THE UNIVERSITY OF IOWA

IOWA GERIATRIC EDUCATION CENTER

INFO-CONNECT

Understanding and Managing Aggression

The Facts . . .

⇒ Although behavioral symptoms are common among physically and mentally frail older adults, these symptoms are often misunderstood and mismanaged.

⇒ Accurate assessment of underlying social, psychological, personal, and medical needs is essential to effective management.

⇒ Both behavioral and pharmaceutical interventions are often required to comfort and reassure behaviorally impaired elders.

Personal Care as a Trigger of Aggression

⇒ Most instances of physical aggression occur while personal care is being given to cognitively impaired individuals.

⇒ Aggression commonly occurs as a reaction to the perception of a threat, **NOT** as an offensive or assaultive attempt to injure the caregiver.

⇒ Aggression during personal care is frequently related to the following situations:

- Touch or invasion of personal space
- Fear of unwanted intimacy
- Frustration related to declining abilities
- Discomfort, pain, or fear of pain
- Loss of personal control or choice
- Lack of attention to personal needs or preferences
- Unfamiliar routine or procedure

⇒ Aggressive behaviors may be reduced or eliminated by adjusting care routines.

Understanding the experience from the patient's perspective is critically important when looking for ways to comfort and soothe.

Common Risk Factors Associated with Aggressive Behaviors

⇒ **Cognitive Impairment Due to Dementia**

- Frustration created by progressive loss of function
- Inability to express feelings, needs, and sensations
- Decreased inhibitions, late-day fatigue, pain, or overstimulation leading to disproportionate responses to minimal events (e.g., sundowning, catastrophic reactions)

⇒ **Other Psychiatric Illnesses**

- Delirium
- Depression
- Bipolar disorder
- Schizophrenia, paranoid disorder, and other disorders causing psychotic symptoms

⇒ **Sensory Impairment**

- Impaired hearing and/or vision
- Communication losses
- Misinterpretation of real-life events

⇒ **Inappropriate Sensory Stimulation**

- Excessive stimulation (e.g., noise, confusion, or too many people) can overwhelm and frustrate (e.g., dining room).
- Misinterpreted stimuli (e.g., radio, television, mirrors, or public address systems) may threaten or frustrate.

⇒ **Lifetime Use of Aggression as a Coping Mechanism**

⇒ **Unmet Psychological Needs**

- Isolation or loneliness (possibly precipitating illusions or delusions)
- Invasion of privacy or personal space
- Changes to long-standing patterns of behavior

⇒ **Sleep Disturbance**

- Reduced hours of sleep
- Poor quality of sleep

⇒ **Health Status**

- Pain and discomfort
- Hunger and thirst
- Constipation, urinary tract infection, and other gastrointestinal problems
- Acute hypoxia (lack of oxygen to the brain)
- Fatigue
- Infectious processes
- Electrolyte disturbances
- Endocrine, cardiovascular, neurological, and renal disorders

⇒ **Medications**

- Side effects (e.g., akathisia with psychotropics)
- Toxicity (e.g., levodopa, coricosteroids, anticholinergics, or barbiturates)
- Withdrawal (e.g., central nervous system depressants)
- Paradoxical reactions (e.g., sedative and hypnotic medications, which may lead to agitated delirium)

⇒ **Neurological Disorders**

- Region-specific central nervous system damage
- Neurotransmitter changes (e.g. serotonin metabolism has been linked to impulsive behavior)
- Deterioration in circadian circuitry (e.g., end-of-day agitation)

Assessment is Key

⇒ **Remember**, assessment is an ongoing process.

⇒ The following factors may interact to trigger aggressive behaviors:

- Mental health
- Physical health
- Medication side effects
- Social and family
- Life history
- Long-standing personality

⇒ To determine the underlying cause(s) of aggressive behavior, perform a comprehensive assessment of the following:

- Current symptoms (including onset, duration, intensity, and changes)
- Medical history and physical exam
- Psychiatric history and mental status exam
- Current and previous medications
- Laboratory tests: CBC; urinalysis; T3, T4, TSH; B12 and folate; Chem screen including Na, Cl, K, BUN, Ca, glucose, creatinine
- Electrocardiogram
- CT scan and MRI

⇒ Identify, assess, and treat medical problems that complicate course of behavioral problems.

⇒ Rule in (or rule out) other conditions that interact with or trigger behavioral symptoms.

⇒ Appreciate how the following experiences affect a patient's perspective:

- Loss of power and control
- Unwanted dependency
- Loss of former meaning and purpose in life

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The A-B-C Model

The A-B-C Model refers to a three-step method of approaching behavior symptoms.

⇒ Identify the target **B**EHAVIOR to be changed.

- Describe the behavior completely, precisely, and accurately using measurable terms.
- Identify the behavior's frequency, duration, intensity, and correlation with other behaviors.
- Consider for whom the behavior is a problem (i.e., the person, family, staff, or other residents).

⇒ Investigate possible **A**NTECEDENT conditions, or triggers, to the target behavior, which may include the following:

- **INTERNAL** antecedents: sensations, feelings, and experiences such as pain, hunger, fear, or perceived invasion of personal space
- **EXTERNAL** antecedents: factors in the physical or social environment such as noise, too many people, confusing surroundings, or demands to function beyond his or her ability

⇒ Examine and describe possible **C**ONSEQUENCES, or reactions and responses, to the target behavior.

Make a Plan . . .

⇒ Set an achievable, realistic **B**EHAVIORAL goal.

⇒ Change the **A**NTECEDENT conditions to reduce likelihood of behavioral reoccurrence.

⇒ Change the **C**ONSEQUENCES for the targeted behavior.

⇒ Evaluate if any or all of the plan worked.

10 Principles of Behavioral Intervention

1) Know the person "behind the disease" and individualize care.
2) Understand that no two people or situations (even with the same person) are the same.
3) Focus on the person, not the task.
4) Pause to assess the person and the situation.
5) Break tasks into steps, allowing the person to do what he or she can do individually.
6) Respond to the patient's emotions; don't argue logically.

Taking more time during personal care may actually save time by avoiding emotional or physical conflict.

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7) Use the patient's agenda.
8) Slow down; follow the patient's lead.
9) Redirect the patient with a positive approach.
10) If things are not going well, leave and try again later.

Medication Management

⇒ **Always,** try non-pharmacological therapies unless there is a:

- Danger
- High level of patient distress
- Specific indication (like depression or psychotic symptoms) for which medication is an effective solution

⇒ Target one or more specific symptoms.

⇒ Establish a specific therapeutic goal, which may be to:

- Resolve delusions
- Decrease frequency of hitting
- Reduce disruptive vocalization

⇒ Develop outcome criteria in advance to facilitate decision making.

⇒ Select medication on the basis of the drug's side effect profile in relationship to the patient's symptoms.

⇒ Start at the lowest dose possible and slowly titrate upwards.

⇒ Carefully monitor symptom improvement while watching for problematic side effects.

⇒ Apply principles of medication management outlined in practice guidelines and algorithms for specific disease states.

COMMON CARE CHALLENGES:	Bathing	Toileting	Mealtime	Disruptive Vocalization
Common Antecedents/ Sources of Stress:	• Room temperature (e.g., cold, drafty) • Water temperature (e.g., too hot, too cold) • Unfamiliar facilities or routine (e.g., sterile, not home-like) • Embarrassment or emotional discomfort • Physical discomfort or pain with movement • Misperception or fear	• Lack of privacy or comfort • Misperception (e.g., thinks trash can is the toilet) • Way-finding problems (e.g., unable to see or find toilet) • Language loss (e.g. unable to communicate needs) • Functional deficits (e.g., unable to disrobe or get to the toilet in time) • Unaware of "social rules" • Urinary tract infections • Medications (e.g., diuretics and medication side effects)	• Incontinence/need to void • Pain (e.g., mouth, gums, ill-fitting dentures, mobility) • Overstimulation (e.g., noise, confusion, crowding) • Competing demands for attention (e.g., medications, food, or conversation) • Eating utensils are not understandable • Food or eating style is unfamiliar • Overwhelmed by choices or demands	• Sensory overstimulation or understimulation • Immobility • Pain or discomfort • Fatigue • Vocal tics • Psychotic symptoms (e.g., hallucinations or delusions) • Psychological distress (e.g., boredom, loneliness, anxiety, or fear) • Caregiver behaviors (e.g., indifferent or impersonal)
Behavioral Interventions:	• Collect a "bathing history" • Base bathing method and time of day on history • Use past memories to encourage cooperation • Provide a reason to bathe • Use one person to assist rather than several • Cover all body parts not being washed • Provide a washcloth to cover face and eyes • Wash hair last or wash in a beauty salon or barber shop • Distract person with familiar conversation • Use familiar terms or words • Offer choices, encouragement and feedback • Bathe in room using bed, towel, or sponge bath as an alternative	• Clear pathways to toilet • Provide cues to find toilet (e.g., pictures or signs) • Use color contrast (e.g., a white toilet with a bright-colored wall) • Develop a personalized routine using patient's long-standing habits • Monitor behavior • Use easy-to-remove clothing • Cue or assist as needed • Monitor intake after 6 pm to avoid accidents • Eliminate caffeine • Monitor medication type, interactions, and side effects • Monitor intake/output to assure adequate intake and hydration • Minimize 'fuss' if accidents occur	• Develop calm, quiet, home-like routines • Dine with small groups or in own room • Use tablecloths, flowers, candles, and lowered lighting (all are associated with less mealtime aggression) • Provide space so each has his or her own territory • Tolerate "messy" behavior • Cue or assist as needed • Simplify food presentation • Provide appropriate utensils (e.g., use color contrast and one plate/utensil rather than several) • Redesign routines to avoid overstimulation and confusion • Adopt flexible, adaptable mealtime policies (e.g., open kitchen, cafeteria style, or restaurant style)	• Offer adequate pain medication • Avoid large group activities, noise, and commotion • Create home-like setting • Offer environmental sounds (e.g., tapes of waterfalls, rain, or wind) • Use aroma or pet therapy to soothe or distract • Maximize sensory function • Treat underlying physical problems • Ambulate or escort outdoors • Use one-to-one activities, reassurance, and reminiscence to distract • Reassure through touch, conversation, music, or a taped voice of loved one • Schedule naps and monitor routines