially if the person is also mentally disturbed, and can result in self-mutilation or a suicide attempt. Secretiveness amongst carers and take-it-for-granted customs and practices aggravate clients.

Ideally, you should take preventive measures so that there is a diminished prospect of severely disruptive incidents occurring. While it is acknowledged that this is usually not possible with organically induced episodes of aggression, early detection of the client's agitation is the key to early intervention and prevention of violence. Therefore, it is important for you to observe your clients' behaviour even while other tasks are being performed. This prevents an escalation of aggression, with its risks of injury and damage to people and property.

Chapter five

THE PERSON WHO IS DEPRESSED

LEARNING OBJECTIVES

At the conclusion of this chapter you should be able to:

- recognise the difference between episodes of despondency and depression
- understand that the causes of depression are both external and internal
- demonstrate knowledge of the grieving process
- identify warnings that a person may be thinking of attempting suicide
- make useful approaches to clients with withdrawn/depressed behaviour

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INTRODUCTION

Depression, which used to be called “melancholia”, directly affects millions of people around the world. It also affects indirectly those who are friends and relatives of the sufferers. Even though women are at higher risk than men, depression strikes people of all ages, races, creeds and classes. In fact depression is the most common mental illness. It is particularly common in elderly people.

Depression comes in many forms and degrees of severity: mild, moderate, severe and profound. Mildly depressed people can be talked with fairly easily and are responsive to appropriate counselling and environmental interventions. Often mild depression is due to disturbing events in a person’s life, e.g. being made redundant or the break-up of a close relationship. Seriously depressed people, on the other hand, have substantial mental changes that make the intensity of their gloominess more difficult to deal with. Usually serious depression results from both environmental stimuli and chemical imbalances in the brain, although there are some people whose depressive episodes arise solely from an imbalance of chemicals in the brain pathways.

RECOGNISING DEPRESSED BEHAVIOURS

Literature contains astounding stories of people who overcome unendurable adversity for long periods of time and who, despite episodes of depression, emerge triumphant. One such man was Jean-Dominique Bauby, one-time editor-in chief of *Elle* magazine. Following a massive stroke, he found himself totally paralysed, incapable of feeding himself or breathing unaided, with his left eyelid as his sole means of communication, but in full possession of his faculties. Despite everything, he worked out a communication code by blinking his left eyelid, wrote his award-winning book, *The Diving Bell and the Butterfly,* and started an international association for all those suffering from “locked-in syndrome”.

Most people experience feelings of sadness at some time during their lives. Such sadness is usually related to some kind of loss or disappointment and, as such, is not an abnormal state. It is a fleeting experience. Depression, however, emerges as an inappropriately despondent mood of great intensity and duration. It interferes significantly with the person’s ability to cope with daily living activities. Therefore, the fundamental difference between a “fit of the blues” and depression is the intensity and duration of the experience.

Depression is often overlooked in an environment that judges people, e.g. “He should snap out of it.”, “She should make an effort.” Depression is an illness not a case of laziness or self-indulgence.

Depression is a distressing and disabling condition. The best way to pick up the feelings of sadness that indicate true depression is to listen actively, that is, suspend your judgement and listen to what the depressed person is actually saying. It is most important for health workers to observe for and report on early signs of depression so that assistance can be provided for this painful yet treatable condition (McKissock 1991).

Learning Activity 5.1
RECOGNISING DEPRESSION

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

From the following lists of words circle the ones that describe aspects of depression.

sad
agitated
playful
insomniac
excitable
pessimistic
well groomed
withdrawn
extroverted

hostile
talkative
restive
overweight
drowsy
optimistic
anorexic
expressionless
dependent

Check your answers from the following list of the signs of depression:

- Overall sad mood
- Feelings of misery
- Diminished interest in, or pleasure from, activities
- Significant weight loss or weight gain
- Loss of, or increase in, appetite
- Insomnia or other disturbed sleeping patterns
- Speed-up or slow-down of physical processes
- Fatigue, loss of energy
- Feelings of worthlessness and excessive guilt
- Inability to think straight or concentrate
- Chronic indecisiveness
- Recurring thoughts about death or suicide, plans to attempt suicide

Depressed people look depressed, act depressed and talk depressed. William Styron (1991), a writer, experienced his first episode of depression when he was 60 years old. An extract of his description of what happened to him is printed below. The description illustrates the diversity of symptoms of depression. It gives you some clues as to what you need to look for in deciding whether a client is depressed.

> . . . I began to experience a vaguely troubling malaise, a sense of something having gone cockeyed in the domestic universe I'd dwelt in so long, so comfortably. . . It was not really alarming at first, since the change was subtle, but I did notice that my surroundings took on a different tone at certain times: the shadows at nightfall seemed more sombre, my mornings were less buoyant, walks in the woods became less zestful and there were moments when a kind of panic and anxiety overtook me, just for a few moments, accompanied by a visceral queasiness . . . [Later on] I felt a kind of numbness, but more particularly an odd fragility as if my body had actually become frail, hypersensitive and somehow disjointed and clumsy, lacking normal co-ordination, and soon I was in the throes of a pervasive hypochondria. Nothing felt quite right with my body; there were twitches and pains, sometimes intermittent, often seemingly constant . . . Anxiety and feelings of dread were always present now; a fidgety recklessness that kept me on the move, somewhat to the perplexity of my family and friends. I found myself eating only for subsistence and my sex drive disappeared, as did sleep. Exhaustion combined with sleeplessness is a rare torture.

It is reasonably easy to see moderate, severe and profound depression. People who are depressed look dejected and sad. They may cry often for no apparent reason. Often they do not eat, and sleeping is disrupted. Weight loss and constipation are additional problems that emerge.

More difficult to detect is depression in clients who mask their condition with somatic symptoms. These are the clients who develop headache or back pain or some other elusive complaint. The client does not experience marked change in affect until the physical symptom, or depressive equivalent, is successfully treated, that is to say, until the physical symptom disappears. The presence of the physical symptom is a smokescreen that masks the depression underneath.

Masked depression is more difficult to detect

Some people develop depression after discharge from hospital. This type of depression is often in reaction to feelings of deep loss, e.g. as a response to the disfigurement of mutilating surgery. Sometimes elderly people develop depression after admission to nursing homes. This could be connected to the loss of their own home, their independence, their physical abilities, the lifestyle that they have lived for so many years. When clients are slow in their actions, slow to talk, slow to respond to questions, or make responses that are few and brief, carers should suspect that the person is more than mildly depressed. When a depressed person becomes preoccupied with dark thoughts, burdened by guilt, plagued by (often imagined) imperfections, a more serious depression has developed. Another feature to be on the lookout for is resistance to joining in with others and the strong wish to remain isolated, sometimes in bed with the covers over the head.

Vulnerable times for depression

Depression may or may not be linked to particular events. Psychological, social or environmental events that can be linked to depression are:

- the death of a loved one or the end of a close relationship;
- postnatal depression — estimated to afflict one in five women who give birth;
- major surgery;
- traumatic events such as loss of income or career;
- mid-life crisis; and
- late-life crisis — serious depression can be caused in old age by retirement, physical incapacity, loss of spouse, the “empty nest syndrome” after the children leave home, or the loss of a clear role in life.

Can depression be normal?

Most people get depressed at some time in their life, especially following a loss or some other traumatic life events. That type of depression is a normal human experience. Depressive illness is not normal. It can cripple people’s ability to live their lives, it can even cause them to kill themselves. Sometimes normal processes of adjustment become fixed and people need assistance to make sense of their lives and to move on to the next parts of their lives.

THE GRIEVING PROCESS

Grieving is the process of psychological adjustment experienced by people during periods of loss. Grieving can also occur when people are preparing to die. The grieving process varies from culture to culture. In some cultures wailing is essential and people are encouraged to be overwhelmed by grief; in others it is important to be under control in public and to grieve in private. Sometimes special clothes or other signs of mourning are worn or rituals are performed.

Mourning rituals are often performed to ensure that the dead person’s spirit or soul reaches the spirit world. If people are prevented from expressing grief in culturally appropriate ways, depression may develop. If mourning rituals are not performed correctly then the living person responsible may become depressed because of the guilt they feel for not assisting the dead person’s spirit. In these cases the correct performance of ritual alleviates the depression (Rice et al. 1994).

Emotions experienced during grieving

It is very common for people to experience a succession of different emotions at different times in the grieving process. There is no “correct” order in which to experience these feelings; sometimes several different emotional states occur on the same day.

Dr Elizabeth Kübler-Ross (1975) described the emotions of grieving under the following headings:

Denial

A sudden death often causes such a shock that the bereaved person is unable to understand what has happened. They may appear to be carrying on as usual but are acting only in an automatic way. Initially the loss may be too hard to bear and the person may deny that it has happened, or act as if it has not affected them. This is protective at first but unhealthy if it leads the person to avoiding the necessary adjustment.

Anger

Anger may replace the initial denial — “Why has this happened to me?”, “It’s not fair, I don’t deserve it.”, “If they had done the right thing this would not have happened.” Anger is often displaced onto those around, making it difficult for family and friends to continue to offer support. Sometimes this can result in rejection of the grieving person.

Bargaining

Another grieving behaviour is bargaining — “Dear God, if you let me live, I’ll go to church every week.” or “Please take me to be in heaven with him.” This bargaining, although it seems unrealistic, is a stage in coming to acceptance of the loss.

Depression

An overwhelming feeling of sadness pervades the person’s day, often with long bouts of crying (especially in the early stages of grieving) and feelings of hopelessness — “I wish I were dead.”, “Why do I keep on living? I’m too old.”, “There is nothing worth living for.” Depression also includes feelings of guilt — “It’s all my fault.”, “She wouldn’t have died if I had done this or that.”, “I’m the cause of the trouble.” Depression may be seen as resignation — “What else can you expect?”, “There isn’t anything else you can do about it.”, “Life will always cause loss.”

Acceptance

Eventually the person may, in their own time, come to an acceptance of the altered circumstances. In the situation of loss of a spouse or child this may take many years. What is important is to help the person to understand that each of these feelings is a valid expression of their grief and to encourage them to continue the difficult process of adjustment.

People who are dying are grieving, as well as their family and friends. For the client with a terminal illness, dying is a process that takes place over a period of time that will vary for each individual. Clients may ruminate over the negative aspects of death, e.g. fear of poor pain control. There are usually signs which indicate that the body is preparing itself for the final stages of life. Even when many of these signs are present it is difficult to predict the length of time before death (Allan 1993).

Learning Activity 5.2
THE KÜBLER-ROSS MODEL OF THE GRIEVING PROCESS

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

When Mr Fong was almost 79 years old he died suddenly at home of a heart attack. Mrs Fong, 66 years old, was in the next room when Mr Fong fell but she knew instantly that he had died. They had been married more than 44 years.

Since migrating to Australia from Hong Kong 30 years before, they had earned a reasonable living with a small clothing factory where they had several employees. Mrs Fong had discovered some time before her husband's death that he was having an affair with a female machinist. Mrs Fong had remained loyal to him in her duties as a business partner and homemaker but became distant in their personal relationship.

Based on your understanding of the grieving process, what emotional and behavioural responses might Mrs Fong experience in the first few months after her husband's death?

Mrs Fong is likely to experience immediate feelings of shock and denial, followed by a range of mixed reactions including guilt, regret and relief. In turn, these mixed feelings and unresolved issues about her relationship with her husband could lead to depression.

Anyone who has experienced one or more losses, of whatever kind, has to endure some form of grief process. If the process gets blocked a serious depression may develop. People who are most at risk of serious depression occurring are those with:

- intense guilt feelings;
- no perception of support;
- no attempt to adjust to a new life after three months; and
- a previous history of depression.

A useful concept, when trying to assist someone who is grieving, is to encourage the person to incorporate the dead person into their life (White 1988) — "If Jack could see you now what would he notice about you? How can you live your life so that you are the person he appreciated?"

SUICIDE RISK

When people are afflicted with a serious, prolonged depression, ultimately the whole body is sapped and drained. With their minds turned agonisingly inward, these people are usually dangerous only to themselves. Their responses are slowed down, their energy levels dive. Murderers externalise their violence; profoundly depressed people internalise their violence.

Any client who is severely or profoundly depressed should be suspected of having suicidal ideas. You need to be constantly vigilant. If necessary the client should be **specialled**, on a one-to-one basis, or admitted to a psychiatric unit.

The following can be warning signs of suicidal thinking:

- acting very calmly after a period of agitation;
- making statements that indicate a farewell, e.g. "We've been good friends, haven't we?", or indicating that things are all in order now, e.g. "You won't have to worry, I've paid for my funeral.";
- being evasive about future events;
- expressing ideas of guilt e.g. "I'm not worth bothering about.";
- giving away possessions and making wills; and
- stating that they are going to kill themselves.

It is critical, indeed life saving, for you to observe for ideas of suicide in depressed people and you should treat very seriously any indication that a person may be suicidal. A danger time for suicide attempts occurs when the person who has been profoundly depressed begins to improve because at that stage they are more able to act on their feelings. You may need to seek an expert psychiatric assessment, for example, by contacting a psychiatric crisis assessment team (see chapter 6).

THE CARER AND DEPRESSION

As we have said already, mild depression is common. You may have experienced it yourself at some time. Your own experience of depression can be helpful in identifying with the psychic pain that your depressed client is feeling. It can help you to realise, for instance that there is no point in telling a depressed person to “pull your socks up” or “look on the bright side of things” because the nature of depression makes that an impossible thing to do. Jollying people along is often done because the carer is uncomfortable with the feelings engendered by the sight of a client who is withdrawn, sad and uncommunicative.

It is crucial that you recognise depression and that you do not ignore it. Nor should you underestimate its crippling effects.

Whenever a seriously depressed client successfully ends their misery by taking their life, it is inevitable that carers will have mixed feelings about the event. On the one hand it might be seen as a merciful release for a tortured human being, but, on the other hand, there are feelings of guilt that one was not able to prevent the suicide.

The more you understand yourself the more likely you are to anticipate how you will respond to different situations and the more you can prepare yourself for those situations. It is also true that the better your understanding of yourself the better you will understand others. As you gain life experience and self-awareness you will have a greater ability to interpret successfully the behaviour of other people (Miller 1990).

DEPRESSION AND THE HEALTH CARE ENVIRONMENT

Physical environment

Depression will reduce in an environment that is safe, clean and cheerful and indicates to clients that they are “worthwhile”. The quality of the furnishings and the pleasantness of the outlook will all communicate value to the depressed person because they seem to say, “Look around you. You are worthwhile. We are trying to make things really nice for you.”

Clients need variety: outings and visits, activities and visitors. However, too much noise and activity can overwhelm a depressed client. Depressed people can be very sensitive to loud noise and boisterous behaviour. As the carer you need to observe each client’s responses to the surroundings and the various activities so that you can ensure that the environment is interesting but not stressful.

Social environment

Depression feeds on social isolation. People should be encouraged to communicate and to develop caring relationships. It is through relationships with other people that we develop feelings of self-worth. In residential care the staff often become the people the residents feel closest to, therefore the quality of the relationship between staff and residents may help residents avoid depression. People in long-term care need the opportunity to feel worthwhile by having a say in their own lives. They should be consulted about their preferences and involved in decision making as far as they are capable.

It is very important to encourage your clients to maintain their relationships with family and friends. You may also need to encourage the family and friends to keep your client as part of their lives. Perhaps you could help your client to acknowledge birthdays, festivals and other significant events. Try to make sure that there are visiting rooms at your establishment that are attractive and easily available. If you are working in a client's home, try to make the environment as pleasant as you can without changing it in ways that will upset your client or the client's family and friends. Your aim is to create pleasing and comfortable surroundings that will make your client's family and friends feel happy to visit.

Psychological environment

As already noted, whenever people suffer significant loss in their lives, whether it be loss of role such as after retirement, loss of a loved person, or the feeling of loss accompanying the physical disabilities that may develop with ageing, then the opportunity and encouragement to grieve is essential. Depression develops when grieving is prevented, often by well-meaning people who fail to see grieving as a process of adjustment.

CARING INTERVENTIONS

Caring for depressed people can be daunting. It is difficult not to be infected by the feelings of hopelessness that are part of depression; it is hard to maintain creative and beneficial caring approaches. Caring can be most effective in the development of an environment that encourages people to respond in positive and healthy ways.

Communication

Another essential in caring for a depressed person is effective communication. It is often very difficult to spend time trying to communicate with a depressed person. Their answers are very slow and difficult to hear and discourage further conversation. Because, as we have seen already, depression emerges from a combination of anger, anxiety and a complexity of unmet needs, telling a depressed client to "cheer up" is not useful. Such well-meaning remarks may actually add to the depressed person's feelings of helplessness and worthlessness because they are unable to overcome their misery.

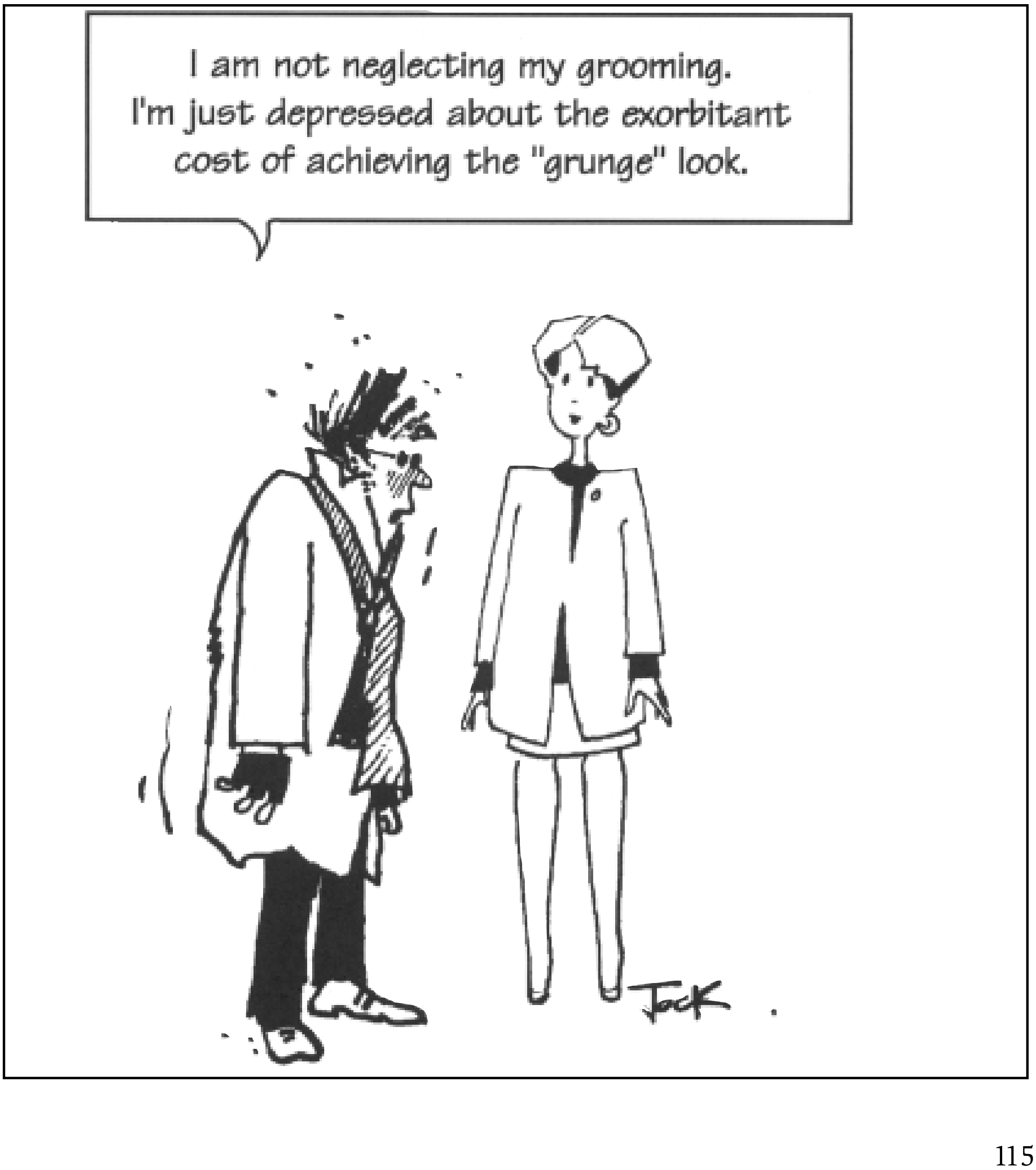
It is important to develop the skill of being able to continue to spend time with a depressed person. You must be able to tolerate silence. Studies have shown that carers who are a sustaining presence for their clients, through difficult times, are a comfort to those who are depressed. Being a sustaining presence means being physically and empathetically present, just sitting with a client, perhaps holding a client's hand, but not necessarily saying anything if that's what you feel your client wants. You are just being there for your client. However, you should take any opportunity that comes along to encourage a person with depression to talk because it is only through talking (however little that may be), and being listened to, that a depressed person will begin to look outward, will start to overcome the depression and will resume involvement in their former activities.

Hygiene and grooming

When people are depressed, the whole body, physically and mentally, slows down. Invariably this results in the neglect of hygiene and grooming, even though prior to the depression the person may have been very fussy. As a carer, you will be able to judge how much assistance is required to encourage, supervise or actually take over the washing of hair, paring of fingernails, changing of clothing and other areas of self-care that the client is unable to attend to.

Activities

The mood of a depressed person will vary throughout the day but is often worse in the morning. At times when the mood is lighter encourage the person to do something on their own that they particularly enjoy, to join in group activities and to develop an interest in others. Focus on the parts of the day when they are most receptive. Praise every effort that is made, no matter how small. If circumstances and time permit, you could accompany a client on an outing of their choice, e.g. to a museum.



Counselling or therapy

Sometimes more skilled help is needed, particularly when there are issues from the past that need to be dealt with. This is the time to seek the services of a counsellor or therapist. There are many different types of therapy — individual, with the family, or in a group with others suffering similar problems. Therapy usually includes the opportunity to express feelings of sadness, anger, and so on that are associated with past events. The person is then assisted to understand how they responded to these events by developing behaviours such as depression, and, finally, how they may now develop new, more fulfilling, responses. Where depression arises from more physical causes counselling can focus on finding rewarding experiences that counter despair.

Medication

There are occasions when the depression is so severe, and the person is suffering so acutely, that they have stopped caring for themselves and are at risk of developing suicidal ideas. At these times medication is needed and may be life saving. Antidepressant medication may take some time to become effective so it is very important to observe the person closely during this period for any further deterioration in their condition. Make sure that you know what side effects the antidepressant medication may have so that you can be alert for them and report on them if they occur.

Electroconvulsive therapy

Very occasionally a person does not respond to medication, or is too much at risk of suicide to wait for the medication to become effective. In these cases electroconvulsive therapy (ECT) is a life-saving treatment, effective in 80 per cent of cases. Usually the person is treated in a psychiatric hospital or unit for specialist care. ECT is safe and effective and has very few side effects when administered by specialists to selected clients.

Follow-up support

A person who has experienced severe depression may continue to be at risk at times of crisis and therefore should be encouraged to seek psychological support at these times. There are a number of self-help organisations such as GROW and ARAFEMI (Association of Relatives and Friends of the Emotionally and Mentally Ill) — both listed in the telephone book — that offer this support.

CASE STUDY

Here is an illustration of how the Solution-focused Behavioural Change Model was used to solve a problem of depression.

Millie Johnston was an 82-year-old woman with severe arthritis and consequent difficulty with movement. Her husband Frank, 79 years old, was no longer able to care for her alone so arrangements were made for a team of workers to come to Frank's and Millie's home to help him: a home help for domestic work, a personal care assistant for showering and hygiene needs and regular meals on wheels so that Frank didn't have to cook very often.

During the first weeks after the new arrangement began Millie was bright and cheerful and much liked by the care team. She often gave the team members little gifts. Then, over a period of four weeks, she became increasingly grumpy, with many little complaints. She was very reluctant to get out of bed and she refused to go on outings that Frank arranged, saying that her arthritis was "too bad today". When her personal care attendant greeted her each morning, Millie replied with, "I'm still here". She began squabbling often with Frank. On two occasions the personal care attendant arrived to find Frank with tears in his eyes saying, "My Millie has never been like this before. She is talking about all these unpleasant things that happened years ago that I thought were forgotten."

Some of the care team began to see Millie as a difficult person to care for and occasionally made negative comments about her, such as, "Why does she always talk about how she was in the army during the war? Why doesn't she talk about anything cheerful?" After she accused one of the team of taking a personal item that had been given as a present, the team felt even less positive towards her.

One day Millie and Frank had a letter from their only son, John, who lived interstate with his family. The letter said the family would not be coming to visit at Christmas time. Millie burst into tears and began to blame her daughter-in-law saying, "She's never liked me, that's why she took my son and grandchildren away."

One of the care team sat with Millie and encouraged her to talk about her family, finding out about her grandchildren and anything else Millie wanted to talk about. After a while Millie began to say how unhappy she was, how she had tried hard to be positive about the new arrangement because she knew that Frank could no longer care for her alone, but the days had become more and more bleak and she really wished she were dead. The carer let Millie cry and held her hand for comfort.

The care team decided it was time for a reassessment of Millie to see how she was adapting to the new arrangements.

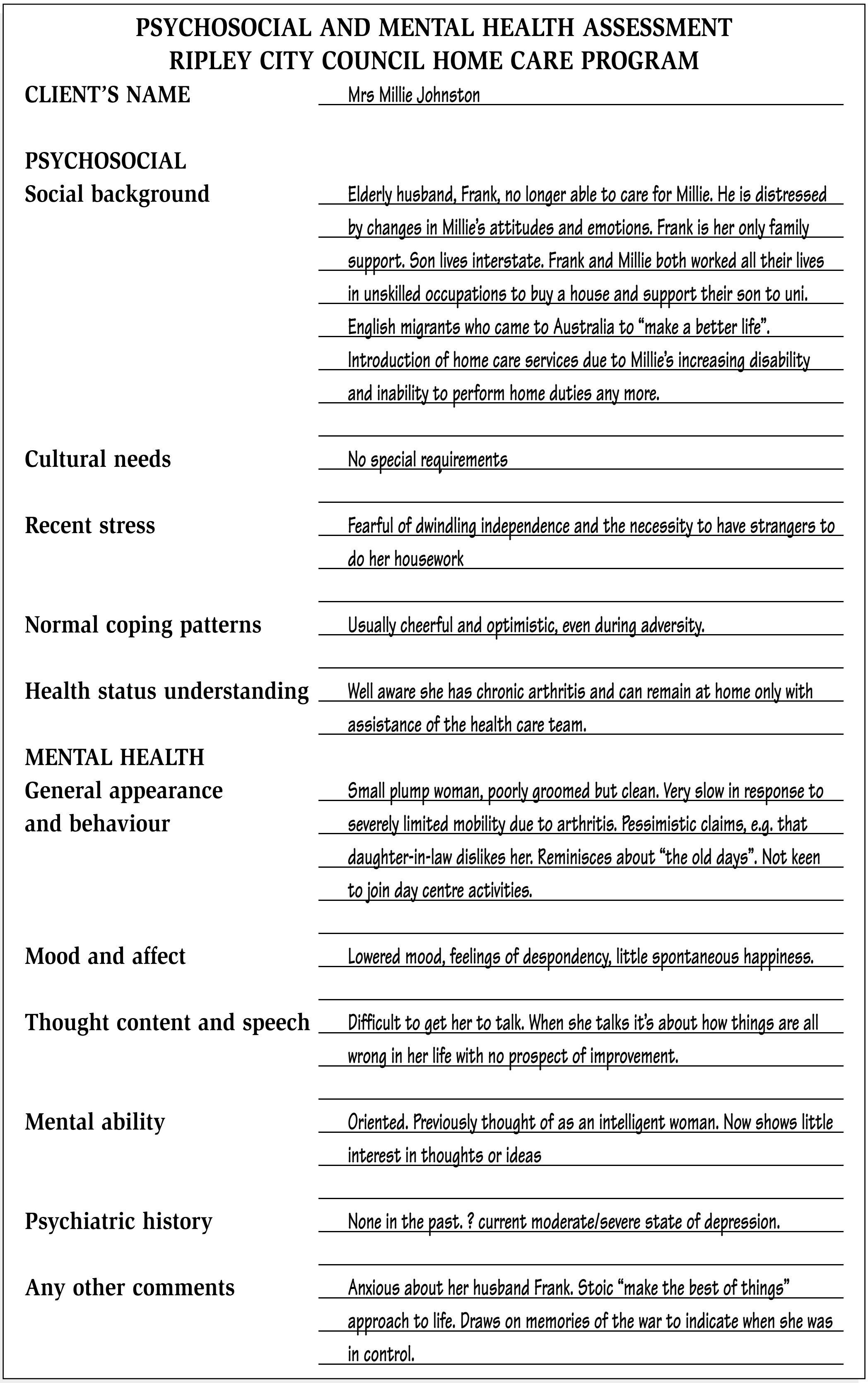


Figure 5.1 Psychosocial and mental health assessment: Mrs Millie Johnston

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT
RIPLEY CITY COUNCIL HOME CARE PROGRAM

CLIENT'S NAME	Mrs Millie Johnston
PSYCHOSOCIAL	
Social background	Elderly husband, Frank, no longer able to care for Millie. He is distressed by changes in Millie's attitudes and emotions. Frank is her only family support. Son lives interstate. Frank and Millie both worked all their lives in unskilled occupations to buy a house and support their son to uni. English migrants who came to Australia to "make a better life". Introduction of home care services due to Millie's increasing disability and inability to perform home duties any more.
Cultural needs	No special requirements
Recent stress	Fearful of dwindling independence and the necessity to have strangers to do her housework
Normal coping patterns	Usually cheerful and optimistic, even during adversity.
Health status understanding	Well aware she has chronic arthritis and can remain at home only with assistance of the health care team.
MENTAL HEALTH	
General appearance and behaviour	Small plump woman, poorly groomed but clean. Very slow in response to severely limited mobility due to arthritis. Pessimistic claims, e.g. that daughter-in-law dislikes her. Reminisces about "the old days". Not keen to join day centre activities.
Mood and affect	Lowered mood, feelings of despondency, little spontaneous happiness.
Thought content and speech	Difficult to get her to talk. When she talks it's about how things are all wrong in her life with no prospect of improvement.
Mental ability	Oriented. Previously thought of as an intelligent woman. Now shows little interest in thoughts or ideas
Psychiatric history	None in the past. ? current moderate/severe state of depression.
Any other comments	Anxious about her husband Frank. Stoic "make the best of things" approach to life. Draws on memories of the war to indicate when she was in control.

USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

The assessment suggested the problem — Millie was experiencing sadness and emotional withdrawal from daily life in response to significant losses. Her doctor was notified of these observations. The doctor agreed that Millie had a significant lowering of mood.

Name the solution

The solution for Millie was to overcome her depression and become again a cheerful and friendly person. Another task for her was to develop a new way of being a wife to Frank.

Look for causes

The carers felt that Millie's behaviour was brought on by a number of social and psychological factors:

- loss of independence because of her arthritis;
- loss of a close relationship with her husband because of her inability to do the things she used to do;
- loss of her role as mother and grandmother because her family lived interstate;
- loss of support from some members of the care team who judged her as "difficult"; and
- loss of feelings of "worth" due to "ending up like this".

These losses together added up to a major personal and social upheaval in her life.

Develop and implement strategies

Following discussions including the doctor, the carers and Millie, a decision was made that it would be of more benefit for Millie's long-term mental health for her to be assisted to overcome the depression without medication, and thereby to make a better psychological adjustment to her new circumstances. This decision would be reviewed regularly with Millie to make sure that she was making progress and that medication was not necessary.

The aim was to return to Millie feelings of self-worth and to assist her to feel more contented about life.

Strategies were developed in the following areas:

Millie's feelings of sadness

When the carers were at Millie's house they encouraged her to talk about how she was feeling by making statements such as, "You must be missing the things you used to do.", "It sounds to me as if you are feeling a bit sad today.", "It's hard to be cheerful when you feel sad inside, isn't it?"

If Millie was grumpy, the carers would say, "I like caring for you Millie, but I find it a bit hard when you are criticising me."

Millie's relationship with Frank

Millie was encouraged to think about how Frank was feeling: "It must have been very hard for Frank to admit he could not manage to care for you on his own any more." She was also encouraged to talk about the good times she and Frank had shared. Frank was asked to bring out their photo album so that Millie could show her wartime photos. The carers encouraged Millie to think of ways that she and Frank could still have a loving relationship even though her disabilities were growing increasingly worse. When Millie did make an effort the carers gave her lots of positive feedback.

Millie's relationship with John and his family

Millie remained very angry with her son and especially with her daughter-in-law whom she continued to blame in spite of the carers encouraging her to see the situation from her daughter-in-law's position.

The carers discussed this matter with Frank and suggested that Frank encourage John and the grandchildren to keep in contact, even though, at this stage, Millie was not able to respond positively. Carers explained to Frank and to John, on the telephone, that Millie was quite depressed and that this anger with him and his wife was a sign of her depression and not something she could overcome easily. The carers encouraged Frank and the rest of the family to remember the good times with Millie and not to focus on present difficulties. The carers demonstrated that they understood this was also a very difficult time for Frank, hard for him to understand, and that he was managing well.

Daily activities

It was explained to Millie that the carers understood that, due to her depression, she did not feel like doing anything during the day. It was also explained that if she did make the effort then she would feel better afterwards. Activities were sought that she might enjoy and eventually she agreed to be picked up by the adult care centre bus to attend a singalong. It was arranged that there would be songs from the war on the program.

Frank and Millie had a neighbour who was blind but could get around quite well. The carers asked Millie if she would be agreeable to reading to her blind neighbour if the neighbour came to Millie's house. This encouraged Millie to feel worthwhile because she could still do things for other people.

Pain control

Many of Millie's complaints centred around the pain she suffered. There was disagreement amongst the carers as to the level of pain she was experiencing. The carers talked to Millie about her pain and together they decided that Millie's experience of pain was linked to her depression as well as to her arthritis. They agreed to handle Millie very carefully and to use a variety of strategies for relief, such as local applications.

Reward success

Gradually Millie began to respond to the different strategies as she worked through the losses in her life and came to a feeling of acceptance about the way she was going to have to live. Whenever she spoke about her feelings to someone on the care team they acknowledged her efforts: “It must be hard to talk about things that are so painful. You are a very brave woman, Millie.” Whenever she made a particular effort to show her love for Frank, she was given positive feedback: “What a caring person you are, Millie, you are so concerned for Frank.”

Although there was very little change in her attitude towards John and his family, the care team continued to ask about them and to encourage her to talk about them. She did make a greeting card at the day centre and she sent it to her granddaughter.

After Millie had been receiving home care for six months the care team felt that she had made such a wonderful effort to overcome the depression that they organised, with Frank, through the day centre staff, a special outing for her birthday. A taxi for people with disabilities took Millie and Frank to the botanic gardens, a favourite place for Millie. They had lunch in the restaurant then a volunteer was organised to assist Frank to wheel Millie to see all the best displays.

As Millie began to feel more positive about her life she began to play a more active role at the day centre. She became the spokesperson who sought ideas from the other members for suitable activities and presented these suggestions to the staff. She also took a special role with new members, helping them to settle in. She was often heard to say, “I was depressed when I first started here but it didn’t do me any good — so you might as well make the best of it.”

YOUR OWN CASE STUDY

NB Do not write in this textbook.
Photocopy the pages and complete the case study on the photocopy.

These three pages have been prepared for you to write your own case study showing how the Solution-focused Behavioural Change Model can bring about a change in behaviour. Maybe you have been lucky enough to work somewhere that this kind of solution-focused problem-solving plan was used and you can simply write down what happened. But it is more likely that a problem arose that was solved in a different way or that was not solved at all. This is your chance to show that you understand solution-focused problem solving by showing how you would have gone about solving the problem.

Think of a client whom you have cared for who was depressed. Jot down a few notes about the person. Carefully fill in the psychosocial and mental health assessment format. Work out what the client's problem was and state it succinctly then continue through the Solution-focused Behavioural Change Model.

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT

*Client's initials*____
(use initials only to preserve confidentiality)

Background (i.e. reason for this assessment)

____

____

Psychosocial

Social background

____

____

____

Cultural needs

____

____

____

Recent stress

____

____

____

Normal coping patterns

Health status understanding

Mental health

General appearance and behaviour

Mood and affect

Thought content and speech

Mental ability

Psychiatric history

Any other comments

USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

Name the solution

Look for causes

Develop and implement strategies

Reward success

CONCLUSION

Most people are disappointed and very sad at some stage, especially from grief, loss or other traumatic events. That is normal. Depression is not normal. It can greatly disturb people's home and working lives and their relationships. It may even drive them to want to kill themselves if they feel that life is no longer worth living.

Because depression is so draining, those who are afflicted with it need your empathetic support to help them make sense of their lives and to resume their usual activities of daily living. Assessment and reassessment of the level of depression are crucial activities when someone in your care is depressed. You should aim to promote understanding and acceptance by talking about the condition and by active example. Educating the family is especially important so that they gain some understanding of what's going on and don't reject the person with depression.

CHAPTER SUMMARY

We all have mood changes. There are times when we are really happy and times when we become sad. Depression, though, is a persistent disturbance of mood in which the dominant symptom is deep, unremitting sadness. Recognition of this disturbance requires knowledge and skills. Your observations of your client's appearance, communication, and eating and sleeping patterns will provide ample evidence that the client's "get-up-and-go has got up and gone".

Caring interventions include empathetic communication, particularly a tolerance for reduced responsiveness and silences, and extra assistance with hygiene and grooming. Medication may be ordered as part of the treatment program. In very serious cases your client will have to be transferred to a psychiatric unit for specialised care.

Whenever you encounter someone who is seriously depressed, it is advisable to suspect they may be harbouring suicidal ideas. Clues include unusual farewells or suicide notes or the tidying up of business affairs. Any actual suicide attempt is because the depressed person is desperate and can see no other alternative. If self-harm is to be prevented, carers must share vigilance of at-risk clients. If this is not possible in your present situation it is best to make arrangements to transfer your client to a safer environment where shared vigilance and empathetic understanding can be maintained. Following a suicide attempt extra thought is needed to ensure that the client is not avoided or rejected, because this can add to their depression.

Chapter six

THE PERSON WHO HAS A MENTAL ILLNESS

LEARNING OBJECTIVES

At the conclusion of this chapter you should be able to:

- recognise the indications that a person is becoming mentally ill
- assist clients with psychotic illnesses
- understand the features of personality disorders
- use a range of effective strategies when dealing with unco-operative behaviours
- explain how to access the mental health care system

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INTRODUCTION

Behaviour is the complex pattern of actions and attitudes that makes up our everyday activity. Our behaviour is comprised of voluntary actions and automatic bodily functions such as breathing. As we have seen in other chapters in this book, patterns of behaviour are often learnt in childhood and therefore become very fixed and difficult to change. In order for groups of people to co-operate to perform tasks, individual behaviour must be modified so that collective action can occur within a social context. People whose behaviour is rigid and inflexible often have difficulty co-operating with others. Such people may be said to have a **personality disorder**. Other people whose behaviour is different, strange or difficult may be suffering from a psychotic mental illness such as schizophrenia. Schizophrenia is a serious and often disabling disorder. Mental illnesses are those illnesses that affect people's thinking, feelings and behaviour in the absence of any obvious changes to the brain.

This chapter will deal with some of the ways a person in your care may step over the boundary between mental health and mental illness (see chapter 1) and behave in ways that make it difficult for you to assist them. In particular, personality disorders and schizophrenia will be explained in more detail. If a person is behaving in a way that is not acceptable as appropriate, something serious may be wrong. It is important for you to observe your client carefully, to use your knowledge of psychology to try to work out the causes of strange behaviour and to gain informed insights about what might be the unconscious motivations for your client's behaviour. Your observations will assist you in making decisions about the best support you can provide your client and the professional assistance that may be needed.

THE CARER AND MENTAL ILLNESS

Although up to 20 per cent of all people experience symptoms of a mental illness at some time in their lives, much of the community has little knowledge of how to assist and care for people experiencing major disturbances of their mental processes. People who behave strangely may be avoided through fear of the person or ignorance of how to assist. When such ignorance and fear is expressed as prejudice against people with mental illness, it becomes stigma (see chapter 1). Major changes in the delivery of psychiatric care worldwide, have led to the closure of large psychiatric hospitals. This process is called **deinstitutionalisation**. Psychiatric services are now legally required to ensure that people with mental illness receive treatment and care in the "least restrictive environment". For most people with a mental illness this will be in their own homes, sometimes resulting in great difficulty for families as they struggle to handle very complex situations. In spite of these changes, and an increased interest in and awareness by the media towards mental illness, much stigma remains. The families and other carers of mentally ill people, as well as the sufferers, often feel stigmatised and may become isolated from community activities and supports. In other instances the person with the mental illness becomes isolated from family and friends and may become a homeless person. Studies have shown that at least 30 per cent of homeless people have a mental illness (Burdekin Report 1993).

It is not unusual for carers to have intense feelings, prejudices and preconceived ideas about some clients. For example, some carers react negatively to drug-dependent clients or to clients who do not co-operate with carers' efforts to provide care. Such people may lie or be rude. Most carers feel uncomfortable when they experience such negative feelings towards clients and may withdraw or avoid that difficult client. While this response may work in the short term, the ideal carer–client relationship requires that the carer solve, not ignore, the problem (Montgomery 1987).

It is important that you as a carer separate your prejudices (yes, we do all have them!) from your observation of, and care for, clients so that you do not subject your clients to blaming and rejection. Remember to think of unco-operative behaviour not unco-operative clients.

> In working with sick and disabled people daily, it becomes easy to underestimate the profound impact illness has on people. Most patients feel very vulnerable and frightened by their dependence on nurses, and some patients perceive staff avoidance as abandonment. Such patients will do whatever it takes to counteract this distancing behaviour; to keep the care staff involved (Nelson 1991).

Other people will interpret avoidance as dislike and conclude that they are not valued as people. This is especially true of people who have been stigmatised by the community, with the result that they feel worthless. Therefore, as a carer, you are in a very powerful position to make a significant contribution to a client's feelings of self-worth when you approach with an attitude of unconditional positive regard and provide support and encouragement.

RECOGNISING MENTAL ILLNESS

Not all behaviour outside the range of what is generally acceptable can be considered as a sign of mental illness. At times of change and stress all people behave in ways that are not usual for them. We are familiar with the extremes of emotion that are common during adolescence, or at times of loss or grief. This unusual behaviour is to be expected. In chapter 1 we discussed the grey area between mental health and mental illness. Most people dip into the grey area at times of stress. Some people who are considered unusual or eccentric may live most of their lives in the grey area. In chapters 3 and 5 we showed how anxiety and depression can increase in intensity until the sufferer can be assessed as mentally ill and in need of psychiatric assistance. These are common mental health problems. Less common are the psychotic mental illnesses in which behaviour is irrational and strange and not within our range of experience. Other extreme types of behaviour are “bad” or criminal, and the behaviour is said to be “anti-social”.

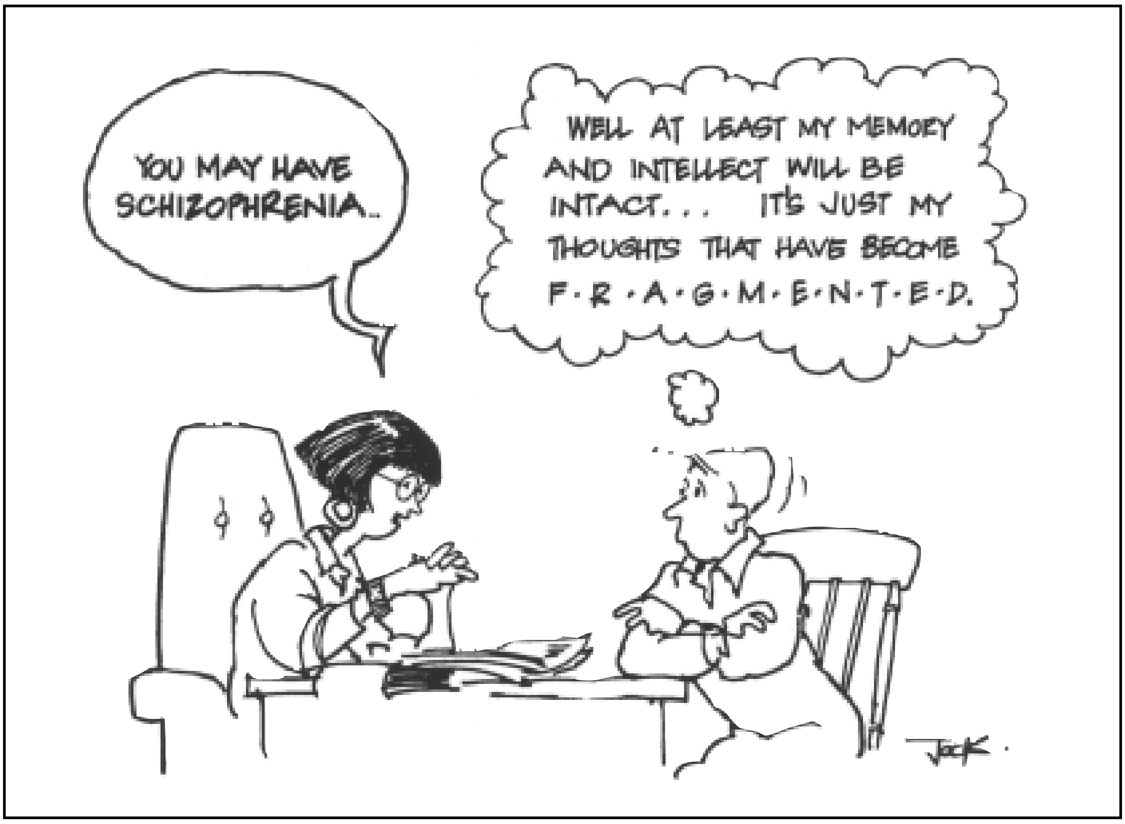
The following table lists some of the signs that indicate a person may be developing a serious mental illness.

Table 6.1 Signs of mental illness

Emotions	Withdrawn completely from family, friends and workmates Afraid to leave the house even in the daytime Panicky or extremely anxious Suicidal or severely depressed No variation in mood; lack of emotional expression Great variation in mood, such as from quiet to elated Mood not in keeping with the circumstances
Thoughts	Extreme preoccupation with a particular topic, e.g. politics Belief that own thoughts are being interfered with by others Belief that they can interfere with the thoughts of others Difficulty concentrating or remembering things Talking or writing about things that do not make sense Belief without reason that people are plotting against them Belief that they have special powers
Behaviours	Sleeping all day, staying awake all night; eating or sleeping poorly Neglecting family and personal responsibilities Spending extravagant and unrealistic amounts of money Showing deterioration in performance at school or work; leaving work Being preoccupied and giggling when there is no-one speaking Repeatedly causing harm to self such as by cutting Neglecting personal hygiene; dressing in a bizarre manner

Drug and alcohol misuse

Sometimes unusual, strange or difficult behaviour is the result of the misuse of alcohol or other drugs. The effect of alcohol is usually obvious — such as in drunkenness — but sometimes drinking is well concealed. The influence of some other drugs may not be obvious, requiring careful observation of the client for side effects of prescribed drugs and also for the ingestion of nonprescribed drugs. Some mentally ill people misuse drugs in an effort to remove the unpleasant feelings that accompany the mental illness. If drug usage is causing behavioural problems these problems should disappear if the drug is ceased. People with drug and alcohol problems can be referred to drug and alcohol services for assistance. Drug and alcohol misuse should not be a reason to refuse a person physical or mental health care. Sometimes health workers or carers think that people who are drunk should be turned away from a health agency. It can be especially challenging for nurses working in emergency departments where drug-overdose and alcoholic clients may present repeatedly for treatment. The discipline of good caring dictates that these clients be treated as others are — in an unbiased, competent manner. People who misuse drugs and alcohol are very vulnerable to physical and mental illness and are in need of active assistance.



SCHIZOPHRENIA

Strange behaviour that may be seen in people who are psychotic is a response to their internal mental world where they experience delusions (false beliefs that cannot be shaken by sensible argument and are not held by other people around them) and hallucinations (seeing, hearing, touching, tasting and smelling things that are not there — hallucinatory experiences can be in one or more of the senses). As psychotic features are manifestations of an illness, it is not possible to reason the person out of being strongly affected by such occurrences.

Schizophrenia is a particular psychotic disorder that is characterised by a broad range of symptoms including, hallucinations, delusions and withdrawal from the external, “real” world. The powerful nature of these experiences interferes with the person’s ability to communicate and to deal with life’s demands. The person may feel that they are under external control or external threat (for example, they may believe that a radio station is sending out “rays” to control their thoughts) or that they are able to control events outside their usual reality. Different people show different clusters of symptoms.

As well as undergoing the psychotic experience, people suffering from schizophrenia have behavioural responses to the things that are happening to them. These responses may include:

- talking to themselves (in response to an hallucinatory voice);
- becoming completely isolated from others;
- not caring for themselves; and
- occasionally, becoming aggressive in response to hallucinations.

People with mental illness who do not abuse drugs or alcohol, are only very slightly more likely than others to be aggressive (Mullen 1997). They are more likely to be very passive and isolated.

People with schizophrenia have disturbances in their thinking that will be reflected in the way they speak. Take, for instance, the example of a client who had been admitted to hospital for a hernia operation but also had a psychiatric history of schizophrenia. The client told the carers that God had talked to him in a dream and said that an angel of mercy, dressed in white and with brown hair, and possessing "spiriterious", was coming to help. Many of the client's carers were dressed in white and a number of them had brown hair. They were faced with the challenge of trying to help someone with a delusion to re-establish contact with reality.

Arguing against delusional ideas is fruitless. The client cannot be persuaded by reasoning and logic. You should approach these types of clients cautiously, allowing them plenty of time to recognise familiar faces and voices. Reassuring them about who you are is helpful; so too are some activities or conversation that force the client's attention onto real things. As a carer you need to steer a delicate course which involves accepting what the deluded client has to say, yet, where appropriate, making clear that carers do not share these views. A comprehensive documentation of any delusional ideas should be included in the psychosocial and mental health assessment record.

There are no schizophrenics.
There ARE people who suffer from schizophrenia.

Schizophrenia affects about 1 per cent of the population. It usually begins in young adulthood. Men and women suffer equally. People experiencing schizophrenia usually have periods of time when they are psychotic and other times when they are quite rational. For some people there is a deterioration of the personality following each psychotic episode, so that the person gradually becomes very disabled socially and emotionally. They may lose their job, or fail in their studies, and cease to keep contact with family and friends. The aim of current psychiatric care is to minimise such deterioration by stabilising the person on medication to avoid or reduce psychotic episodes. Treatment is begun as soon as possible and the person is assisted to maintain their daily life as far as possible.

CARING INTERVENTIONS

Communication

The person who is psychotic is intensely isolated and under great stress. A warm, friendly acceptance will assist them to feel that they can trust you and your responses to the external world. Explain to them what you are doing to allay any suspicions; be concrete and direct in your requests and directions. Lead the person towards co-operation, present alternatives rather than confront. Discourage unacceptable behaviour and offer diversions. Gently encourage even the smallest relationship responses. Express empathy for their experience by showing that you have some understanding of what they are going through.

Listening

Reassure by listening without judgement to whatever the distressed person is trying to say. Speak calmly and confidently to reinforce reality. Don't attempt to argue with any ideas that stem from hallucinations and delusions that the person may be experiencing. If you are asked what you think, suggest cautiously that you may have a different experience. If the person becomes agitated, step back from helping them challenge their psychotic thoughts. Listening will reveal the person's concerns and give clues to further relationship development.

Observation

Observing your clients unobtrusively when you are providing care will assist in identifying what is happening for them. Areas to observe include:

- appearance,
- behaviour,
- mood,
- interactions with other people, and
- changes in behaviour.

If your observations cause you to feel concern for the wellbeing of your client seek expert assistance. Do not assume that all behavioural change is just "part of the illness".

Physical care

The psychotic person may need assistance to meet basic physical needs such as hygiene, nutrition and hydration. They may also be unaware of the symptoms of physical illness and injury, therefore the carer needs to be alert to any sign that the person is unwell. When psychotic, the person is at risk because of impaired judgement and sometimes because of commands from an hallucinatory voice which may tell them to do something that is harmful, for example, "You are a useless person, go and kill yourself". The carer should try to provide a safe, calm environment and should seek assistance for any concerns about the client's safety.

Activities

All people need meaningful activities in their day in order to feel worthwhile. People who are acutely psychotic are helped by doing things, such as simple art/craft work, which divert their attention from psychotic thoughts and aid them in sorting out what is real in their world. People who are recovering are assisted by activities that give a sense of worth and bring them into contact with other people. Recreation activities may be individual, such as creative writing, or group, such as a swim club. Activities should be tailored to meet each client's particular needs. Bringing isolated "writers" together to produce their work in booklet form is an example of how recreation can promote a sense of self-worth and assist people to overcome isolation. Participation in consumer advocacy activities has assisted in the recovery of many people with a mental illness.

Family/carer support

Families of people with schizophrenia often blame themselves for contributing to the person's illness — "Where did we go wrong?" As stated previously they may also feel stigmatised and they may be objects of the client's suspicions and delusions. Therefore families, friends and other home carers need particular support and understanding to be able to continue to offer care to someone with schizophrenia. All health care workers should include families and other people important to clients in care activities and plans for those clients. Self-help groups such as the Schizophrenia Fellowship provide practical assistance and personal encouragement as well as advocacy for improved services. The provision of printed material is also helpful as it gives families information that they can read and digest in their own time and use later, in times of need. Learning about the illness also assists people experiencing schizophrenic symptoms to understand that their experiences *are* an illness and that other people have the illness too. This realisation reduces their sense of fear and of being all alone.

Medication

Increasingly effective medications are available to assist in controlling the psychotic features of schizophrenia. Through treatment with these antipsychotic drugs the disabling side effects of the disorder that sometimes occur can be reduced. Sufferers need every encouragement to continue with the medication, especially if unpleasant side effects from the drugs occur. Such side effects may include "restless legs", pacing up and down, making unwanted movements of the mouth, and tremor or shaking of the hands. Medication should be reviewed regularly by the treating doctor to reduce the possibility of permanent unwanted effects and if any side effects are causing the client distress.

Practical and emotional support

Many people with schizophrenia need someone who is their regular emotional support person, who ensures that:

- they are receiving their treatment;
- their condition is not deteriorating; and
- they are able to care for their basic needs, such as housing and nutrition.

Such a support person is usually called a case manager and may work from a community mental health clinic. If a person with schizophrenia has great difficulty attending a clinic, the case manager will need to be assertive in offering support to ensure that the client receives the care they need to remain well. This means that the case manager will seek the person out at home or in whatever community venue they are to be found. Working with clients in a variety of community settings is called "outreach".

People with schizophrenia and their families and other carers also need information on how to receive assistance if a crisis develops. Intensive support from a case manager helps the client and carers to learn the warning signs of that person's illness and how to get additional support. Early treatment in the acute stage aids in reducing the severity of the symptoms and the longer-term disabilities.

OTHER PSYCHOTIC DISORDERS

Another important psychotic illness is bipolar disorder or manic depressive psychosis. In this illness the person may have highly exaggerated moods such as elation or despair. The person's mood swings between "normal" and extreme, sometimes over a matter of days. The swing may be from normal to high or from normal to low or sometimes from high to low. When a person's mood is high their judgement is faulty as they feel on top of the world. They may be hyperactive to the point of exhaustion. They may spend all their money or even other people's money, leaving themselves destitute or in debt, or they may enter into unsuitable relationships without a thought for their current partner or family. When a person's mood is low they may become so depressed that they are at risk of suicide. Treatment of bipolar disorder with mood-stabilising drugs is very effective, so the person should be encouraged to seek assistance without delay.

CASE STUDY

Here is an example of how the Solution-focused Behavioural Change Model was used to solve a problem that accompanied a lifetime of schizophrenia.

Rena Kevic was a 68-year-old woman who had suffered from schizophrenia since she was 18 years old. She had lived in a boarding house for the last 10 years since the psychiatric hospital where she had spent 30 years of her life had closed. Rena had not seen her family during all that time. The people who ran the boarding house were concerned about Rena's safety because of her constant smoking. They felt that she needed closer supervision so she was admitted to a supported aged care facility.

Rena wanted to smoke almost all the time and frequently forgot to go outside to do this. Sometimes she smoked in bed and often she asked other residents for cigarettes. She scorched her bed on several occasions, setting off the fire alarms in the process. The night staff were particularly concerned about her safety and that of the other residents. She had a very heavy and frequent cough but she could not be persuaded to cut down on her smoking. She also needed encouragement to ensure that she attended to personal hygiene activities.

Rena took to going into local shops and asking for food or cigarettes The aged care facility was in a different area from the boarding house so she was not known to local shopkeepers. Some were abusive to her. The new case manager from the local aged care psychiatry team did not know Rena very well as he visited only fortnightly to administer medication in the form of a long-acting injection.

The staff of the aged care facility believed that they needed to take action to ensure the safety of Rena and the other residents.

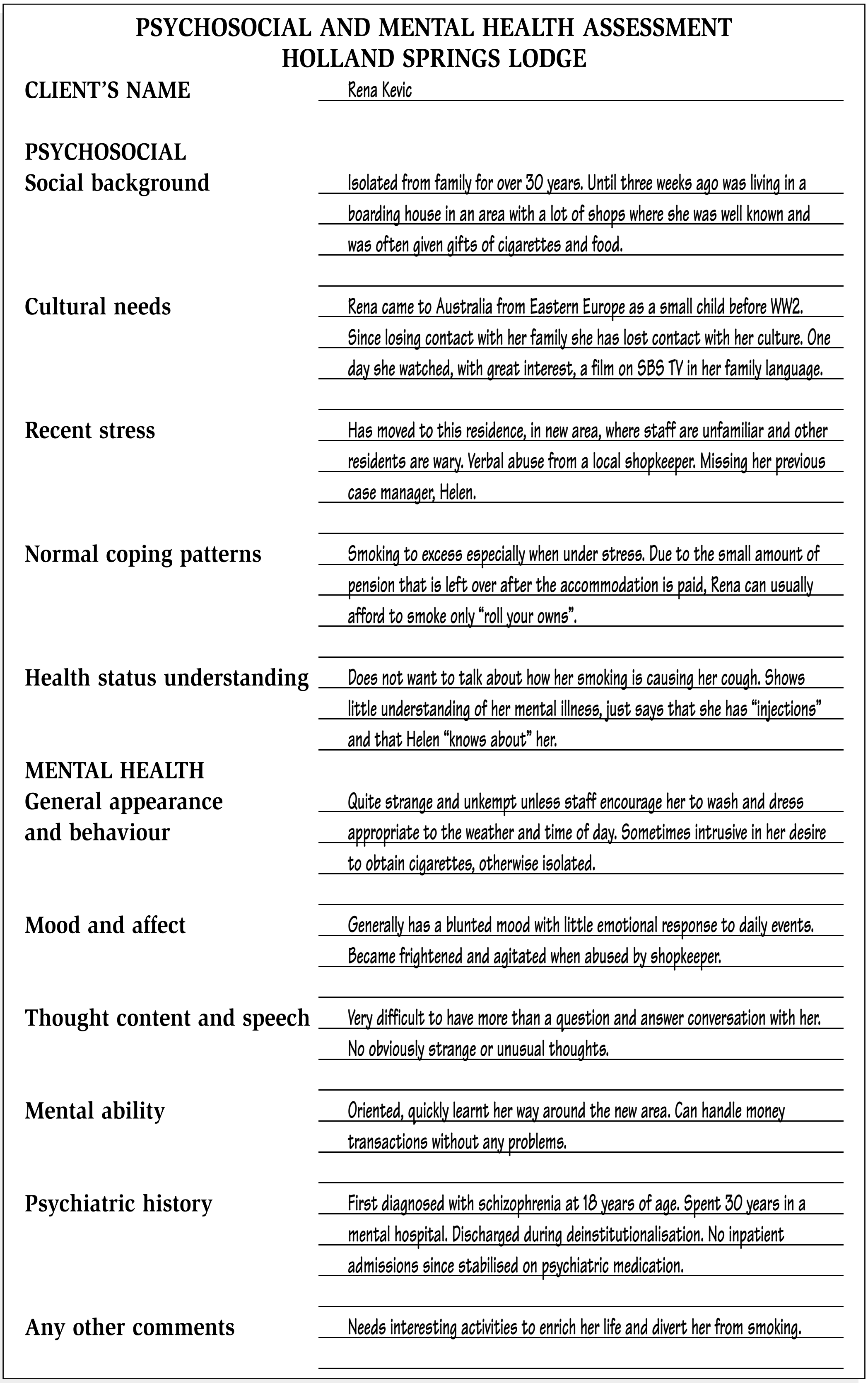


Figure 6.1 Psychosocial and mental health assessment: Ms Rena Kevic

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT
HOLLAND SPRINGS LODGE

CLIENT'S NAME	Rena Kevic
PSYCHOSOCIAL	
Social background	Isolated from family for over 30 years. Until three weeks ago was living in a boarding house in an area with a lot of shops where she was well known and was often given gifts of cigarettes and food.
Cultural needs	Rena came to Australia from Eastern Europe as a small child before WW2. Since losing contact with her family she has lost contact with her culture. One day she watched, with great interest, a film on SBS TV in her family language.
Recent stress	Has moved to this residence, in new area, where staff are unfamiliar and other residents are wary. Verbal abuse from a local shopkeeper. Missing her previous case manager, Helen.
Normal coping patterns	Smoking to excess especially when under stress. Due to the small amount of pension that is left over after the accommodation is paid, Rena can usually afford to smoke only "roll your owns".
Health status understanding	Does not want to talk about how her smoking is causing her cough. Shows little understanding of her mental illness, just says that she has "injections" and that Helen "knows about" her.
MENTAL HEALTH	
General appearance and behaviour	Quite strange and unkempt unless staff encourage her to wash and dress appropriate to the weather and time of day. Sometimes intrusive in her desire to obtain cigarettes, otherwise isolated.
Mood and affect	Generally has a blunted mood with little emotional response to daily events. Became frightened and agitated when abused by shopkeeper.
Thought content and speech	Very difficult to have more than a question and answer conversation with her. No obviously strange or unusual thoughts.
Mental ability	Oriented, quickly learnt her way around the new area. Can handle money transactions without any problems.
Psychiatric history	First diagnosed with schizophrenia at 18 years of age. Spent 30 years in a mental hospital. Discharged during deinstitutionalisation. No inpatient admissions since stabilised on psychiatric medication.
Any other comments	Needs interesting activities to enrich her life and divert her from smoking.

USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

The main issue that concerned the carers was Rena's compulsive smoking because of the risk it presented for the safety of Rena and the other residents, and because of the damage to Rena's health.

Name the solution

For the carers, the solution was to assist Rena to overcome her current feelings of stress caused by leaving a familiar environment, thereby reducing her need to smoke as much. They wanted her to be able to smoke enough to satisfy her need, but in a way that was safe for all.

Look for causes

The carers could see that the smoking habit, developed over a long period of institutionalisation, would most likely continue for the rest of Rena's life. They recognised her stress occasioned by the move to a new area with unfamiliar carers, different fellow residents, a new case manager and unfriendly shopkeepers. They knew that Rena was bored because she had little to interest her. They also knew that smoking reduces some of the strange feelings associated with schizophrenia.

Develop and implement strategies

The carers decided to meet with the case manager, Max, to find out what activities were available for Rena in the area. Their hope was that when she had interesting things to do she would feel less stressed and more positive about her new home. She would also have less time to smoke and less interest in smoking.

Max arranged for Rena to attend a social activity afternoon each week at a day centre run by the Schizophrenia Fellowship. To Rena's surprise she met some other people whom she had known in the mental hospital. Although she participated only in a passive way, she appeared to enjoy her visits and the time spent there. The carers always made sure that they talked with Rena following these visits and asked her about the things that she enjoyed.

The carers felt that the smoking in bed at night was extremely dangerous, so they discussed with her how they were going to ensure everyone's safety. In these discussions they found out that she felt unable to resist smoking when she woke up in the night. She agreed that if the carers held her tobacco at night that would be safer for everyone. To cement this agreement the carers arranged for three ready-made cigarettes to be available each night to motivate Rena to hand over her tobacco. She was given two before bed and one in the morning. She accepted this arrangement. She was given lots of positive feedback about what an important and responsible action it was for her to give the night staff her tobacco.

One of the carers who came from a country close to Rena's birthplace contacted the local migrant resource centre and found a volunteer who spoke her first language. This retired man visited fortnightly and conversed with her in their language even though she had forgotten many words. She became very animated at these times. Sometimes they went out for coffee and cake. On these days she needed no prompting with hygiene.

Gradually Rena appeared to become more settled in her new home and to be less compulsive about smoking. She was linked in with a local doctor who monitored her physical health and continued encouraging her to reduce her smoking.

Rewarding success

After Rena had been in her new home for three months the carers arranged a special afternoon tea for her. They invited Helen, Max and the volunteer. They all contributed to buy her a video of a film in her first language. This they presented to her for being “the most responsible smoker” at Holland Springs Lodge.

YOUR OWN CASE STUDY

NB Do not write in this textbook.
Photocopy the pages and complete the case study on the photocopy.

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Think of a client whom you have cared for who was suffering from schizophrenia. Jot down a few notes about the person. Carefully fill in the psychosocial and mental health assessment format. Work out what the client's problem was and state it succinctly then continue through the Solution-focused Behavioural Change Model.

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT

*Client's initials*____
(use initials only to preserve confidentiality)

Background (i.e. reason for this assessment)

____

____

Psychosocial
Social background

____

____

____

Cultural needs

____

____

____

Recent stress

____

____

____

Normal coping patterns

Health status understanding

Mental health

General appearance and behaviour

Mood and affect

Thought content and speech

Mental ability

Psychiatric history

Any other comments

USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

Name the solution

Look for causes

Develop and implement strategies

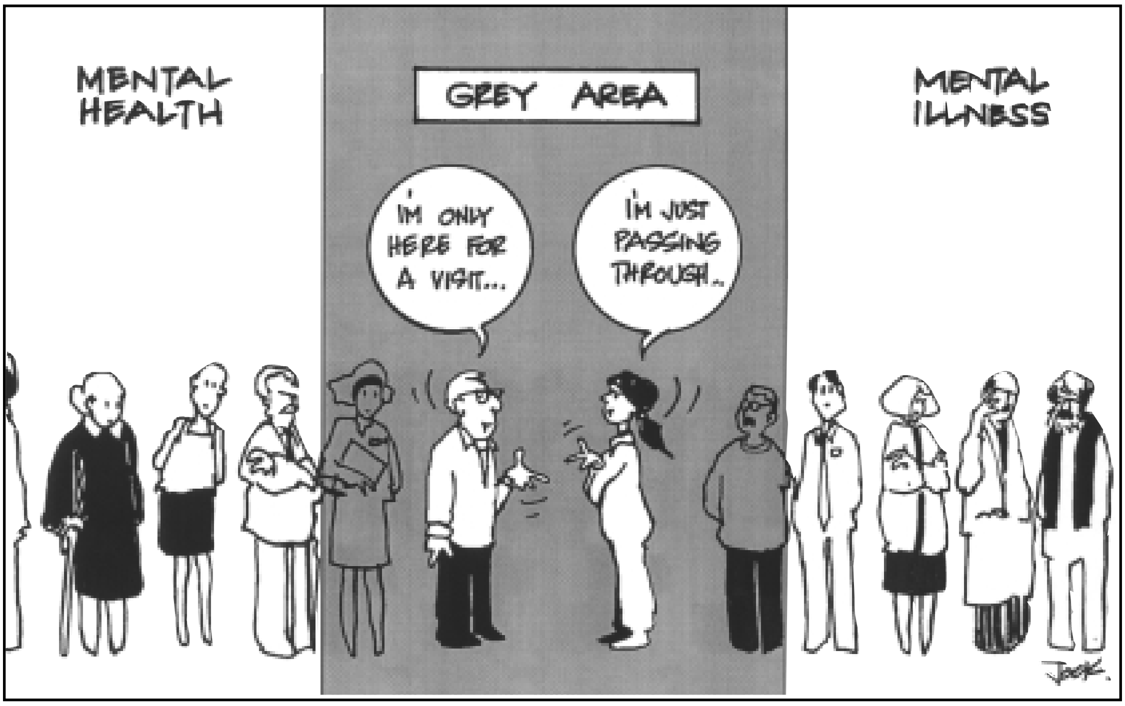
Reward success

PERSONALITY PROBLEMS AND PERSONALITY DISORDERS

Clients whose behaviour can be especially difficult are those with personality disorders. During their early life people with **personality problems** develop ways of behaving that do not fit in with the behaviour expected by the people around them. They are often labelled “difficult” or their behaviour is described as “challenging”. Such behaviour has usually developed in early childhood as a response to unsatisfactory experiences such as abuse or being taken away from parents. (Whilst this is very often the case, it is not always so.)

Sometimes personality problems emerge when a child is not assisted to learn how to become independent of its parent(s), resulting in a very dependent personality or feelings of extreme anxiety associated with thoughts of abandonment. Some children may feel unloved or insecure about the love they are receiving so they do not learn to co-operate and fit into a loving environment. They may spend the rest of their lives trying to force people to care for them or punishing themselves or the community at large for their experiences. Some of the words used to describe such behaviour are: rebellious, manipulative, attention seeking, “acting out”, eccentric, histrionic and dependent.

People with personality problems appear to others to be very self-centred, unable to consider anyone but themselves. Some people with personality problems appear not to experience anxiety and may behave in ways that hurt other people, or they may be unable to see how the people they meet get “turned off” them by their frantic efforts to be loved. Because people with personality problems have great trouble understanding how other people feel about them, they usually have relationships full of upset and difficulties. For them, it is very hard even to think of changing their behaviours. These patterns of behaviour are very difficult to alter because they have developed in response to very early, very painful events in their lives.



People with personality problems require a lot of time and patience from carers. These people often sense that they would be happier if they could fit in better but their behavioural patterns are very powerful. It seems almost impossible for them to understand the part these behaviours play in causing the difficulties in their lives, or to learn from their experiences (Haber et al. 1997). Personality problems fit into the grey area of mental health as described in chapter 1.

Personality disorder refers to people whose personality problems or difficulties are so severe and enduring that their unsatisfactory personality characteristics interfere with almost all aspects of their life, including their work, their family relationships and their friendships. ***Antisocial personality disorder*** is one type of personality disorder and refers to people who act aggressively and destructively towards other people and objects in their world, without fear of retribution. In the media this type of personality disorder is frequently referred to as "psychopathic". Other people with personality disorders turn their distress on to themselves and may cut their body or take overdoses of tablets. These actions are usually an expression of distress and an attempt to get someone to care for them. Suicide is not their immediate goal. Self-harm behaviours can be very distressing for carers. People who use such behaviours may be said to have a ***borderline personality disorder.***

There are some particular behavioural warning signs that can alert you to the fact that your clients may have personality problems. In the table below they are listed alongside the reasons for the person using these behaviours.

Table 6.2 Personality disorders

Behaviour	Why they behave this way
Using ploys to get their "own way" — manipulative, attention-seeking behaviours, playing people off against one another, flattering people, exuding superficial charm, using sexuality inappropriately, lying	The person with a personality disorder does not believe they will be valued as themselves. Therefore they believe they need to make people do, or trick them into doing, what the person with the personality disorder wants.
Indulging in outbursts of emotion, staging "drama queen" performances	People with personality disorders feel so emotionally insecure that they use these behaviours to get an immediate response.
Making threats, throwing things, employing sarcasm	Threatening people physically and emotionally aims at trying to make them respond as the person with the disorder desires.
Threatening self-harm, engaging in impulsive behaviours, attempting suicide	People with personality disorders are often emotionally overwhelmed by events in their lives and may feel that they "cannot go on".

CARING INTERVENTIONS

Based on previous experiences, people with personality disorders are usually aware that their behaviour is affecting the people with whom they interact, especially their carers. They may even worry that the carers will retaliate or will reject them. It is the fear of, or expectation of, rejection that fuels the clients' anxiety and thus their behaviour. Many who are acting unreasonably because they are exceedingly anxious feel guilty because they cannot control their behaviour (McCracken 1992). Such clients feel a sense of relief when supportive limits are placed on them.

Problem behaviour, not problem client

Communication

You, the carer, need to define the offending behaviour specifically, e.g. ringing the call bell unnecessarily, and then confront that behaviour but without blaming the person. You need to exercise good communication skills in such a situation. Use "I" statements. This technique neither attacks nor threatens; it merely gives the client information about the effect their behaviour has on others. It is an honest and responsible way to communicate with those who present with unco-operative behaviours (Montgomery 1987).

Generally an "I" statement consists of three parts:

- "I feel. . ."
- ". . . when. . ."
- ". . . because. . ."

For example, "I feel frustrated when I'm running back and forth to answer your bell every five minutes because I don't feel I'm meeting your needs in a very effective way." The final part of this message is: "How might we work on this together?" Communicate clearly what kind of behaviour you expect from clients and what response they can expect from you.

Learning Activity 6.1
THE “I” STATEMENT

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Write “I” statements that respond to the following statements from clients:

Statement 1

“You don’t care if I live or die. I hate you.”

“I ____

Statement 2

“You’re always giving me the wrong tablets. Why don’t you wake up to yourself?”

“I ____

Statement 3

“I think you only do this for the money. You don’t really care about me.”

“I ____

How do you respond to someone with a personality disorder?

Typical carer reactions to the difficult behaviours of clients with personality disorders include feelings of:

- exasperation,
- impotence,
- inadequacy,
- anxiety,
- annoyance, and
- frustration.

The difficult behaviours can lead to tensions and disagreements among carers. Sometimes carers fail to see the manipulative behaviour and actually join the client in their view of the world.

It is very important that your response to a client with a personality disorder should not be the typical reaction. Your response must be to work with the client to change the behaviour that is being exhibited. As with all behavioural problems if you manage the health care environment effectively you will have a better chance of reducing behavioural difficulties.

Physical environment

Due to their poor ability to tolerate frustration, clients with personality disorders are best cared for in a simple, nonstressful physical environment.

Social environment

One of the ways that people with personality disorders attempt to meet their needs is by manipulation, therefore clear, unambiguous communication is essential. In order to avoid manipulation, carers must work as a team, using an agreed approach. For example, if home care staff encounter someone with a personality disorder then all carers must be educated in the limit-setting approach. A similar united carer approach needs to apply to inpatient/residential settings. Manipulation is only possible when carers are disunited and disagree on the best way to assist the client. A consistent approach helps the client to develop a sense of security, a belief in the willingness of the carers to provide care.

Keep negative behaviour in its place by focusing on the client's positive behaviours. Giving praise can more than compensate for the negative attention the person was getting previously. Recognise and support the client's legitimate requests, e.g. "That's a reasonable request. I'll be glad to get your clothes right away."

Warm emotional atmosphere

Lack of felt affection in childhood makes this group of people very much in need of emotional support. It is important to keep this in mind, particularly when they are exhibiting their most difficult behaviour. As a carer, you must never act in a way that could be interpreted as punishment. On the other hand, you must be wary of being too indulgent, especially in response to manipulative ploys. The person with a personality disorder needs to be confident that you will continue to offer care in a supportive way. They also need to know that you can maintain emotional control when they are out of control.

Win-win negotiation

This may be a useful technique, e.g. “I know you want to go out for the evening to see your friends, but I don’t think you’re well enough so how about having your friends over to visit you here?”

Specific strategies for specific behaviours

Manipulative behaviour

An example of manipulative behaviour is the client who is overly affectionate. Usually carers establish good relationships with clients who admire them, respect them and, in general, have warm feelings toward them. Such honest, admiring feelings should never be confused with clients having crushes on carers or making frank sexual overtures to carers. When you, as a carer, are offered an extravagant compliment do not assume that it is entirely because of your pleasant manner or helpful skill. On occasions compliments can be purposeful manipulation by a client to get their own way. In other words when a client says, “Thank goodness you’ve come back, none of the others understands me like you do.”, it may be a warning trigger to be on your guard.

If you notice any signs of increasing or exaggerated affection, you are justified in being most circumspect and businesslike and in foregoing pleasantries (Nelson 1991). If the situation has not gone too far, this caution may be enough to deter the client from further efforts at manipulating you by being nice to you. If you judge that the client would understand, let them know that you are willing to offer your best care without flattery, that they can have confidence in your reliability.

Attention-seeking behaviour

An example of attention-seeking behaviour is the client who cries whenever things do not work out immediately as the client wants. Tears are a useful way of expressing strongly felt emotions. When a client cries it is helpful if you sit nearby as a sustaining presence but beware of the tears seducing you into feelings of sympathy and tenderness that may lead you to “giving in” to the client unnecessarily. Try to remain objective without being callous. Analyse your own feelings carefully: do these tears have a genuine basis or do I know intuitively that they are aimed at manipulation? Assist clients to focus on things and people external to their immediate emotional state. Encourage them to do little things for others. In this way they are taught to behave in a way that will gain them genuine respect not shallow and short-lived attention (Pelletier and Kane 1989).

Limit setting

The person needs to be very clear about the rules of the place in which they are being cared for and the consequences for breaching those rules. If a client’s unacceptable behaviour continues in spite of your attempt to communicate assertively, a limit-setting plan can help the client alter the behaviour. After targeting the specific behaviour that you want the client to change, determine what need the client is trying to meet with this behaviour. Some way has to be found to get the client to find a more acceptable way to meet that need. The “broken record” technique works with clients who want to argue. You can acknowledge what the client says while continuing to repeat the same expectations, in the same words, with a polite but firm tone. For example, “I realise you’re tired but you need to get out of bed now.” and “I know it hurts but you need to get out of bed now.” Sometimes, especially with long-term clients, a written plan is helpful. This can be a simple statement of what the client will do and what the carer will do. Ideally, it should be signed by both parties and each should keep a copy.

When speaking with unco-operative clients, try to allow limited choices (Montgomery 1991). For example, use a leading question that includes a choice, “Do you want to get up now or just before lunch?” rather than a closed question such as “What time do you want to get up?” (response: “Never!”) or “Do you want to get up now?” (response: “No!”).

If a conciliatory, compromising approach fails, explain the limits clearly but concisely. For example, imagine that you are in a hospital and one of your clients is a diabetic who is soliciting prohibited food from visitors. You might say, “It is not acceptable for you to get your visitors to bring you these foods. I am going to take them away.” Avoid long-winded explanations and do not allow an argument to arise (Pelletier and Kane 1989). Remember that the goal of setting limits is to re-establish appropriate control. Even if a client’s behaviour does not change overnight or dramatically, a limit-setting plan is a success if the client feels a greater sense security and the carers feel that they are achieving their objectives for the care of the client.

Recognising desired behaviours

It is very useful for both clients and carers to recognise progress. Progress may begin with “one-off” occasions when the desired behaviour occurs. Praising the client enthusiastically at such times promotes further co-operation and encourages the carer to think of new strategies to assist. Assisting the client to identify ways to achieve this outcome develops their skill further and helps the carer to know which strategies are the most useful. Keeping a record of progress shows both carer and client how much they have achieved together.

Learning Activity 6.2

WHY YOUR CLIENT HAD DIFFICULTY COOPERATING

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Think about someone that you have cared for with personality problems or a diagnosed personality disorder and whom you found did not co-operate with you and other carers no matter how hard all of you tried.

Describe the kinds of unco-operative or difficult behaviours your client used to exhibit.

Describe how you felt when your client exhibited these behaviours.

Using the descriptions you have written above about the reasons for the difficult behaviours, identify what might have been the cause of your client's lack of co-operation.

Now that you have some understanding of the causes of the behaviour of people with personality problems, how do you feel about your client?

CASE STUDY

Here is an illustration of how the Solution-focused Behavioural Change Model was used to solve a problem of unco-operative behaviour.

Roger Bloggs was a 23-year-old client in the rehabilitation unit at the Metropolitan General Hospital. He had had a most unhappy family life and eventually he had run away when he was 14 years old after being assaulted by his alcoholic father. For the next seven years he had lived on the streets. During this time he was arrested several times for shoplifting and on suspicion of car stealing. Shortly before his 21st birthday he was initiated into the Death's Head bikie gang. He had lived on the dole ever since, an active member of the gang, living at their headquarters in Nallengang.

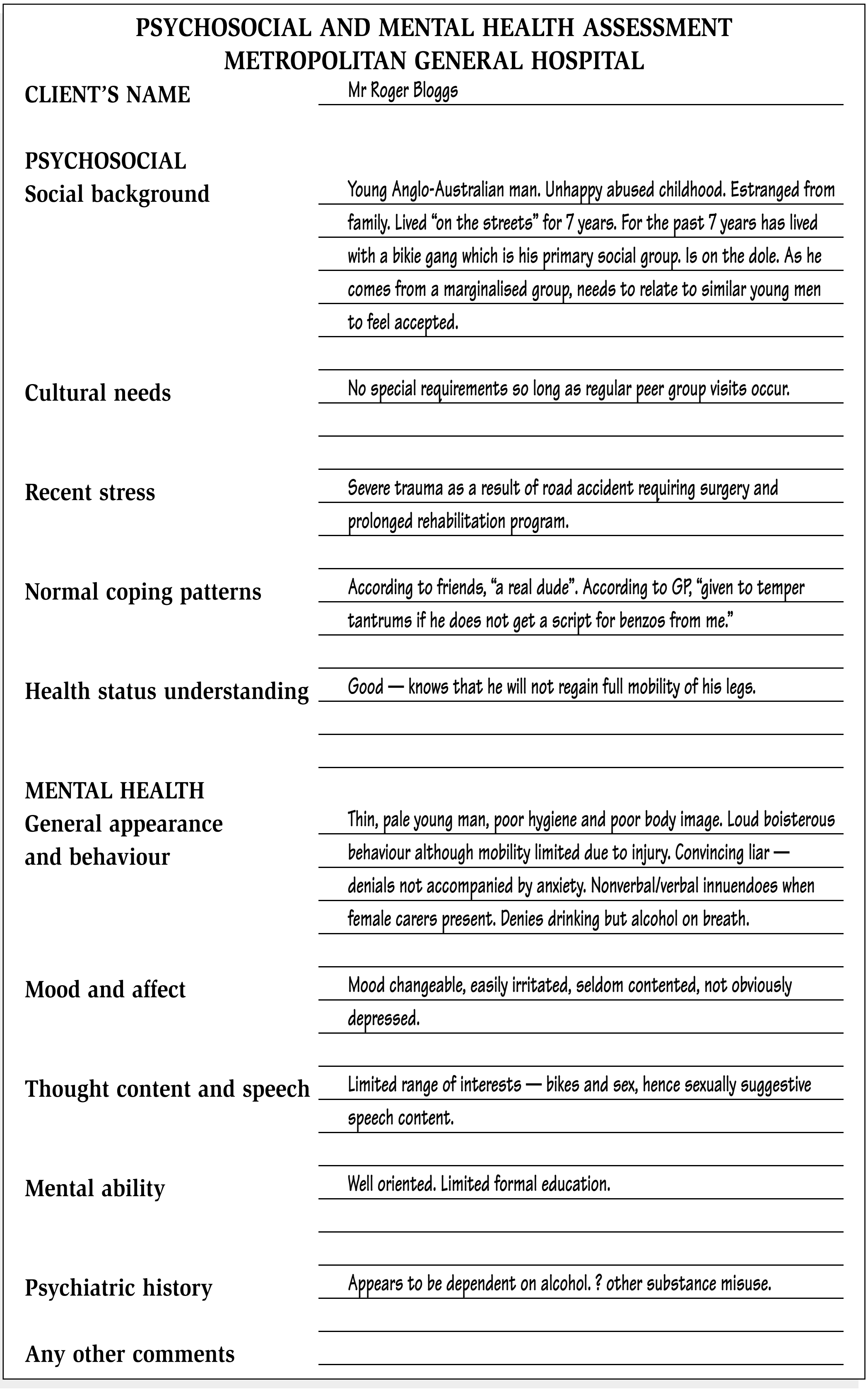
Recently he was involved in a road accident when he drove his bike into the back of a stationary truck. He sustained multiple injuries, especially deep lacerations and fractures to his legs. He arrived in the rehabilitation unit a fortnight ago for intensive mobility work. In particular he needed to learn to walk again.

At first the carers found Roger to be humorous but gradually they realised that along with his wit were sexual innuendoes. For example, he would talk in a loud voice with other male residents in the unit about female sexual characteristics. As well, he used flattery and sexual double meanings when talking directly to female carers. When they protested he would respond: "Don't be so sensitive. You should be pleased I'm paying attention to you."

The sexually explicit behaviour increased. For instance, Roger would hold up "cheesecake" pictures in magazines and make comparisons between the photographic models and the on-duty female carers. It was observed that these outspoken episodes occurred mostly after visits from his bikie-gang pals. After those visits he also smelt of alcohol. When challenged by the carers about breaking the hospital ban on "nonprescribed alcohol", Roger denied that his pals were bringing it in during visiting times. The carers' suspicions persisted but they were unable to locate where he hoarded the alcoholic drinks.

As a first step in helping Roger to overcome his problem behaviour, the unit staff looked again at Roger's psychosocial and mental health assessment.

Figure 6.2 Psychosocial and mental health assessment: Mr Roger Bloggs



PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT
METROPOLITAN GENERAL HOSPITAL

CLIENT'S NAME Mr Roger Bloggs

PSYCHOSOCIAL

Social background Young Anglo-Australian man. Unhappy abused childhood. Estranged from family. Lived "on the streets" for 7 years. For the past 7 years has lived with a bikie gang which is his primary social group. Is on the dole. As he comes from a marginalised group, needs to relate to similar young men to feel accepted.

Cultural needs No special requirements so long as regular peer group visits occur.

Recent stress Severe trauma as a result of road accident requiring surgery and prolonged rehabilitation program.

Normal coping patterns According to friends, "a real dude". According to GP, "given to temper tantrums if he does not get a script for benzos from me."

Health status understanding Good — knows that he will not regain full mobility of his legs.

MENTAL HEALTH

General appearance and behaviour Thin, pale young man, poor hygiene and poor body image. Loud boisterous behaviour although mobility limited due to injury. Convincing liar — denials not accompanied by anxiety. Nonverbal/verbal innuendoes when female carers present. Denies drinking but alcohol on breath.

Mood and affect Mood changeable, easily irritated, seldom contented, not obviously depressed.

Thought content and speech Limited range of interests — bikes and sex, hence sexually suggestive speech content.

Mental ability Well oriented. Limited formal education.

Psychiatric history Appears to be dependent on alcohol. ? other substance misuse.

Any other comments

USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

Following the reassessment, Roger's problems were identified as:

- unacceptable overt and covert sexual overtures to female carers
- drinking nonprescribed alcohol on hospital premises
- lying about drinking alcohol.

Name the solution

The solutions were for Roger to:

- treat female carers in a respectful nonsexual way
- tell his mates not to bring alcohol to the hospital
- tell the truth.

Look for causes

The carers concluded that Roger's present unco-operative behaviours probably stemmed from poor role models during childhood and adolescence. They recognised that Roger may have a core of depression and insecurity against which he was protecting himself by the undesired behaviour. They also suspected that Roger may have a personality disorder, i.e. established antisocial personality behaviours.

Develop and implement strategies

The carers decided on the following limit-setting plan:

- to try to build up trust with Roger by acceptance, nonblaming and friendliness;
- to ensure that all the members of the care team used consistent and clear communications about the behaviour that is expected in hospital;
- to provide well-structured days that would include activities for rehabilitation and skills development;
- to encourage Roger to use direct nonmanipulative communication with carers; and
- to work with Roger and his friends so that their behaviour was acceptable during visits.

They also decided that, if limit-setting strategies failed to extinguish Roger's unacceptable behaviours, then a thorough psychiatric assessment would be instigated for the purpose of ascertaining his need for specialist interventions.

The first element of trust is for the client to feel liked. One of the female carers, whose brother had known Roger at school, agreed to spend time each day with Roger because it was felt that one of his strongest emotions was loneliness. Roger had talked about what fun it was to belong to the gang — "there's always mates around". The carer spent time talking with him about his life and his ideas for how that would be when he left hospital. If he became lewd or suggestive, the carer would say, "I enjoy talking with you when we talk about bikes and other interesting things. I cannot stay here if you are going to put women down. I will come back and talk later." In this way limits were set.

After a couple of days Roger got the message — he found the carer sincerely interested and he felt better about himself after their talks. Other carers agreed to be friendly towards Roger and to allow a level of humour short of "sleaze". After a few days, some of them began to remember jokes to tell Roger.

Once Roger felt accepted as a worthwhile person the issue of alcohol was discussed. Roger was shown his x-rays and explanations were given in an atmosphere of honesty and respect. It was explained that if he did not complete his rehabilitation in full his chances of riding his bike again would be severely reduced. It was recognised that Roger's childhood experiences sensitised him to attitudes of rejection. Then it was explained to Roger that if his friends persisted in bringing in alcohol they may have to be banned.

Roger confided that he felt very dependent on alcohol as a way to stop thinking about his childhood and his accident. The unit manager agreed to discuss with Roger's mates the fact that their behaviour was jeopardising his chances of proper rehabilitation. Arrangements were made for Roger to have two cans of beer each evening. The carers also arranged that, after his discharge, Roger would be offered ongoing support by the drug and alcohol counsellor at his local community health centre.

Each day that Roger behaved within expected limits, i.e. not drinking "nonprescribed" alcohol and speaking to female carers with respect, he was "rewarded" with lots of attention and praise — "We are so proud of how well you are doing.", "We are amazed that you are progressing so well.", "How is it that you are able to learn respect in such a short time?"

On one occasion Roger's mates did bring in alcohol. They became very raucous and disruptive towards other clients and visitors. The unit manager asked them to leave. When they refused, they were advised that the police would be called if they did not leave. It was up to them to choose to leave in order to enable their friend to continue his rehabilitation. The most sensible member of the group persuaded the others to go. When Roger sobered up, he was extremely contrite and apologetic and it was agreed that, as he had obviously been trying to modify his behaviour, he could continue rehabilitation provided those particular friends did not visit again.

One of the carers made contact with Roger's sister, whom he had not seen for several years, and she agreed to visit. Before the visit the carers discussed with Roger his sister's possible attitude of hostility based on past events. Roger was able to maintain a friendly atmosphere throughout the visit although he became distressed and verbally aggressive afterwards. The carers agreed that it was important to spend more time with him that evening provided he stopped swearing. The next day they held a special barbecue lunch to acknowledge his efforts with his sister.

Reward success

Towards the completion of Roger's rehabilitation, as a reward for the effort he had put into trying to change the behaviours that had offended the carers, he was given day leave to attend a bike race that was important to him.

He never returned. Attempts to contact him were unsuccessful.

Despite Roger's disappearance, the carers felt that, although he had not completed his rehabilitation program, they had, through their approach of acceptance, empathy and problem solving, ensured that he did remain long enough to gain the major benefit. They recognised that, in order for Roger to make significant changes in his behaviour, a longer time and a more focused approach was needed. Therefore they spoke with the drug and alcohol worker at the community health centre close to Roger's home. The worker agreed to call on Roger to see if a relationship could be established and to encourage Roger to continue rehabilitation with the physiotherapist at the community health centre. The carers at the rehabilitation unit felt proud of their success with a very difficult situation.

YOUR OWN CASE STUDY

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PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT

*Client's initials*____
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Thought content and speech

Mental ability

Psychiatric history

Any other comments

USING THE SOLUTION-FOCUSED BEHAVIOURAL CHANGE MODEL

Name the problem

Name the solution

Look for causes

Develop and implement strategies

Reward success

ACCESSING MENTAL HEALTH SERVICES

If you believe one of your clients may have a mental illness or is already known to have an existing mental illness, it is important that you know how to obtain assistance from mental health/psychiatric services. As large psychiatric hospitals close they are replaced by:

- mental health care teams that treat people in the community if at all possible, and
- small inpatient mental health units in general hospitals.

As with general health services, mental health services are provided to all people in the community depending on need. The focus is on people with severe or major mental illness. Mental health services are provided on a regional and local basis. In some remote areas services are less readily available, but increasingly tele-medicine or tele-psychiatry is being used. The psychiatrist or other mental health care worker can see the client as they converse via video link. Each mental health service consists of a number of different programs or teams, each with a particular focus. The range of mental health services is described in Table 6.3. Mental health teams are staffed by workers from a variety of backgrounds:

- psychiatric nurses;
- occupational therapists;
- social workers;
- psychologists;
- psychiatrists; and
- psychiatric medical staff.

Table 6.3 Mental health services

Service/Program	Description
Acute or crisis response teams	Crisis teams assess whether a person is acutely mentally ill and the level of treatment that is required. If the person is acutely ill and is able to be treated at home the team may visit the home several times a day to treat and care for that person. If the person is too ill to be treated at home the team will arrange admission to hospital.
Inpatient or hospital care	Most large psychiatric hospitals in Australia have closed or are in the process of closing. Inpatient treatment of people with acute mental illness occurs in psychiatric wards attached to general hospitals. It is legal for people whose illness leads them to refuse treatment or who are at risk of suicide to be treated against their wishes (sometimes referred to as "certified") until their condition improves and they are able to make such decisions for themselves.
Case management and community care	Some mental illnesses such as schizophrenia can be very disabling. Many people with mental illness need treatment and care for long periods of their lives. Clients can receive treatment from psychiatric medical staff at a local community mental health clinic or from their GP or a private psychiatrist. Each person may also have a case manager from the local community health centre. Case management is a form of assistance where the mental health worker develops, with the client, a plan to assist in those areas of their life where they are having difficulty. Such areas may be basic living skills, housing, finances, family relationships, recreation and employment preparation. The job of the case manager is to coordinate and facilitate assistance to the client. The case manager and the client review the plan regularly and adjust the support as needed.
Rehabilitation/ long-term support	Some people with mental illness have severe disabilities and are unable to care for themselves independently. They may live in a long-term care setting such as a community care unit or other supported accommodation or they may live in their own accommodation and be visited one or more times a day by a support team. Some of this client group become homeless and lead very itinerant lives. The aim is always towards rehabilitation and greater independence, which may take many years for people who have lived for long periods of their life in institutions.
Child and adolescent psychiatry	This branch of mental health care, specialising in the care of young people, includes inpatient and community-based services, usually provided on a regional basis. Child and adolescent psychiatry treats childhood mental disorders and developmental difficulties and provides early intervention for mental illness developing during adolescence.
Aged psychiatry	Treatment and care is provide for people with long-standing mental illness who are now growing older, usually aged 65 and over. Aged psychiatry also specialises in psychiatric disorders that develop in older people. Depression is the most common mental illness of older people. Aged psychiatry includes the full range of mental health care programs, such as acute care, inpatient care, case management and long-term support.
Nongovernment community-based support	Schizophrenia Fellowship, ARAFEMI, different church organisations and local community-based groups provide specialist programs for people with mental health problems. They may include supported accommodation, living skills programs, day centres, 'drop-in' centres, recreation facilities, supported employment, client and family/carer education and consumer advocacy.

The development of community-based mental health services is a relatively new way of providing mental health care and treatment. Many sections of the community have little understanding of how to obtain assistance when needed. It may be useful for you to find out about the services in your area.

Learning Activity 6.3
DISCOVERING PSYCHIATRIC SERVICES

NB Do not write in this textbook.
Photocopy the page and complete the learning activity on the photocopy.

Using your local telephone book and health service directory, identify the mental health services in your area. The duty worker (mental health professional on duty) at the local community mental health clinic can assist with information on services.

Service focus	Name of service	Description of service	Address	Phone
Acute/crisis	Mount Alice Crisis Team	Assessment and home treatment during acute illness. After-hours crisis support.	12 Elizabeth St, Nerrida	9876 1234
Inpatient care				
Community care/ case management				
Rehabilitation/ long-term care				
Child and adolescent psychiatry				
Aged psychiatry				
Nongovernment community support				

Keep this information where you can find it quickly in time of need.
Suggestion: Make contact with each of the agencies in your area. Networking in this way facilitates working together and expands your caring role.

CONCLUSION

Mental illness may be one of the reasons clients exhibit behaviour that makes it difficult for them to co-operate easily in their care and treatment. Through skilled observation and assessment, carers should be able to identify reasons for this lack of co-operation. Appropriate strategies can then be developed to promote good carer–client relationships. You can lose opportunities for harmonious carer–client relationships if you cannot reach agreement with your clients on routines, treatments, social behaviour and acceptable ways of communicating.

This chapter has used a case study of a person with schizophrenia and another of a person with personality problems to illustrate the need to understand each client's unique circumstances and to provide care that attends to all aspects of the client — social, behavioural and physiological. The case studies also illustrate the need to be flexible and to consider a number of different approaches to achieve your goals.

CHAPTER SUMMARY

Most people with mental illness now live in community-based accommodation. Therefore, from time to time, all workers in the health care and welfare systems may find themselves caring for a person with mental health difficulties or personality problems. Recognising the signs of mental illness, and knowing how to access the mental health care system, are essential skills for carers to be able to fully assist these groups of people.

In this chapter you have been presented with a range of useful caring interventions for people with schizophrenia and people with personality problems. Two case studies have demonstrated the use of the Solution-focused Behavioural Change Model.

Chapter seven

THE ELDERLY PERSON WHO IS CONFUSED

LEARNING OBJECTIVES

At the conclusion of this chapter you should be able to:

- understand key characteristics of delirium as an acute episode and dementia as a chronic condition
- recognise the different features of delirium, depression and dementia in elderly clients
- explain the incidence, characteristics and principles of management of people affected with dementia
- use practical approaches in the care and management of people who are diagnosed with organic brain disorders

CHAPTER REFERENCES

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INTRODUCTION

In everyday language the word “confusion” is used in a generalised sense to mean lack of comprehension, for example “I’m in a state of complete confusion!”. In medicine, **confusion** has a more specific meaning which will be explained in this chapter.

When elderly people present with marked confusion a formal diagnosis will reveal that they are experiencing either an episode of **delirium** or the early stages of **dementia.** Delirium is an acute condition while dementia is a chronic condition.

In this chapter we will explore:

- the clinical features of these two types of organic brain disorder;
- their similarities (of which there are many);
- their differences; and
- a summary of the causative factors.

It is important to note that in this chapter the Solution-focused Behavioural Change Model, as presented in other chapters in this text, is not the framework used. The Solution-focused Behavioural Change Model is an interactive model based on a partnership between clients and carers. Those who are diagnosed with delirium or dementia, because of the nature of these disorders, cannot always make decisions or co-operate. Instead of the Solution-focused Behavioural Change Model, we will look at a range of practical and useful strategies that can be linked to the assessment requirements of the Resident Classification Scale (RCS), which refers to the behaviour of elderly frail clients, as required by the Aged Care division of the Commonwealth Department of Health and Aged Care. Special emphasis is placed on the symptom characteristics and management approaches to clients suffering from various stages of dementia.

The solution-focused approach in this context motivates carers to work out what actions *they* can take to solve the problems that arise for *them* in caring for people who are confused.

Figure 7.1 Confusion

ORGANIC BRAIN DISORDERS

The dominant feature of both delirium and dementia is CONFUSION

DELIRIUM		DEMENTIA
Rapid onset occurs at any age	ONSET ⟷	Gradual onset — usually occurs after age 60
Usually brief — from hours to weeks	DURATION ⟷	Chronic and largely irreversible
Good	PROGNOSIS ⟷	Poor

Organic brain disorders are impairments in the working (functioning) of the brain which are seen as disturbances of behaviour and awareness. The fundamental process is disturbance in the way the brain cells work, or even their complete destruction. All cells need oxygen and glucose to work effectively, so anything that interferes with the blood supply that brings these substances to the brain cells will cause a disruption of brain function. (In contrast, there is no obvious physical malfunctioning of the brain in the mental illnesses discussed in chapter 6.)

Central to both delirium and dementia is the alteration in the person's conscious state, giving rise to confusion. Confusion is an impairment of:

- memory,
- thought processes, and
- awareness of surroundings.

The emotions and co-ordinating functions of the brain are also disturbed. It is the clinical feature confusion, in both delirium and dementia, that distinguishes organic brain disorders from other mental illnesses.

Delirium, or acute confusional state, is particularly common in the aged and is often produced by a combination of factors, e.g. advancing **arteriosclerosis** causing reduced blood supply to the brain together with a respiratory or urinary tract infection.

Dementia is sometimes called senility (or, when it occurs prior to age 60, "pre-senility"). The most common age of onset is at about 75 years. The progress of the disease is slow yet steady with an average of 18 to 25 years between the age of onset and death. Dementia is a chronic condition because of the death and decay of cells in the brain.

Table 7.1 Incidence of dementia

After the age of 50 years the incidence of dementia increases with age. According to the Commonwealth Department of Human Services and Health, the incidence of moderate to severe dementia is estimated to be:

Under 60 years	1 in 1000 people
From 65 to 70 years	1 in 25 people
From 70 to 80 years	1 in 10 people
Over 80 years	1 in 4 people

Source: Commonwealth Department of Human Services and Health, September 1994

CAUSES OF ACUTE CONFUSIONAL STATE

- ***Infection —*** especially in the very young when high fever is present, and in the elderly (in particular, chest infections or urinary infections). Most of us, during a high fever experience, have had at least some fuzzy-headedness.
- ***Infection of the brain itself*** or its coverings, e.g. in meningitis.
- ***Reduced oxygen supply to the brain*** caused by narrowing of the blood vessels (arteriosclerosis) carrying oxygen to the brain.
- ***Toxic substances*** introduced into the body, such as alcohol, heroin or other poisons; also intentional or unintentional overdose of prescribed medications such as cardiac drugs or benzodiazepine drugs.
- ***Withdrawal of alcohol after long-term heavy use,*** giving rise to a particular confusional state called **delirium tremens** or DTs.
- ***Injury to the brain*** including bruising or concussion, commonly seen in contact sports.
- ***Stroke,*** which results in part of the brain dying because of a blood clot or bleeding into the brain.
- ***Diseases*** that affect the working of the whole body, such as diabetes and kidney failure.
- ***Following surgery,*** because of the effects of the anaesthetic and a reduced blood supply to the brain, and particularly if one of the sense organs is affected, such as sight or hearing.
- ***Epilepsy***
- ***Brain tumour***

CAUSES OF DEMENTIA

In about a quarter of the cases of dementia there is a genetic link (Quayle 1998). This means a predisposition to develop dementia has been inherited. Other causes (as listed by the Commonwealth Department of Health and Human Services 1994) include:

- Alzheimer's disease;
- zinc depletion;
- poor blood supply to the brain caused by arteriosclerosis;
- trauma and infections;
- merging from a delirious episode to a dementing process, e.g. someone with delirium tremens (DTs) who does not recover, but instead goes on to develop the alcohol-induced dementia called "Korsakoff's psychosis";
- rare conditions such as AIDS and Huntington's disease (which can have dementia symptoms); and
- less common diseases such as brain tumours.

CLINICAL FEATURES

Confusion is seen in both delirium and dementia. The impairments which constitute confusion may be summarised by the acronym JOMAC — judgement, orientation, memory, affect and cognition.

Table 7.2 The JOMAC assessment of confusion

Judgement	Judgement is tested by asking the person questions which will reveal how they deal with judging what is to be done in a situation, e.g. the geriatrician might say: "You are walking along a street and you find a sealed, stamped, addressed envelope. What would you do?"
Orientation	Orientation capability is always examined with reference to the person's understanding of time, person and place. Therefore assessment questions might include: What is the date? Who are the people you see around you here? Who is the Prime Minister of Australia? What is this place where you are currently residing?
Memory	Memory capacity is tested with a range of questions which are intended to demonstrate short-term and long-term memories, e.g. Where did you go to school and what was it like there? What did you and your family usually do on Christmas Day? What did you do this morning? Where are you going this afternoon? When you go out on the bus where will you be going to?
Affect	Affect is assessed though inquiries about feelings and mood, but more particularly on the demeanour of the person before, during and after the interview, e.g. do they smirk or laugh when a sad topic is being discussed or, do they cry for no particular reason, or are they inappropriately sensitive and subject to unexplained mood changes within a short span of time?
Cognition	Cognition is the ability to absorb new material and to comprehend its meaning. One assessment approach is to tell a story to the person and then ask the person to repeat the story back to the assessor (which also tests memory), then the comprehension level is tested through the use of discussion questions.

During an assessment a geriatrician would consider all these aspects of the person's functioning. This process is lengthy and complex. Only one simple example for each item has been offered here.

Clinical features of delirium

Delirium in its mild forms is very common. In its severe forms it is very frightening because of the presence of sometimes extremely vivid hallucinations. This break with reality, which is superficial and temporary, does not extend into the mind's deeper organisation levels. (Compare this with schizophrenia, as described in the previous chapter, where the break with reality penetrates all levels of the mind but without confusion.)

People in a state of delirium lose the ability to orient correctly, especially with respect to time and place. Loss of normal orientation regarding place and person implies a greater degree of disturbance. Often there is a variation during each day, with increasing disorientation emerging toward evening. This gives rise to what is known as the "sundown syndrome". People become disoriented as the day comes to a close. They cannot see as well in half-light or darkness and because they cannot see, they also become confused about what they hear.

Confused people will show a marked loss of short-term memory because of interference with the capacity to take in new material and to remember recent events. Long-term memory is much less affected. There is interruption of normal thought processes and reduced ability to concentrate. Confused people are easily distracted and have difficulty coping with simple mental tasks. They may include trivial and irrelevant material in their conversations. Fragmentation of thought processes varies, ranging from totally disorganised thinking to subtle deviation from normal thinking patterns.

Disorders of the senses are very common and may range from misinterpretations of sensory cues to vivid hallucinations. The hallucinations in delirium are usually visual (seen) or tactile (felt on the skin). People who are acutely confused may also experience illusions in which they misinterpret the events around them, for example, they may misidentify carers and believe them to be family members. The illusions are brought about by the confusion, disorientation and reduced mental functioning of the person. Sometimes people may be experiencing auditory hallucinations (hearing voices) but they manage to be self-contained and even secretive about the fact that they are being assailed by the so-called "voices in the head". Most outsiders might just think they were mildly distracted. When such hallucinations are present and the carer is speaking to the person experiencing them, the carer actually has to work hard to get the person's attention, e.g. "Ernie, I'm aware you are troubled by the voices just now. However, your mother has arrived and I need to know when you are coming to speak with her". Visual hallucinations are far more common than those which affect the other senses, and are particularly frequent and frightening in delirium tremens when they can take on the form of flocks of animals and so on.

The emotional state associated with delirium varies from person to person and may alter with time in any one individual. Anxiety and noticeable agitation are common and are often mixed up in the confusion. The emotional state, whatever form it takes, reflects the patient's response to the experience of delirium. Emotional swings, irritability and inappropriate excitement are sometimes the earliest evidence of developing delirium.

Both overactivity and underactivity occur and there can be changes from one to the other depending on the cause of the delirium and the progress of the treatment. If the underlying medical condition is life threatening the person may go from confusion into unconsciousness or coma.

The personality of the confused person and their habitual way of attempting to overcome problems will colour the clinical picture. For instance, the person with an obsessional personality is particularly threatened by disorientation and memory loss.

Delirium is a temporary disturbance of the working of the brain. It commonly fluctuates in intensity and content, showing a continually changing picture and decreasing in intensity as the symptoms disappear with treatment of the underlying cause. Essentially, delirium is an acute disorder, a symptom of another acute illness, often having a sudden, dramatic onset, with symptoms persisting relatively briefly.

CASE STUDY

Maggie Elbowlink was a 68-year-old lady who, for some years, had been suffering from a disease of her arteries, causing her to gradually lose the sight in both of her eyes. She was admitted to the surgical unit of an acute hospital to have her left leg amputated because of loss of blood supply in her legs. On admission, Maggie's brother described her as an intelligent, highly educated woman who, prior to her failing eyesight, worked as a librarian and used her quick wit, acid tongue and argumentative nature to make life difficult for those around her. One of her favourite pastimes was listening, through earphones attached to her Walkman radio, to music, news and talkback programs.

On the day of the operation, three hours after Maggie's return from theatre, the nurse who was attending to Maggie noticed that she was becoming agitated, mumbling to herself and picking at the sheets in a highly restless manner. After some time, Maggie called the nurse over and asked her to look at the flower arrangement on the nearby bench. The florist had placed a large, colourful, artificial bird amongst the flowers. "That bird is whistling and singing to me and I can't get any sleep," Maggie complained. "Take it away. I think it's going to attack me." Then Maggie frowned, looked confused and began to weep.

To help settle Maggie, the nurse removed the bird from the floral arrangement. As well, each time she attended to Maggie she reminded her who she was, where she was and what day it was. On advice from the surgeon, oxygen was administered to Maggie and the confusion gradually reduced.

Learning Activity 7.1
MAGGIE — A CASE OF CONFUSION

NB Do not write in this textbook.
Photocopy the page and complete the learning activity on the photocopy.

Using the headings provided, suggest some reasons for Maggie's odd behaviour. What care and management approaches can be used by the hospital staff?

What are the possible causes of Maggie's behaviour?

____

____

____

What care and management approaches can you suggest?

____

____

____

The real story

The staff eventually worked out that Maggie had marked sensory deprivation as a result of her very poor eyesight and the surgical procedure. The nurses thought that moving Maggie to a single room would only increase the likelihood of sensory misinterpretations and isolation. Instead, Maggie was transferred to a bed near the door so that she could hear what went on outside. Staff members began to re-introduce themselves and talk with her while touching her gently whenever they passed her bed. A volunteer came each morning to read her extracts from the newspaper. After three days, Maggie's brother was requested to bring in Maggie's Walkman radio and earphones. Uninterrupted access to the radio restored the lifeline of sensory input which had been missing, and the confusion resolved. By the time Maggie was transferred to a rehabilitation centre she was no longer in a confused state, her stump was healing satisfactorily and she had been referred to a service dealing with the visually impaired.

Table 7.3 The difference between organic brain disorders and psychoses

A person with organic brain disorder is CONFUSED	**A person with a psychosis is THOUGHT DISORDERED**
The confused person has a diminished state of awareness of both their internal and external world and a reduced understanding of what is happening to them. Instead of being alert to the events in their world they are baffled and befuddled. Confusion shows itself as disorientation and poor concentration, with rambling speech or incoherent muttering.	The thought disorder may take the form of delusions (or false ideas) but the person remains at all times alert to the world around them. The psychotic person may be very absorbed with their delusions or hallucinations but, with encouragement, they are able to respond promptly and to identify where they are and whom they are.
The ***hallucinations*** are often visual, such as ants on the bedclothes, and these misinterpretations may come and go. Confused people may also mistake the health worker for someone else, e.g. a family member. It is the confusion that leads to the misinterpretation of their circumstances.	The ***hallucinations*** are usually auditory and often the voice they hear is saying unpleasant things. Delusions are usually about believed threats to the person themselves. This can result in the psychotic person becoming very fearful and suspicious. Although they know who you are they may believe false things about you.
The ***behaviour*** of the confused person is understandable in terms of the loss of full mental functioning. The presenting behaviour is said to be purposeless, without any aim.	The ***behaviour*** of the psychotic person is understandable in terms of their delusions and hallucinations They are very alert to these experiences and respond in a purposeful way.

Clinical features of dementia

As has been noted already dementia may sometimes emerge from a delirious episode, but on the whole dementia develops insidiously. Permanent impairment of intellectual ability and memory is the main feature due to increasing loss of brain cells.

Typical early signs of dementia are:

- loss of interest and initiative;
- inability to perform up to the usual standard; or
- minor episodes of muddle and confusion.

As the dementia progresses, episodes of bizarrely inappropriate behaviour may occur, such as a housewife unloading her shopping into the oven. People who are becoming increasingly intellectually impaired have trouble making decisions and acting on any decisions. Although fully conscious, they cannot concentrate on what is happening around them, are easily distracted and become tired quickly. Inability to learn new tasks is a key feature, as is increasing forgetfulness Gradually the ability to remember recent events is lost. Eventually the capacity to remember the past also disappears.

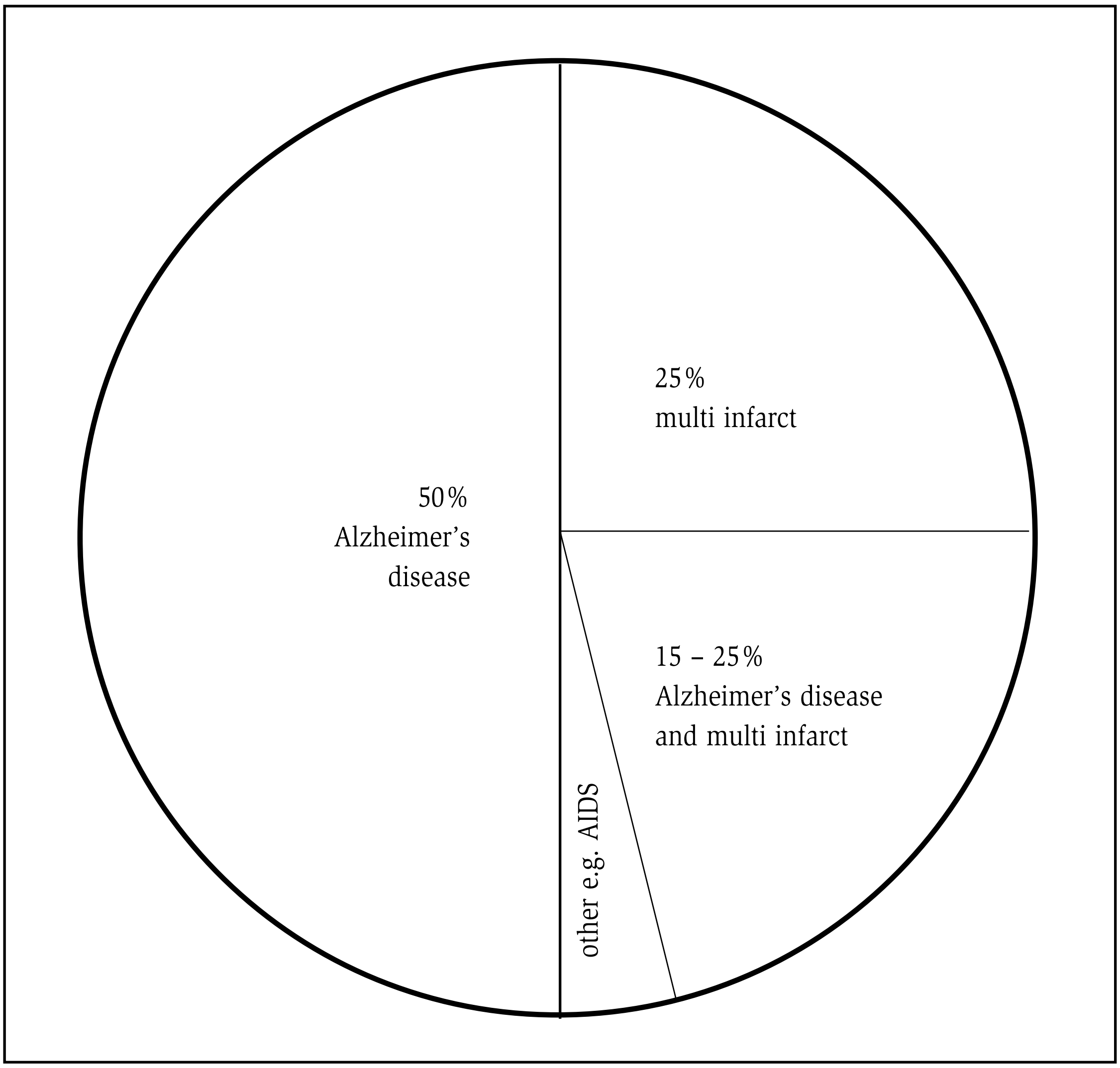
There is also a deterioration in social skills which may show as self-centredness and a lack of concern or even callousness towards others, including loved ones. This is a particularly distressing feature of the illness for family and friends. As well, some people display sexually inappropriate behaviour in public while others withdraw from social contact altogether. Emotional unresponsiveness may become apathy or total disinterest in life. Occasionally inappropriate excitement occurs. Other behaviours seen include restless wandering and the hoarding of useless objects and rubbish.

Types of dementia

The most common form of dementia is Alzheimer’s disease, named after a Russian clinician/researcher, Dr Alois Alzheimer. According to the Commonwealth Department of Health and Human Services (1994) Alzheimer’s disease accounts for 50 per cent of all types of dementia. Multi-infarct dementia, which is caused by many small strokes, is the second most common form. It accounts for 25 per cent of all cases. Another 15–20 per cent of dementias are a combination of Alzheimer’s disease and multi-infarct dementia. The remaining 5–10 per cent of cases arise from:

- excessive use of alcohol;
- brain disease/injury;
- AIDS; and
- Huntington’s disease.

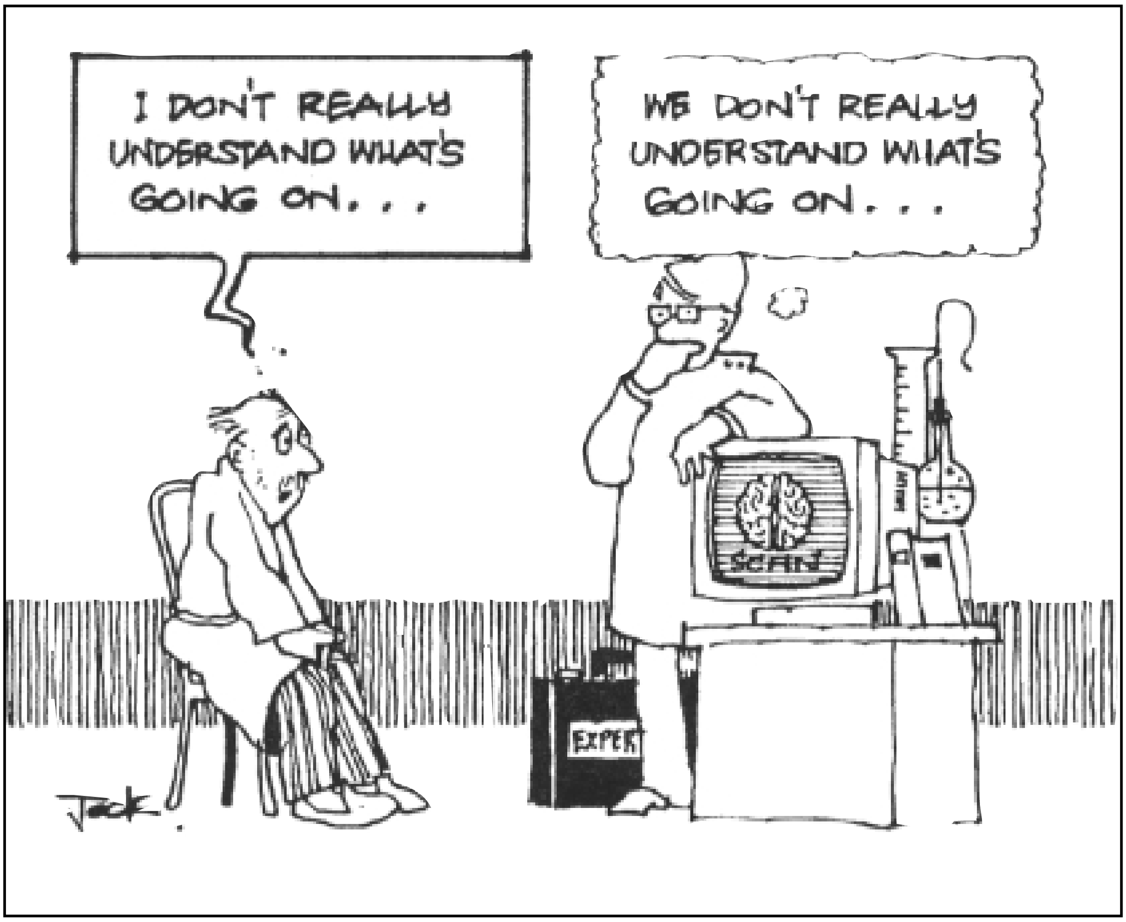
Figure 7.2 Main types of dementia



Diagnosis

There is no single test to diagnose dementia. A clinical evaluation will cover:

- detailed medical and psychiatric history;
- thorough physical examination, and in particular, a specialist examination of the brain and nervous system;
- psychiatric assessment to exclude mental illness;
- laboratory tests, e.g. blood and urine; and
- use of medical imaging such as Magnetic Resonance Imaging (MRI) and Positive Emission Tomography (PET) to examine the brain.



It is only at postmortem that the identification of ravages to specific areas of the brain signals a certain diagnosis of dementia.

In delirium there is distortion of function
In dementia there is loss of function

Differentiating between delirium/dementia and other disorders

Even though we know that the medical practitioner is responsible for diagnosis, a few notes on this topic will no doubt be helpful for carers. Many of the conditions/diseases that produce symptoms similar to dementia can be treated. Therefore, a carer's observations and accurate reports, combined with a medical and psychiatric assessment, are important to ensure that a person with a treatable condition is diagnosed and treated correctly.

There are more than 160 disorders which have symptoms similar to dementia (Commonwealth Department of Health and Human Services 1994:97). It should not be assumed that someone has the disease just because some earlier signs similar to those of dementia are present. Strokes, depression, drugs, alcoholism, infections, hormone disorders, nutritional deficiencies, brain tumours and head traumas can all produce dementia symptoms. In addition, there is a range of diseases that may have dementia associated with them. These include Parkinson's disease, AIDS and Creutzfeldt-Jakob disease.

The difference between depression and dementia

These conditions can occur concurrently or depression can be mistaken for dementia. It is, however, important that depression is distinguished from dementia. Loss of interest in surroundings and lowering of mood may be misinterpreted as early signs of dementia when they are actually indications of a developing depression.

All elderly people who are experiencing changes in their lives in terms of relationships (loss of peers and family) and in terms of mental and physical abilities (illness, loss of sensory faculties and mobility) should be considered vulnerable to depression. Elderly people respond to the social and emotional stress of ageing by the use of the same coping devices that they found effective in their earlier lives. Therefore, before making decisions about the mental state of an elderly person, it is essential to speak with the general practitioner and to interview relatives/friends. Examples of responses might be "Dad has always been an easily irritated person, this is nothing unusual." or "Mum often thinks she has a serious illness even when there are no signs. It is just her way of not facing things." Remember, as discussed in chapter 5, depression is a treatable condition and therefore medical assistance should always be sought.

Depression is much more common than dementia

Assessing the person with dementia

Family members are an invaluable aid in collecting data because they are usually familiar with the confused person's activity patterns. Also they can provide information regarding the person's likes and dislikes if the person is unable to verbalise these adequately.

As the symptoms of dementia progress, it is usually the family's general practitioner who recommends:

- the specialised assessment services which are provided by an aged care assessment team (ACAT), or
- a private consultation with a specialist such as a neurologist, psychiatrist or geriatrician.

An ACAT is responsible for approving a person for entry to residential care, and for deciding whether a high or low level of care is required. At this stage, if the family is not already connected, it is advisable to inform them about the services offered by the Alzheimer's association in their state/territory.

In aged care hostels and nursing homes, there is a compulsory assessment tool which is stipulated by the Aged Care division of the Commonwealth Department of Health and Aged Care. This tool, on which funding decisions are made, is called the Resident Classification Scale. Very importantly, the manner in which the assessment observations are documented is a critical element in the evaluation of care standards. In the classification appraisal, a number of questions are asked about resident behaviours (Commonwealth Department of Health and Family Services, 1997). They cover the following areas:

- communication;
- understanding and undertaking living activities;

- problem wandering or intrusive behaviour;
- verbal disruption or noise;
- physical aggression;
- emotional dependence;
- danger to self or others; and
- other behaviour requiring attention (e.g. aberrant/socially alienating behaviours such as screaming, repetitious talk etc).

Another consideration, during the formal assessment phase, concerns legal and financial matters. Both the person with dementia and the family carer may require professional legal and financial advice to arrange a will, an enduring power of attorney or guardianship. Information on these matters can be obtained from:

- a solicitor or government guardianship authority;
- a public advocate; or
- a state/territory trustees' office.

The psychosocial and mental health assessment form used throughout this book can be a guide for your assessment activities. It is important that there be ongoing documented assessment of the changing needs of the person and of any new problems that emerge.

CASE STUDY

Alex Elmtree was born in a country town in 1920. He had a passion for playing sport, especially Australian Rules Football. He took up a plumbing apprenticeship and spent all of his spare time playing football. Later on Alex married Val and moved to the city where he and his wife operated a family plumbing business.

In the last few years of her life, Val suffered from a heart condition which confined her to the house for most of the time. As Val's health deteriorated, Alex sold the plumbing business and his whole attention was focused on caring for her, with some assistance from a domiciliary nursing service (his daughter Nancy lived in the country). More help was offered, but Alex was used to being independent and saw caring for Val as his responsibility. Some years later, she died.

As a consequence of his long-term care for Val, Alex had lost touch with his outside interests. Many of his friends had died and others had moved away.

Prior to Val's death early in 1999, Alex managed all of his affairs with no apparent problems. After her death he started forgetting to pay his bills. At one stage his telephone and electricity supplies were disconnected. When Nancy realised his phone had been disconnected, she went to see Alex and found him shivering in front of an electric heater which was not turned on. His refrigerator was full of rotting food and the water from the hot taps was cold. Alex did not appear to have noticed these problems and when questioned responded apathetically. Alex had always been very fastidious but Nancy found him not interested in washing his clothes or himself.

Nancy took Alex to see his general practitioner who examined Alex and found no physical illness. The GP put Nancy in contact with the local council aged care service. Home help to do his cleaning and meals on wheels for a daily meal delivery were arranged. As the weeks passed, Alex had no visitors and appeared to have no interest in seeing anybody including his daughter. The meals on wheels volunteer reported to her supervisor that Alex only picked at his meals and appeared to be getting very frail. Nancy was contacted and arrived to find her father very upset; in fact, at first, he would not let her in. Nancy contacted the GP who referred Alex to the Aged Care Assessment Team.

Learning Activity 7.2

YOUR PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT OF MR ALEX ELMTREE

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

Based on the details presented in this case study fill in the following psychosocial and mental health assessment form for Alex Elmtree as you think it should be done.

PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT
LOCAL AGED CARE ASSESSMENT TEAM

Client's name ______________________________

Background (i.e. reason for this assessment)

____

____

____

Psychosocial

Social background

____

____

____

Cultural needs

____

____

____

Recent stress

____

____

____

Normal coping patterns

Health status understanding

Mental health

General appearance and behaviour

Mood and affect

Thought content and speech

Mental ability

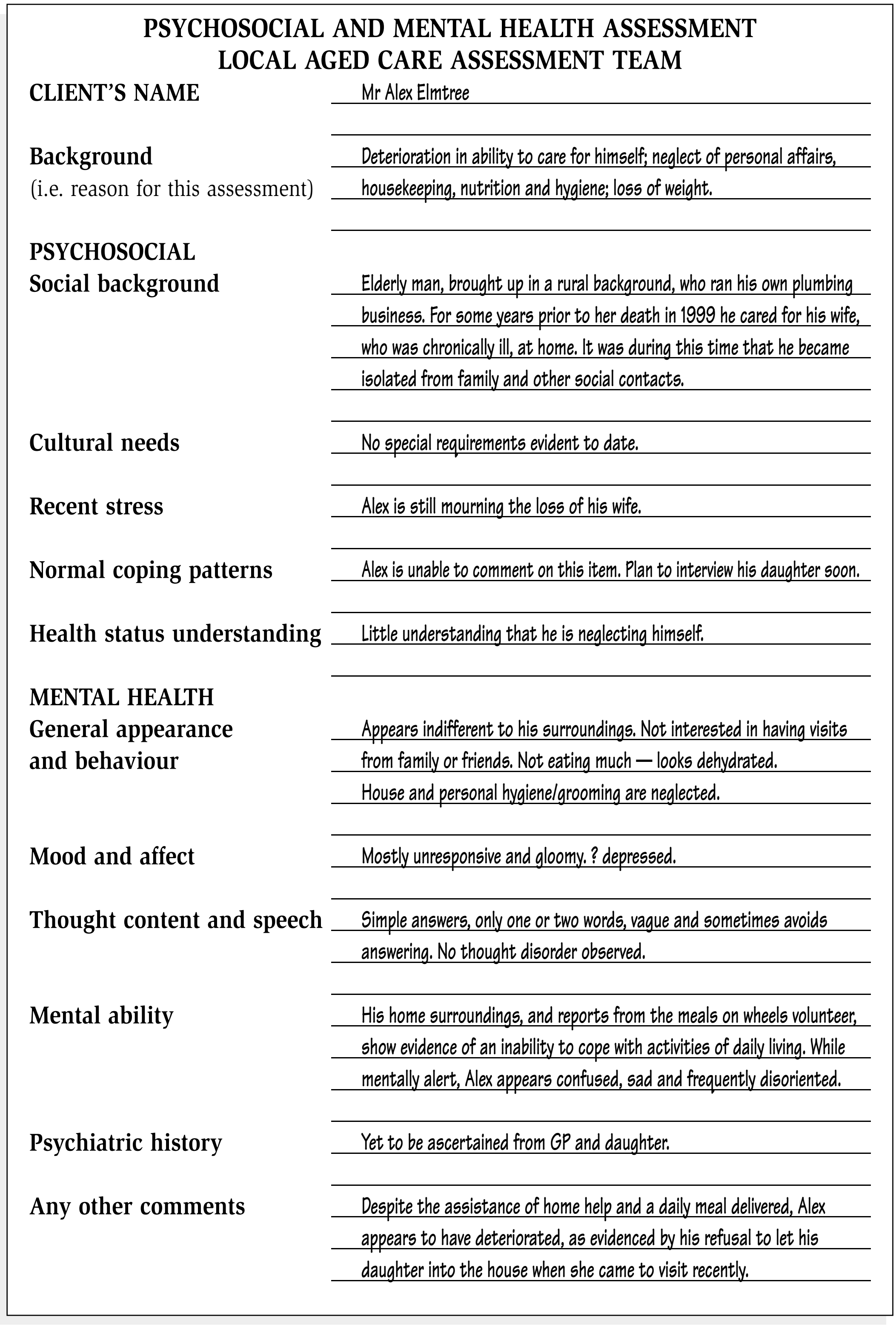
Psychiatric history

Any other comments

What the ACAT assessment said

Your concise and accurate assessment notes might be something like the following:

Figure 7.3 Psychosocial and mental health assessment: Mr Alex Elmtree



PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT
LOCAL AGED CARE ASSESSMENT TEAM

CLIENT'S NAME Mr Alex Elmtree

Background (i.e. reason for this assessment) Deterioration in ability to care for himself; neglect of personal affairs, housekeeping, nutrition and hygiene; loss of weight.

PSYCHOSOCIAL

Social background Elderly man, brought up in a rural background, who ran his own plumbing business. For some years prior to her death in 1999 he cared for his wife, who was chronically ill, at home. It was during this time that he became isolated from family and other social contacts.

Cultural needs No special requirements evident to date.

Recent stress Alex is still mourning the loss of his wife.

Normal coping patterns Alex is unable to comment on this item. Plan to interview his daughter soon.

Health status understanding Little understanding that he is neglecting himself.

MENTAL HEALTH

General appearance and behaviour Appears indifferent to his surroundings. Not interested in having visits from family or friends. Not eating much — looks dehydrated. House and personal hygiene/grooming are neglected.

Mood and affect Mostly unresponsive and gloomy. ? depressed.

Thought content and speech Simple answers, only one or two words, vague and sometimes avoids answering. No thought disorder observed.

Mental ability His home surroundings, and reports from the meals on wheels volunteer, show evidence of an inability to cope with activities of daily living. While mentally alert, Alex appears confused, sad and frequently disoriented.

Psychiatric history Yet to be ascertained from GP and daughter.

Any other comments Despite the assistance of home help and a daily meal delivered, Alex appears to have deteriorated, as evidenced by his refusal to let his daughter into the house when she came to visit recently.

CARING INTERVENTIONS FOR THE PERSON WITH DELIRIUM

Early recognition of delirium is important because it indicates a disturbance in the working of the brain. Delirious clients will show evidence of diminished attention and difficulties with memory, orientation and thinking.

Once the underlying cause of the delirium has been identified (e.g. a urinary infection), the physical treatment will be ordered by the medical practitioner. Sometimes medications are required, such as antibiotics or tranquillisers. Otherwise care focuses on the presenting symptoms, e.g. headache or dehydration.

The person with delirium has a diminished ability to cope with their world so every effort must be made to simplify it, and to disregard unnecessary complications. Keep the client informed of the time of day and the day of the week. Explain all routines and procedures in direct, simple language. The importance of frequent reassurance cannot be over-emphasised.

Visitors should be restricted, although brief appearances by close relatives at appropriate times is a good idea. Those who are delirious are prone to weave absences into disorganised thought processes so that they come to believe that they have been deserted or are being avoided. Explaining the nature of delirium to relatives is important, with reassurance that the condition will improve with treatment of the cause.

Where restlessness is a problem, caring for the client in a low bed (so that the client can get in and out easily) and taking them for brief walks will make life easier for everyone. Don’t forget that a full bladder is a potent trigger of restlessness. At night, reduce noise and light to help the client sleep better. However, a dim light can be kept on as those in delirium cannot see and hear as well in the dark and this increases their confusion. A sweet drink is useful at night to maintain the supply of glucose to the brain.

As the symptoms abate and the client’s judgement, orientation, memory, affect and cognition return to normal, more active and complex routines can be introduced.

CARING INTERVENTIONS FOR THE PERSON WITH DEMENTIA

When a person has developed dementia, one or more areas of the brain might be damaged. This damage can vary from person to person and this is one reason why people with dementia behave differently from each other. Even people with damage in the same areas can have different behaviours.

Dementia progresses at different rates. There is no “normal” progression. You can expect people with dementia to be individuals both in the way they are affected (as evidenced by their behaviour) and the rate at which the disease progresses. The differing levels of deterioration as the dementia progresses give rise to increasing physical, mental and social incompetence. They may be described as:

- mild,
- moderate, or
- severe.

As a preparation for the exploration of useful care and management approaches to those suffering from dementia, here is a two-part learning activity. It will help to establish what you know already about how to care for a person with dementia.

Learning Activity 7.3a
NEGATIVE APPROACHES TO PEOPLE WITH DEMENTIA

NB Do not write in this textbook.
Photocopy the page and complete the learning activity on the photocopy.

Using the letters for the word NEGATIVE, as shown below, compose a list of attitudes, values, beliefs and/or actions that could be most unhelpful in caring for a person with dementia.

N ______________________________
E ______________________________
G ______________________________
A ______________________________
T ______________________________
I ______________________________
V ______________________________
E ______________________________

Learning Activity 7.3b

POSITIVE APPROACHES TO PEOPLE WITH DEMENTIA

Using the letters for the word POSITIVE, as shown below, compose a list of attitudes, values, beliefs and/or actions which will help carers, relatives and friends to care for a person with dementia.

P ____
O ____
S ____
I ____
T ____
I ____
V ____
E ____

Negative and positive ways of managing a person with dementia

NEGATIVE attitudes, values and actions include:

N ot trying to understand dementia
E ngaging in arguments
G etting angry
A voiding caring for people with dementia
T reating elderly people with dementia as children
I nsensitively speaking to elderly people with dementia
V ague communications
E xpecting consistent responses

POSITIVE attitudes, values and actions include:

P artnership with families
O rientation activities
S killed assessment
I nvolvement and innovation
T aking time
I ndividual care management
V alidation and reminiscence therapies
E ducation of families

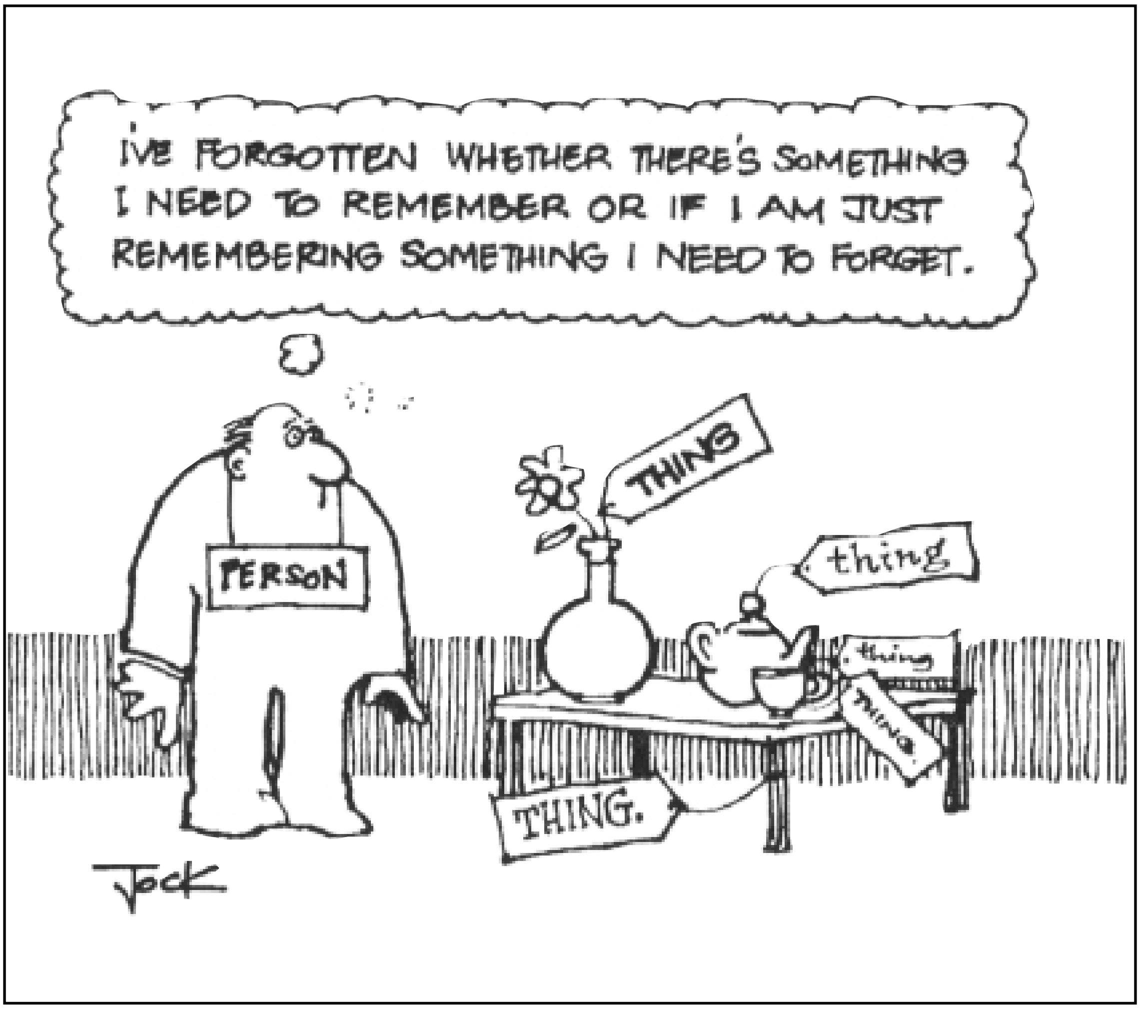
Managing early or mild dementia

If you have any suspicion that someone in your care may be suffering from the early stages of dementia you should report your suspicion so that a formal, thorough assessment can be made.

However, before a diagnosis is made (and even when the diagnosis has been made) there are some simple, helpful strategies that family, friends and carers can use. Some of these have been outlined by Dr Sue Quayle (1998).

Orientation problem: The ability to remember days and dates and to recognise people and places will become increasingly impaired.
Strategy: Provide information that relates to place, time and key people, e.g. in a prominent place display the date in a clear format.

Memory problem: Short-term memory will suffer while long-term memory usually remains intact in the early stages.
Strategy: Develop a habit of writing things down. Label drawers and cupboards clearly. Compile a life story, including photographs, as a **validation** tool.



Problem-solving ability: The speed at which problems are worked out will become impaired and solving complicated problems will eventually become impossible. Multiple items of information will not be able to be held simultaneously.
Strategy: Avoid complicated tasks. Focus on tasks where the capacity for decision making can still be exercised, e.g. shopping and housekeeping routines. Assist with complicated tasks, e.g. filling out the annual income tax return form. Above all, help family and friends to see that it is no use getting cross when someone they have always known to be decisive cannot do something as simple as choose a meal from a menu. If the person always says, "I'll have what you're having", be careful to choose something that they will enjoy.

Other behavioural problems: These will vary in character and in level of disability.
Strategy: This will depend on the presenting problem. For example, neglected hygiene will require personalised supervision, advice and assistance.

Mood problem: Mood swings will be evident.
Strategy: It is important to accept that emotional control will be difficult at times. Understanding this will mean that you resist over-reacting when people are crying for no reason. Gentle, comforting reassurance is helpful.

People in the early stages of dementia may be extremely anxious because they realise that "all is not quite right". In the early stages people can still carry on a conversation and most will enjoy chatting. Some may still be able to read, but eventually this capacity is lost. When the dementia progresses to the moderate and severe stages, the affected person is much less anxious, and later on the affect is one of indifference. As dementia progresses it is family, friends and health workers who become stressed.

Confusion and the environment

The crucial principle, in this regard, is safety. Whether the environment is at home, in the community or within an aged care residential facility, it should be safe, allowing the client some physical freedom and some degree of risk, while at the same time ensuring safety. Such a setting will permit positive emotions of pleasure, comfort and belonging to be experienced by the elderly person with dementia.

Depending on the presenting problems, environmental modifications may have to be introduced. High handles on door, with special coded locks, will certainly contain even the wildest aspirations of wandering clients.

Attempts should be made to modify any obvious environmental aggravations which could add to the confusion of the client. Noise reduction is an obvious example.

Managing moderate and severe dementia

There are a range of structured models which it may be helpful to adopt. ELTOS (Garratt and Hamilton-Smith 1995) is a model for residential care which resulted from four years of action research with residents at the Montefiore Homes for the Aged in Melbourne.

The ELTOS acronym stands for:

Enhanced
Lifestyle
Through
Optimal
Stimulus

The central purpose of this model is to improve the lifestyle of the affected person. Indirectly, of course, this improves the situation for the carers.

The two fundamental pre-conditions in order for the ELTOS model to work in a residential setting are:

1. genuine teamwork and
2. effective communication.

Embedded within these fundamentals are the three key elements of the model:

1. validation
2. lowered stress
3. positive stimulus.

Essentially validation is the acknowledgement of memories as being valuable, while at the same time acknowledging the reality of the feelings which accompany memories, regardless of the correctness of the "facts" related to these memories.

With regard to stress levels in people with dementia, the ELTOS model assumes that, in most instances, a behavioural incident will arise from a stressor. It follows that the reduction of stressors is seen to be beneficial.

The final element of the model, positive stimulation, is found to have a good effect on the welfare of those suffering from dementia whether that stimulation is through specific recreational activities or the normal activities of daily living (Garratt and Hamilton-Smith, 1995).

Much of the book, entitled *Re-thinking Dementia — an Australian approach*, is devoted to the need to create the right conditions for the correct use of the ELTOS model, e.g. management priorities, environmental modifications and adequate carer education.

Whether or not you are in involved in the application of a particular model of care, the following therapies and care guidelines will be very useful.

Reminiscence therapy

This approach is based on a belief that if elderly clients with short-term memory impairments are unable to live in the present, they should be assisted to recall past memories and achievements. Being able to recall long-term memories facilitates reminiscence activities. As a carer, it is helpful for you to accept that those with dementia have regressed to an earlier stage of development. If you can cue people into their memory bank you can remind them of who they used to be, which is useful in helping them maintain a sense of who they are. Also, reminiscence therapy enables carers to keep communication pathways open between them and the client.

The technique uses various sensory triggers — such as songs, foods, family photographs or special occasions — to help bring forward memories in people with dementia. Items from the personal life of a person can be collected, discussed and/or displayed as a way to encourage remembering. Preparations for special occasions, e.g. Easter or Christmas, can involve the active stimulation of recollections about Easter and Christmas celebrations in times past. Reminiscence therapy can be used on a one-to-one or on a group basis, in the hope of making life more interesting, personalised and meaningful to the participants. It is important to remember, though, that rambling does not constitute a therapeutic reminiscing experience. When a person with dementia is speaking in a rambling, unfocused fashion this should not be mistaken for reminiscence. A reminiscence occurs when a long-term memory is recalled and explored. The therapeutic outcome of reminiscence is usually one of increased self-esteem and feelings of belonging — however fleeting — and this is good. Rambling does not lead to a positive outcome.

Actively helping people to live in the past if they have lost the capacity to live in the present

Music therapy

Music therapy, as distinct from pure entertainment, uses songs and pieces of music with which the clients may be familiar, to stimulate positive memories and emotions.

Approaches for specific behaviours

Robinson et al. (1992) offer a broad range of practical care and management guidelines for:

- anger/agitation,
- sleep problems,
- paranoia/delusions,
- eating/feeding,
- dressing,
- incontinence,
- wandering,
- screaming,
- repetitive actions,
- bathing, and
- wanting to go home.

When you are dealing with a specific behaviour you must try to estimate the external and/or internal causes for the behaviour. As examples of the kinds of approaches you might consider here are some guidelines for coping with wandering, screaming/making noises and repetitive actions. These suggestions have been adapted from Robinson et al. (1992).

Wandering

- Document your observations about the wandering behaviour:
  - Is the person trying to find a room?
  - What was going on before the wandering started?
  - What time of day does it occur?
- Consider how medications, mealtimes, weather, bathtimes and other people relate to the wandering behaviour and make appropriate adjustments.
- Make sure the person isn't wandering because of an easily met, yet unexpressed, need, e.g. toileting.
- Arrange for a thorough medical review, particularly if wandering begins suddenly.
- Allow the person to wander if the environment is safe and secure.
- Place familiar objects, furniture and pictures in surroundings.
- Help direct the person with clearly labelled rooms.
- Decrease the noise levels and the number of people interacting with the wanderer at any one time.
- Take the wanderer outside. Walking, or other exercise, can sometimes reduce agitation.
- Remove items that may trigger the person's desire to go out alone, e.g. shoes, coat, purse, umbrella stand.
- Distract the wanderer with conversation, food, drink or activity.
- Keep the environment accident proof, e.g. sharp objects and medications/toxic substances should be locked away.
- Consider using a bean bag chair for sitting and resting because it is comfortable yet getting out of it is difficult.
- Arrange for a drive in a car — but never leave a person with dementia unattended in a car, as they may be frightened of being alone, could wander away or might fiddle with the gear shifts.
- To avoid dehydration see that the person has plenty of fluids.
- Reassure the person frequently about where they are and why they are there. Speak in a calm, normal tone of voice. Alleviate fears, e.g. say "Your family knows where you are".
- Always approach a wandering person in a casual, nonthreatening manner. Fall into step beside them and walk a short distance before guiding them gently back to the correct location.
- Place full-length mirrors on exit doors. Some people will turn around when they see the image, not recognising themselves.
- Put locks on doors out of sight or reach. Use child-proof doorknob covers that prevent the doorknob from being turned. Place warning buzzers/bells over exit doors.
- Make sure your wanderer wears brightly coloured outdoor clothing. Reflectors sewn onto the sleeves/pant legs may be helpful for persistent wanderers.
- Provide the wandering person with some form of identification, e.g. labels sewn inside clothes, in case they become lost.
- Have a current picture of the person available in case they become lost. A videotape of the person may also be helpful.
- As a last resort some form of approved restraint may be used (see chapter 4).

Screaming/making noises
Vocal behaviours are most commonly seen in the later stages of dementia. Many people who shout and cry out are physically immobile and the underlying problem is the person's inability to communicate their needs, wishes or thoughts.

- Have a good medical evaluation to check for illness, infections, pain, impaction or other physical discomforts.
- Provide adequate meals/snacks to minimise hunger, administer prescribed medications on time and institute a regular toileting schedule.
- Change promptly after incontinent episodes.
- Try rest periods to minimise fatigue.
- If the person is bedridden or restrained in a chair, ensure frequent change of position (at least every 1–2 hours).
- If the person wears spectacles and/or a hearing aid, check that they are in place.
- Lower stress and create a relaxing environment.
- Use relaxation strategies to minimise fear, threat and anxiety, e.g. try massaging the hands and neck while talking in a soothing voice.
- Encourage participation in meaningful activities to minimise boredom and frustration, ensuring that the task or recreation matches the person's skill level and interest.
- As a last resort, sedative medication may need to be ordered.

Repetitive talking and actions
Remember that people with dementia do not have the ability to remember because of changes to their brains. Repeated questions, stories or comments might be their unsuccessful attempts to feel a sense of control over their lives or to allay their fears of abandonment.

- Arrange for a medical examination to check medication side effects and for illness or pain.
- Distract the person with a favourite activity, such as walking, or food, such as fruit.
- Try these communication tips:
    Respond to the emotion instead of to the specific question.
    Reassure with simple, brief statements.
    Try a gentle touch when a spoken response does not help.
    Use a calm voice when responding to repeated questions.
    Use simple written reminders, e.g. "We will eat at 6.00 p.m."
    Use pictures to replace written reminders when the ability to read is lost, e.g. a picture of a toilet might replace the "toilet" sign on the bathroom door.
    Avoid discussing plans with the person if this causes agitation and repeated questions.
- Ignore the repeated behaviour or question in the hope that if there is no response or reinforcement, the repetitions may stop.
- Try audio tapes. Sometimes a tape of the caregiver talking in a reassuring voice may be helpful, although it has to be acknowledged that for others the "disembodied voice" may be confusing.

- Use memory aids, e.g. large-print signs and numeral clocks.
- Remove things from the environment that may trigger repetitive questions. For example, a visible coat rack may trigger the question “Is it time to go now?”
- For repetitive movements, such as moving the tongue in and out, rubbing hands together or on legs, and tapping, try:
    - having medications checked by physician;
    - occupying the person’s hands with an activity, e.g. holding a stuffed animal;
    - distracting with food, music, exercise or an outing.

Caring communications

The following helpful hints have been adapted from ADARDS (1993):

- Do everything you can to preserve dignity and self-esteem. Talk to clients normally even when they can’t or won’t respond. Even if they don’t understand what is said they will understand the feelings expressed.
- Give only one instruction at a time and try to use short sentences.
- Address clients clearly, noting how much understanding is taking place. Express yourself clearly and simply. Avoid complex discussions.
- Touching, especially when clients are upset, is a good way to make them feel more secure. A hug or a reassuring pat can go a long way toward making them feel wanted and loved.
- Use names a lot, e.g. “Jack, your neighbour” or “Muffy, the dog you used to have”.
- Arguments over mistaken ideas should be avoided. This approach only ends up frustrating the carer and upsetting the person with dementia.
- Make it easier for the client to join in a group conversation by using questions which require only a “Yes” or “No” response, such as “It’s very cold for this time of the year isn’t it?” or “You’re going to bed now, so you won’t be needing your shoes on will you?”
- Allow enough time for the complexities of hygiene, grooming and dressing of each person with dementia.
- Remind them of their name, their location, the time of the next meal etc.
- Treat the person as a respected, dignified adult.
- Acquire the habit of announcing events, e.g. “It’s time for your bath, John.” and directions “This is the way to the bathroom.”
- Correct the person immediately when there is a disoriented comment, e.g. “No, John, I’m not your daughter, Anne. I’m your carer, Sally.”
- Keep changes of routine to a minimum.
- Allow times for talking about the past, while trying to keep the facts reasonably accurate.

Some final "DOs" and "DON'Ts"

DO Expect confused people to ask the same questions over and over and to persistently repeat certain phrases.
DO Give gentle massage and hugs now and then.
DO Give instructions one step at a time and slowly.
DO Try to ignore behaviours which annoy you but are not harmful.
DO Remain calm and pleasant and maintain your sense of humour.

DON'T Expect answers to your questions to be accurate.
DON'T Give instructions and expect them to be carried out perfectly.
DON'T Press confused people so much that they become stressed.
DON'T Take the dementing person's behaviours and emotions personally.

CARING FOR THE CARERS

Caring for people with dementia requires particular personal skills such as patience, common sense and an optimistic outlook on life. The most effective combination is where there is a trusting relationship among all those trying to help the person with dementia, e.g.:

- if the person is at home — among family members, the family GP, the HACC worker etc.; or
- in a residential setting — among the members of the health care team.

Always the aim is to create a calm, cheerful and confident atmosphere.

Even so, caring for people with dementia, particularly those who are severely disabled, can be a very demanding occupation. Many are able to respond only in minimal or in contrary ways, leaving carers with very little positive feedback for their efforts — all the more reason for identifying existing support networks which can nourish the emotional wellbeing of the carer.

Learning Activity 7.4
CARER SUPPORTS

NB Do not write in this textbook.
Photocopy the pages and complete the learning activity on the photocopy.

This activity is a self-reflection exercise. Consider the ways you, personally, are able to maintain your ability to offer empathetic care to your clients

Actions I take to care for myself

The support and assistance I receive from family and friends

The supports and encouragement from within my workplace

Now that you have completed the learning activity, are there any other actions that you can think of that you could take, either at home or at work, to improve your support network?

CARE VENUE OPTIONS

Government policy for all elderly frail citizens is guided by the "ageing in place" concept. This means that elderly frail people, such as those in the early stages of dementia, should be supported to remain living in their own homes or familiar environments for as long as possible. Listed below are some research findings from a study which evaluated community care for people with dementia (Reynolds 1993:115). What the table is saying is that if the services listed could be provided or improved, more dementia sufferers could stay in their own homes rather than having to be moved to somewhere unfamiliar.

Table 7.4 Community service needs of people with dementia

Services	Frequency of identification
Respite services	45%
Practical assistance at home	43%
Day care	34%
Meals provision/preparation	30%
Support for carer	29%
Social contact/companionship	23%
Personal care	20%
Home nursing and medication	14%
Assistance with finances	7%
Carer education	6%
Transport	5%

Examples of extensions to "ageing in place" services include community day care, respite care, independent living units and residential nursing homes for people with dementia.

In-home respite care

This service enables the person with dementia to be cared for in their home, while the carer is facilitated to have a break. Such arrangements reduce the disruption to daily routines.

Day care centres

Day care centres offer respite for the carer and social contact for the dementing person who lives alone. Day care centres are available from one to five days each week, depending on the assessed needs of the person with dementia. The programs at the centres focus on recreational activities and a nourishing meal, with accompanying care activities depending on the physical and emotional needs of each person.

Short-term respite residential care

To enable a carer to take a vacation, sometimes the person with dementia may be admitted to residential care for two or three weeks, and then return home.

Acute inpatient admission

People with dementia have particular physical, social and psychological life challenges related to their disorder. They may also suffer from other health problems related to ageing, which may necessitate admission to various health services. Leaving the familiarity and security of the family home, in which they have either coped by themselves or received care from family members, will mean being required to adapt to new and unfamiliar surroundings in an institutional setting.

Nursing home care

The time may come when a person can no longer be cared for at home and 24-hour nursing care in a residential centre is required.

In Australia it is estimated that about 25 per cent of people over the age of 65 will experience admission to a nursing home (Rowland 1991). Another interesting statistic comes from Helmer (1990) who predicts the number of cases of people with Alzheimer's-type dementia will triple in the next generation.

When those suffering from dementia are admitted to nursing home care, it is a crucial transition in their lives, as Knepfer and Johns note (1989:168):

> All over Australia there are nursing homes; rabbit warrens full of the darlings of yesterday. The ones who jitter-bugged in the thirties, who strutted their stuff and kept the beds warm for the men at war; the old diggers who have done their duty at war and fathered children for the nation; those who took part in the materialism boom of the fifties — now they shuffle along the corridors in varying degrees of safety and happiness, experiencing varying degrees of nursing excellence

Better-designed residential units and the creation of homelike environments in nursing homes have done much to make the transition from the resident's own home as least disruptive as possible. Even so, carers need to remain vigilant to ensure that there are no unnecessary impositions or restrictions. For example the retention of personal belongings is important, as a contribution to keeping the person in touch with reality (depending, of course, on their level of dementia). Few of us realise how much our equilibrium and our sense of reality depend upon stimuli emanating from familiar objects. Well-worn clothing is particularly important in this respect. The unique way it looks, the familiar way it feels on our body and to our fingers, the special smells, even the sounds it makes rubbing against us — all these sensory perceptions are part of ourselves; they reassure us and support us. In the case of a resident whose hold on reality is already tenuous, removing familiar clothing and possessions is unhelpful.

There is quite a lot of discussion these days about whether residents with dementia should be integrated into the same nursing home quarters as those who have retained their intellectual capabilities. It is not simply a question of quality of care, but also a question of quality of life. For a resident who does not have dementia, it must be disturbing to witness the bizarre and sometimes intrusive behaviours and emotions of those who are affected.

In both public and private nursing homes, architectural variations are being instigated which either partially or fully segregate those with dementia from those who do not have it. In some instances, purpose-built psychogeriatric nursing homes are being created where the overwhelming majority of the residents suffer from dementia. Regardless of whether the environment is specialised, it is crucial that the guiding care philosophy supports a high level of quality of life for those with dementia.

It should be noted that a “high standard of care” extends beyond the facility’s concern for its residents. It includes concern for the emotional wellbeing of family members or significant others. Ideally, the person who has been caring for the person with dementia at home, should be included in the care plan discussions. Their knowledge of the person’s needs, preferences and capabilities will be invaluable. Treating the family as “partners in care” can be rewarding all round.

CONCLUSION

Undoubtedly it is crucial that nurses, health care workers and home workers/carers gain an understanding of organic brain disorders. These mental disorders comprise an acute manifestation known as delirium and a chronic manifestation known as dementia. Both the delirious states and the mild/moderate/severe forms of dementia are dominated by the characteristics of confusion; the former condition occurring at any age and the latter usually emerging after the age of 65 years. Those who suffer from delirium will gradually become less confused with treatment of the medical cause and eventually recover whereas those who are diagnosed with dementia face a gradual deterioration of their mental, emotional and physical capabilities.

The caring interventions which work best with both conditions focus on reducing the confusion and accessing the long-term memory so long as it is preserved, e.g. through the use of reminiscence therapy. The care venue options for those suffering from dementia include their own homes (with support services in place) day care centres, short-term respite residential care, acute inpatient admission and hostel or nursing home care.

Caring is a physically and emotionally demanding role. Those caring at home for relatives afflicted with dementia often have little assistance and may not know where to turn for help. Those who look after residents in an aged care facility are increasingly overburdened and understaffed. All carers, whatever the circumstances, need to make space in their lives for respite and enjoyment so that they have the strength and motivation to contribute effectively in their caring roles.

CHAPTER SUMMARY

Delirium is caused by a disturbance in the brain which gives rise to short-term confusion and extrasensory experiences. With treatment, delirium is usually reversible within a few hours or days or sometimes weeks. Dementia, on the other hand, is a disease process showing increasing deterioration as the brain cells die and are not replaced. It results in chronically impaired memory, thinking and behaviour.

It is important to ensure that the person's dignity is preserved, while still catering for their preferences, customary routines and recreations. Some experimental and innovative approaches can also be most helpful, especially when relatives/friends are included.

In rare cases, young to middle-aged people develop symptoms of dementia, but it is commonly seen from the age of 60 onwards. According to the Alzheimer's Association of NSW (1997) over 135 000 Australians have moderate to severe dementia. Because of the rapidly ageing population, this figure is expected to increase 65 per cent by the year 2016.

POST TEST

INSTRUCTIONS

Read each question carefully and then select the most appropriate answer by placing a tick in the box.

NB *Do not write in this textbook. Photocopy the pages and complete the post test on the photocopy.*

Multiple-choice questions

1. An accepting attitude is important for the development of a helpful relationship. Acceptance means. . .

☐ (a) clients should be able to behave as they like

☐ (b) carers should accept the fact that clients cannot help the way they behave

☐ (c) difficult client behaviours should always be seen as expressions of problems

☐ (d) carers should regard difficult behaviour as a reflection of moral weakness

2. When talking to a client for the first time, the carer should realise that:

☐ (a) hostile behaviour from the client indicates the carer's initial approach was inadequate

☐ (b) the client's case history should be discussed fully with the family before talking with the client

☐ (c) the client's physical appearance provides accurate cues as to whether or not the client will be receptive to the carer

☐ (d) the client and the carer are strangers to each other, and will need time to develop a relationship

3. You notice Mrs G. pacing up and down anxiously. Select the best response from the following options.

☐ (a) "Let's go and get you some tablets to help you to relax."

☐ (b) "Go and sit down and try to relax."

☐ (c) "You seem bothered by something. Would it help to talk to me about it?"

☐ (d) "It can't be all that bad. Come and help me sort out the linen."

4. A client with paranoid feelings confides in you — "They are out to get me, even my doctor is in with them". Select the best response.

☐ (a) "I can understand that you feel worried, but it doesn't seem to me that it is so. You're quite safe here."

☐ (b) "You're letting your imagination run away with you."

☐ (c) "Yes, and the sooner the better. We might get some peace then."

☐ (d) "You feel that way because you're ill."

5. Below are a number of strategies that can be used when a client exhibits difficult behaviours:

(i) engage in solution-focused problem solving

(ii) ignore the behaviours

(iii) warn the client of the consequences

(iv) blame the client for being difficult

Choose the best strategy or combination of strategies to use.

It is best to use:

☐ (a) (i), (ii) and (iv)

☐ (b) (ii) and (iii)

☐ (c) (i) and (iii)

☐ (d) (i) only

6. Below are a number of strategies that carers can use to help prevent suicide in clients who are thinking of taking their lives:

- (i) reassure them of their ability to tolerate the stress being experienced in their present situation
- (ii) assess their strengths and past experiences in coping with stress
- (iii) avoid any mention of suicidal ideas
- (iv) mobilise resources to assist them with personal responsibilities

Choose the combination of strategies that is the best to use.

It is best to use:

- ☐ (a) (ii) and (iii)
- ☐ (b) (i), (ii) and (iii)
- ☐ (c) (i), (ii) and (iv)
- ☐ (d) (ii) and (iv)

7. Which of the following interventions would be helpful when caring for a person suffering from schizophrenia?

- (i) leave the person to get on with their life as much as possible without interfering
- (ii) maintain an attitude of calm acceptance and friendly encouragement
- (iii) understand that even though the person may show little emotion, they do experience feelings, such as sadness, and respond accordingly
- (iv) promote co-operative working relationships with psychiatric services in order to provide better coordinated care.

Choose the combination of strategies that is best to use.

It is best to use:

- ☐ (a) (i) and (ii)
- ☐ (b) (i), (ii) and (iii)
- ☐ (c) (ii), (iii) and (iv)
- ☐ (d) all of the above

8. Possible causes of organic brain disorders are:

- (i) arteriosclerosis
- (ii) some forms of AIDS
- (iii) head trauma
- (iv) skin cancer

Choose the correct answer.

- ☐ (a) (i), (ii) and (iv)
- ☐ (b) (ii), (iii) and (iv)
- ☐ (c) (i), (ii) and (iii)
- ☐ (d) all of the above

9. The permanent impairment of brain functions which occurs in chronic organic disorders produces defects in:

- (i) memory
- (ii) orientation
- (iii) judgement
- (iv) comprehension

Choose the correct answer.

- ☐ (a) (i), (ii) and (iv)
- ☐ (b) (ii), (iii) and (iv)
- ☐ (c) (i), (ii) and (iii)
- ☐ (d) all of the above

10. Orientation can best be understood as:

- (a) a realistic awareness of place, time, circumstances and relationships with others
- (b) a tendency to behave at a fairly concrete level of understanding of the world
- (c) recognition of what is happening to oneself, including the probable causes and the likely outcomes
- (d) the ability to correctly interpret facts and their logical connections

True or false statements

T F

☐ ☐ **11.** Reassurance means keeping the environment clean, tidy and well organised.

☐ ☐ **12.** Feelings have as much influence on our lives as facts do.

☐ ☐ **13.** Personality development is likely to be impaired if parents frequently withhold affection from their children.

☐ ☐ **14.** Psychological needs are less important as we grow older.

☐ ☐ **15.** The use of defence mechanisms is valuable as a protection against overwhelming levels of anxiety.

☐ ☐ **16.** The goal of empathy is genuine understanding of another human being.

☐ ☐ **17.** When dealing with a verbally aggressive client the aim is to prevent this hostility from escalating into physical violence.

☐ ☐ **18.** Only some behaviours have meaning.

☐ ☐ **19.** The best way to deal with manipulative behaviour is to threaten the person.

☐ ☐ **20.** When depressed people don’t feel like talking the carer should leave the room.

☐ ☐ **21.** Carers should encourage clients to be as independent as possible.

☐ ☐ **22.** All people who are sad are depressed.

☐ ☐ **23.** Active listening means spending a lot of time with clients and their families.

☐ ☐ **24.** Holistic care means physical, emotional and behavioural care activities.

☐ ☐ **25.** People who threaten suicide never carry out their threats.

☐ ☐ **26.** Early detection and treatment can improve the life of people with schizophrenia.

☐ ☐ **27.** Dementia is a form of brain disorder.

☐ ☐ **28.** Symptoms of delirium include confusion, thirst, an excited mood and risk-taking behaviour.

☐ ☐ **29.** The primary symptom of dementia is memory loss.

☐ ☐ **30.** There is no cure for Alzheimer’s disease at present.

☐ ☐ **31.** Drugs taken for high blood pressure can cause symptoms that look like dementia.

☐ ☐ **32.** Stuttering is an inevitable part of the dementing process.

TEST ANSWERS

Multiple-choice questions

1. c
2. d
3. c
4. a
5. d
6. c
7. c
8. c
9. d
10. a

True or false statements

11. False
12. True
13. True
14. False
15. True
16. True
17. True
18. False
19. False
20. False
21. True
22. False
23. False
24. True
25. False
26. True
27. True
28. False
29. True
30. True
31. False
32. False

GLOSSARY

active listening means attentive involvement with the other person; it is the ability to hear the other person without interpreting according to one's own values and experiences.

affect is a psychological term meaning feeling tone or emotional expression. It is the quality of one's reaction to other people and events. Often "affect" is used interchangeably with "mood".

AIDS is an acronym for Acquired Immune Deficiency Syndrome, a disease in which the immune protective mechanisms in the body are attacked by a lethal virus resulting in systemic, pervasive episodes of debilitating illnesses, such as a fatal form of pneumonia.

anxiety refers to the strain that arises as a result of conscious/unconscious threat to a person's needs. Anxiety is greatly influenced by perception.

arteriosclerosis refers to hardening of the walls of the large blood vessels, called arteries, with deposits often accumulating along the walls that supply the heart or brain, eventually blocking the arteries.

communication involves the reciprocal process of sending and receiving messages between two or more people.

compulsion — an urge to carry out an act recognised to be irrational. Resisting the urge leads to an increasing tension which can be relieved only by carrying out the act.

confusion is a compound presentation of perplexity, bewilderment, failing memory and a clouding of consciousness.

conscious is that part of the mind where there is an awareness of facts, response control and sensory impressions. Different levels of consciousness are referred to clinically as: alert, wakefulness, lethargy, stupor and coma.

defence mechanisms are conscious and unconscious ways of coping with anxiety so that it does not overwhelm the individual.

deinstitutionalisation is the process of closing state-run psychiatric hospitals and attaching psychiatric inpatient units to general hospitals while developing community care systems

delirium tremens, often called the DTs, is a sometimes fatal form of delirium which arises from ceasing to drink after long-term, excessive intake of alcohol. Frightening visual hallucinations are a major feature of the DTs.

empathy is the ability to approximate the feelings of other people so that one can respond to and understand their experiences on their terms.

fantasies are creative images that are the product of the imagination. This normal mechanism of the mind is like a daydream. Negative fantasies are often caused by pessimistic imaginings of unsatisfactory outcomes based on a combination of myth and fear.

geriatrician — a medical practitioner who has undertaken postgraduate studies and practice in the care and treatment of elderly persons and who specialises in this form of medicine.

guided imagery technique refers to a particular type of stress management relaxation activity where the relaxing person, while in a reduced-awareness state, listens to a description of a story that stimulates the imagination. The person then visualises themselves in the story, which is always situated in a safe and peaceful retreat. This is very relaxing for most people.

Huntington's disease is a rare, hereditary condition that results in severe personality and brain function changes. Uncontrolled shaking movements of the head and limbs are key clinical features of this condition.

hypoglycaemia means an abnormally small concentration of glucose is circulating in the blood.

insight is the ability to understand one's own motives, intentions and behaviours and, as a consequence, to understand better the motives, intentions and behaviours of others.

intellectual disability occurs when people fail to develop full intellectual capabilities due to arrested development of cognitive functions.

labelling is the stereotyped approach to viewing individuals which insists on categorising them into preconceived formats.

mental illness, or psychiatric illness — a group of illnesses that show a disturbance in a person's thinking, behaviour and mood in the absence of an obvious physical cause. The illnesses include extreme forms of everyday behaviour such as severe anxiety and major depression, and psychotic disorders such as schizophrenia.

mood is the feeling tone, particularly as experienced internally by the individual.

nonverbal communication is communication between two or more people without the use of words. Facial expressions, gesture and body postures are examples of nonverbal communication.

personality disorder — a person with a personality disorder exhibits enduring and maladaptive patterns of thinking and believing that interfere with successful functioning in all areas of life.

personal space refers to the invisible bubble of territory around a person's body into which intruders may not come without permission.

phobia — morbid fear of situations, objects and/or places which is relieved by avoidance. A person with a morbid fear who is exposed to the source of that morbid fear is likely to suffer a panic attack.

prognosis — the predicted outcome of a health disruption/problem

psychiatric disorder (see mental illness)

psychiatrist — a medical practitioner who specialises in the prevention, diagnosis and treatment of mental and emotional disorders.

psychologist — one who is engaged in the scientific study of all forms of human and animal behaviour and is sometimes concerned with the methods through which behaviour can be modified.

psychosocial is a composite word meaning psychological and social aspects of a person.

psychosocial and mental health assessment is the assessment of the psychological, social and mental health aspects of the person. Understanding the ways in which a person has been influenced by society and cultural heritage, for instance, as well as knowing if a person has or has not worked through developmental tasks is helpful in predicting responses when caring interventions are planned. The mental health assessment gives the indication of existing or potential mental illness through the use of a process that focuses on areas such as mood, orientation and other features of psychological wellbeing.

psychosomatic is the word used to describe a mind–body illness, an illness in which emotional factors produce physical symptoms, mainly because of overactivity of the autonomic nervous system which is influenced by the emotional state.

psychotherapy, sometimes called "talk therapy", is where a trained therapist deliberately establishes a professional helping relationship for the purposes of removing, modifying or reducing maladaptive emotional or behavioural problems.

psychotic is the adjective from psychosis which is a major mental disorder of organic or emotional origin in which a person's ability to think, respond emotionally, remember, communicate, interpret reality and behave appropriately is impaired. Insight is usually absent.

reflecting is a communication skill in which one reiterates either the content or the feeling message of what the other person is communicating.

schizophrenia refers to a set of psychotic behaviours, disordered thoughts and fluctuating, inappropriate emotions of a person not in touch with reality. Schizophrenia is a psychiatric disorder.

specialled — specialling is a psychiatric nursing procedure in which a person who is in danger of hurting her/himself or others, e.g. by self-harm activities or suicidal attempts, is accompanied closely at all times to prevent harm occurring. Specialling ceases when the person at risk is assessed to be out of danger.

stigma — something that detracts from the character or reputation of a person or group; a mark of disgrace or reproach.

validation is an affirming technique which facilitates communication with sensory-impaired or confused elderly clients by stimulating the link between the client's present feelings and their past achievements, losses and conflicts.

unconscious is theorised to be that part of the mind in which thoughts and feelings are not available to conscious awareness.

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The message of this book is:
"It's not the person that is the problem,
it's the person's behaviour."
That message was so well received by the readers of the first edition of this book that this second edition has been produced.

In *Caring for People with Problem Behaviours* Bernadette Keane and Carolyn Dixon provide a Behavioural Change Model that is solution-focused. It concentrates on finding a solution to a problem and setting that solution in place by way of a partnership between the carer and the person with the behavioural problem — difficulties are recognised and solutions are achieved; success is acknowledged and rewarded. Within this kind of positive context, many people can be supported in their efforts to develop behaviours that are more fulfilling for themselves and for those around them. It is made clear, however, that this is a co-operative model which means it cannot be applied where comprehension is absent.

Bernadette and Carolyn have drawn on their long and wide experience in the health field to provide practical advice to all carers whose jobs bring them into contact with people who present with difficult behaviours.

You don't have to be in the health field to come across problem behaviours. This book can be just as relevant to everyone who works with people — and isn't that all of us?

The Authors

Bernadette Keane is a highly experienced nurse educator who lectured for nine years in the psychiatric nursing programs conducted at Royal Park Hospital in Melbourne, Australia. In addition to psychiatry her clinical background and qualifications include medical, surgical, midwifery and infant welfare areas of care. In 1982, as a Kellogg Nursing Fellow, she studied at the University of California, San Francisco. Since then she has published journal articles and textbook chapters on health care and professional issues.

In 1986 Bernadette launched her private practice, called Continuing Education Consultation, and from 1992 to 1998 she was president of the association called Nurses in Independent Practice. In 1992, together with Rhonda Goodwin and Jennifer Richmond, Bernadette published a nursing history book entitled *Mum and Me and T.L.C.*

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