Disinhibited behaviours in-service

Behaviour Management
A Guide to Good Practice

Working with people with dementia who present with disinhibited behaviours

A presentation for residential aged care staff and community care staff prepared by the Dementia Collaborative Research Centres (DCRC-ABC) for the Dementia Behaviour Management Advisory Services (DBMAS)

Acknowledgment of Country

We acknowledge the traditional custodians of this land

We also pay respect to the elders past and present and extend that respect to other Aboriginal people present

Objectives

At the end of this presentation participants will have an increased understanding of:

• How disinhibited behaviours present in people with dementia
• Diagnostic criteria & potential causes of disinhibited behaviours in people with dementia
• Strategies & considerations to assist in the care of people with disinhibited behaviours in dementia

What do disinhibited behaviours in dementia look like?

• Reduced capacity to edit immediate impulsive responses
• Behaviours include - impaired judgement - reduced awareness of environment & impact on others
• Includes socially & sexually inappropriate behaviours

Socially disinhibited behaviours may present as:

• Swearing, obscenities, offensive language
• Hitting out, kicking, pushing, throwing objects
• Poor self-care/ neglect
• Loss of insight
• Demanding unnecessary attention
• Antisocial behaviour e.g. urinating in inappropriate places, uncontrolled eating
• Low frustration tolerance, impatience
• Finding humour where others don’t

Sexually disinhibited behaviours may present as:

- Unwelcome attempts at sexual acts with others
- Propositioning others
- Sexual aggression
- Exhibitionism
- Unwelcome cuddling
- Requesting unnecessary genital care
- Masturbation in the presence of others
- touching others inappropriately
Disinhibition in dementia may be due to a complex interaction of:

- lack of privacy
- impaired judgement
- environmental triggers
- underlying brain disease
- being unable to find the toilet
- separation from usual sexual partner
- unmet need for human contact or affection
- misinterpretation of the intentions of carers &/or staff

Pathology of disinhibited behaviours

Dementia is associated with brain changes that can lead to disinhibited behaviours

+ Interaction between the individual & the environment

Important consideration in the diagnosis of sexually disinhibited behaviours in dementia

- Determine if presenting behaviours could be a variation of the person’s typical/previous patterns of behaviour
- Can be difficult to determine – may not be known to family

Diagnostic Considerations

Use a person-centred approach to gather ALL potentially important information

▼ Could symptoms be due to a delirium from pain/discomfort, infection, agitation, medication or other physical causes?
▼ Is this a symptom of a psychiatric disorder?
If YES, respond & treat accordingly FIRST
If NO, consider management options

▼ Develop psychosocial strategies & interventions
▼ Only where necessary, individually targeted medication to reduce agitation, distress &/or safety concerns
▼ Review!

Measuring disinhibited behaviours in dementia

Instruments to assist:
- The Disinhibition Scale
- The Behavioral Syndromes Scale for Dementia (BSSD)
- The CERAD Behaviour Rating Scale (BRSD)
- Neuropsychiatric Inventory (NPI)
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Prevalence of disinhibited behaviours

- Not one of the most common BPSD
- Occurs in 2% - 25% of those with dementia
- More prevalent in those with FTD
- Rates dependent on definitions & tools used for measurement
- Likely underreporting of sexually inappropriate behaviours

Rates are reportedly higher in those with:
- dementia severity
- impairment of insight
- rate of cognitive decline
- performance in activities of daily living

Effects of disinhibited behaviours

- Decline in cognition
- Carer burden
- Health care costs
- Quality of life
- Physical health
- Premature placement in RACF

Before you move on, have you:

- ensured that the person & all those in their environment are not at risk?
- provided a full person-centred assessment of the presenting symptoms?
- excluded &/or treated any potentially reversible factors?

Your approach...

- Calm
- Gentle
- Thoughtful
- Avoid overreaction &/or shaming
- Avoid moral judgement

Suggested strategies include:

- Identify potential triggers
- Identify early indicators of potentially problematic disinhibited behaviours
- Where appropriate, indicate to person with dementia that the behaviour is unacceptable
- Avoid ‘knee-jerk’ responses &/or overreaction
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Suggested strategies cont.
• Increase positive contact with family & pets to compensate for loss of companionship
• Reorientate if attention is directed inappropriately

Caring approaches & interventions
Psychosocial &/or environmental approaches
• Scientific evidence lacking however individual responses vary
• Individually tailored should be trialled e.g.
  – Multicomponent intervention including pain management, medication review & social contact
  – Music interventions

Caring approaches & interventions
2nd line approach - biological
• Consider where necessary for safety, but evidence is limited
• Determined by urgency & risk associated with behaviour
• If meds indicated, ChEls or SSRIs may provide safer option
• If no safety risk - no first line medication recommended

2nd line approach – biological cont.
Where pharma is prescribed:
• Use with caution – short term only
• Use in combination with psychosocial interventions
• Be aware of risks with long term use of antipsychotics
• Reduce, discontinue when indicated
• Monitor closely & REVIEW!

Mr A – presentation
• Sexual suggestions toward female staff members & a female resident
• Transferred to another section of facility ➔ behaviours resumed
  ➔ escalated to touching others inappropriately
  ➔ masturbating publicly during meals

A clinical scenario - Mr A
Mr A presentation cont.

- When staff intervene in dining room
- or ask Mr A to return to his room
- he can become verbally aggressive & threatening

What are some of the potentially contributing factors for Mr A’s disinhibited behaviour?

Mr A - potentially contributing factors

- Sexual history & premorbid patterns of sexual interest
- Pain/discomfort/illness/infection
- Medication interactions, dosage, adverse effects, recently prescribed
- Lack of usual sexual partner/privacy

Potentially contributing factors cont.

- Misinterpretation of environmental cues
- Loss of premorbid social controls
- Psychotic symptoms/misidentification
- Sensory impairments
- Altered routines, particular staff &/or family members
- Unfamiliar/ altered/deprived physical environment

Mr A - assessing the situation

- Observe closely for possible triggers
- Ask staff who know Mr A to assist in identifying possible triggers
- Assess immediate environment for possible triggers
- Consult life history/behaviour & clinical charts that may highlight triggers
- Consult with family members to identify previously unknown triggers
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**Mr A – some outcomes**

**Disinhibited behaviours in dementia - conclusions**
- Seek to understand what the behaviour & context means for the individual
- Manage on a case-by-case basis
- Avoid moral judgement
- Aim to allow the person’s appropriate sexual expression while protecting safety, rights & dignity of all

**‘Success’**
- Typically not about eliminating BPSD
- Has BPSD?
- Has person with dementia’s distress?
- Has carers’ understanding of potential causes?
- Has carers’ skills/coping?
- Do carers feel supported?
- Be realistic about goals/outcomes
- BPSD are SYMPTOMS of dementia!

**Reflection & review**

How can you use this information to make a difference in the lives of people with dementia who present with disinhibited behaviours in dementia?

**Thank you for your attention & your participation in DCRC research**

See DCRC website for further resources [http://www.dementiaresearch.org.au](http://www.dementiaresearch.org.au)

**Resources**

Alzheimer’s Australia Help Sheets

Translating what we know about pain recognition & management in people with dementia

Dementia Outcomes Measurement Suite
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