Older Adults in a Changing World: Behavioral Health, Sexuality, Dementia, & Long-Term Care

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• Explore unique challenges to specific areas of health, & their impact on aging in our society
• Review issues related to behavioral health, interpersonal relationships, & the evolution of the aging population
• Highlight topics that can be challenging for care providers
• Focus on issues specific to long-term care
Objectives

• Participants will be able to identify three (3) key factors related to challenges in providing care for the next cohort of older adults

• Participants will be able to demonstrate recognition of the impact of aging on behavioral health needs and expressions

• Participants will be able to identify three (3) areas of current care provision & expectations that will need to be modified with the evolving aging population in long-term care
Aging in a Changing World

- Ageism
- Taboos
- Generational differences – WWII vs Boomers
- Community dwelling vs. LTC
- New pressures & stressors
- Baby Boomers entering retirement
- Different expectations for customer service
AGEISM
World War II: The Greatest Generation

“NEVER WAS SO MUCH OWED BY SO MANY TO SO FEW”
WWII vs. Baby Boomers

• “GI (Greatest Generation)” born before 1924 – few left

• “Silent Generation” – 1924 to 1942/45
  – Used to harder times
  – More conservative than their parents’ generation

• “Baby Boomers” – 1942/45 to 1964
  – A brighter future
  – Responded to their parents’ conservativeness with more liberalized, consumer-based viewpoint
BOOMER DEMOGRAPHICS

- Baby boomers: the generation born between 1946-1964 (ages 51 and 69)
- Nearly 80 million boomers
- $3 Trillion yearly consumer spend
- By 2015, people aged 50 and older will represent 45% of the U.S. population
- By 2017, 50 percent of the U.S. population will be 50+. (Nielsen)

"Those born during that 19-year period – from 1945 to 1964 – were part of the largest, most prosperous, best-educated and, some might say, most indulged and indulgent generation that the world has ever seen"
The Battle Against Aging

- Billions spent annually on anti-aging products & services –
  - Estimated to be **191.7 BILLION USD** by 2019
- Aging faces often seen as “losing” – youth, independence, ability, attractiveness
- Messages received constantly about what is attractive, acceptable, “normal”
- Women targeted more than men
- Baby Boomers – have a lot of money, & many fear aging

Aging is not an illness...

...But we treat it like one.
We’re all likely to need at least a little help as we get into old age. The amount we need will vary, based on our physical & emotional health, resources, & support systems.
Older Adults at Home

• Many individuals “age in place” –
  – Often the ideal arrangement for the person
  – Can be a challenging setup if care/support needed
• Children are often caregivers – most often female children
• Creates the “sandwich generation”
• Huge costs, up front & secondary –
  – Healthcare
  – Mental Health
  – Caregiver stress/burden
In 2013 15.5 million family and friends provided 17.7 billion hours of unpaid care to those with Alzheimer’s and other dementia.
75% of adults who need care are cared for by an unpaid caregiver.

Most often a female family member - upwards of 75%

[Institute on Aging. (2016). Read How IOA Views Aging in America.]
Nearly one-third of caregivers report symptoms of depression

Over 50% of caregivers of those with chronic illness report high levels of stress

Older Adults in LTC

A unique challenge –

- Aging in a communal setting
- Loss of independence
- Reliance on families, caregivers
- Sense of autonomy often reduced
- Chronic, sometimes debilitating conditions

But still – the same emotional needs as any other aging person
“Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.”
Key Issues - Behavioral Health

• Three areas important to addressing in the aging population:
  – Dementia
  – Mental/Behavioral Health diagnoses
  – Sexuality

• Three areas often difficult for caregivers

• Two frequently under-addressed
Dementia

- More than 5 million Americans living with it
- Could be 16 million by 2050
- Every 60 seconds, someone develops Alzheimer’s
- Since 2000 – heart disease deaths down 14%; Alzheimer’s deaths up 89%
- Dementias will cost the US $259 Billion dollars… this year.

- Estimated 80% of nursing home residents
- About 1 million of the 5 in SNFs
- Could be up to 13 million in nursing homes by 2050
- 1 in 3 seniors dies from a dementia
- 6th leading cause of death

What is Dementia?

• Dementia is a loss of intellectual functions of sufficient severity to interfere with a person’s daily functioning.

• It is not a disease in itself, but rather a group of symptoms which may accompany certain diseases or physical conditions.
Types of Dementia

- Alzheimer’s
- Vascular type
- Mixed dementia
- Fronto-Temporal
- Lewy Body
- Korsakoff’s
- Traumatic Brain Injury
Women and Alzheimer’s

Women are at the Epicenter of the Alzheimer’s Crisis
Typical Brain Function

Perception
- The brain is receiving information from our environment and all of our senses, what we see, what we smell, what we taste, what we feel, what we touch.

Memory
- The brain then calls upon our memory to interpret those things.
- The brain cannot go to the next step if the memory piece is missing.

Action

Thought
- After interpreting the information, the brain then can have an appropriate thought and/or take action
- If the brain did not interpret the information at all or it interpreted incorrectly, the behavior may not be appropriate.
The Relationship

Increased neurodegeneration

Decreased cognitive function

And yet, some level of function always remains
## Stages of Alzheimer’s Disease

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>No impairment</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Very mild decline</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Mild decline</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Moderate decline (early stage)</td>
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<tr>
<td>Stage 5</td>
<td>Moderate to severe decline (mid stage)</td>
</tr>
<tr>
<td>Stage 6</td>
<td>Severe decline (moderate stage)</td>
</tr>
<tr>
<td>Stage 7</td>
<td>Very severe decline (end stage)</td>
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</tbody>
</table>
Approx. 80% of all residents currently residing in nursing homes in the United States have dementia.
Alzheimer’s in Epidemic proportions

Every day 10,000 baby boomers turn 65

That is 35 million, 500 thousand every year
Is Dementia a Mental Health Issue?

- Crosses the bridge of physical & mental health
- Impacts function – physical & cognitive
- Can contribute to challenging behavioral expressions

…It could be a clear example of the importance of the mind/body connection - & why emotional/mental health is just as important as physical
Mental/Behavioral Health Diagnoses
Common Challenges of Late Adulthood

- Retirement
- Chronic health issues
- Ageism
- Losses of loved ones
- Reduced finances
- And yet – the majority of older adults describe themselves as happy, healthy, & engaged
Mental Health Disorders in the Elderly

• Mental illness is NOT a normal part of aging

• Disorders may be due to:
  – Preexisting conditions
  – Reaction to losses
  – Late onset illnesses
Mental Health in Older Adults

- Estimated 20% of people 55+ years experience some type of MH issue.
- Most commonly diagnosed include:
  - mood disorders (e.g. depression, bipolar disorder).
  - anxiety
  - severe cognitive impairment
- Mental health issues are often involved in cases of suicide.
- Older men have the highest suicide rate of any age group. Men 85 years or older - suicide rate of 45.23 per 100,000, All ages? Overall rate of 11.01 per 100,000.
Depression: Symptoms in Older Adults

- Increased in psychomotor & somatic changes
  - Slowing, insomnia, weight loss, early morning waking
- Sleep disturbances
- Less likely to report guilt & suicidal ideation
- Language describing emotional symptoms may diminish impression of distress
  - De-emphasis on mood gives impression of “depression without sadness”
- Melancholic features likely to be more pronounced
  - Loss of interest, pleasure, sexual interest

Depression: Risk Factors

Risk factors for late-onset depression included:
- Widowhood
- Physical illness
- Lower education (less than high school)
- Impaired functional status
- Heavy alcohol consumption
Treatment

• Antidepressant medications are the most common form of treatment (SSRIs preferred)

• Older adults prefer psychotherapy over medication!

• Evidence-Based Therapies for Older Adults
  – Behavior therapy
  – Cognitive Behavioral Therapy
  – Problem Solving Therapy
  – Reminiscence Therapy
  – Cognitive Bibliotherapy
  – Brief Psychodynamic Therapy
Some symptoms of depression present similarly to dementia

- Decreased motivation ➔ poor self-care
- Poor attention & concentration ➔ memory loss?
- Irritability, anger, withdrawal, apathy ➔ personality/mood changes
- Changes in appetite, sleep
- Feeling bored, lonely, restless
Presentation of Anxiety in Elders

• May mimic and/or exacerbate physical illnesses
• Less severe disorders more common
  – Lower levels of emotional arousal
  – Better regulation of emotion develops with age
• May express as physical illness – particularly in older cohorts
• May be manifested as irritability or “demanding” behavior
• Masking of symptoms due to symptom confounds & language choices
  – Clinically significant distress may still be present

Treatment of Anxiety

• Pharmacologic – SSRIs preferred over anxiolytics
  – Factor in interactions & comorbidities

• Psychotherapy
  – Cognitive restructuring
  – Behavioral activation
  – Relaxation training
  – Psychoeducation
  – Problem solving therapy

• Modifications in pace, language & scope of interventions

Depression

- Frustration
- Sadness
- Worthlessness
- Irritability
- Loss of interest in normal activities
- Thoughts of suicide or death
- Tiredness
- Disturbance in sleep or appetite

Anxiety

- Trembling
- Increased breathing rate
- Feeling nervous or powerless
- Having a sense of impending danger or panic
- High heart rate
- Sweating

Excessive worrying

- Trouble thinking, concentrating, or making decisions
- Unexplained physical complaints, such as headaches or stomach aches

Restlessness

- Shaking
- Feeling restless or restless
- Difficulty sleeping

Agitation

- Difficulty concentrating
- Feeling agitated
- Feeling testy or irritable

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http://www.blissfulmindtherapycentre.com/
Serious & Persistent Mental Illness

A Special Population of Elders
Serious & Persistent Mental Illness

Affective disorders
- Depression
- Adjustment disorders with related mood issues
- Bipolar Disorder
- Dysthymia
- Cyclothymia
- Seasonal Affective Disorder

Anxiety disorders:
- Anxiety unspecified
- Generalized Anxiety Disorder
- Panic Disorders
- Social Anxiety
- Obsessive-Compulsive Disorder
- Hoarding

Personality Disorders

Eating Disorders

Psychotic Disorders

Substance Abuse

Number of older adults with SPMI are increasing with improved healthcare

Experiences with institutionalization may affect function, adjustment & social supports

“Late life” for person with SPMI may be earlier than others
  - 20% shorter lifespan
  - Increased comorbidities & functional deficits due to lifestyle, medications & stressors
Challenges to Care

• Health issues, medications & functional losses may exacerbate or trigger SPMI symptoms
• Cognitive changes with SPMI can challenge traditional MH care approaches
• Services & supports for older adults with SPMI may be limited
  — Community service providers may be uncomfortable with geriatric care
  — Geriatric care providers may find these clients daunting
• PTSD: Post-traumatic stress disorder
• Not always just a pre-existing condition – the transition to LTC, for many, is traumatic
  – Multiple losses – independence, home, abilities
  – Feelings of abandonment, neglect
  – High stress situation
  – Adjustment issues – major life change, generally seen as a negative

Trauma can lead to increased risk of risky or unwanted behaviors
Exploring Sexuality in Older Adulthood

- What is “normal?”
- What is acceptable?
- What is sexual?
- Supporting sexual connection & healthy boundaries
- Defining “healthy” in terms of older sexuality
- Supporting healthy sexuality is a Quality of Life issue
Defining Sexuality

What is sexuality?
...Is it who we’re attracted to?
...Is it who we choose to have sex with?
...Is it how we feel about our bodies?
...Is it how we feel about having children?
...Is it what we call ourselves, female or male?
What is Sexuality?

“...a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.” (WHO, 2006a)

http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/
So...

Why is this important?
Circles of Sexuality

Adapted from the Circles of Sexuality, Life Planning Education, Advocates For Youth, Washington, D.C. 1995
What’s “normal?”

Mom? What is... Normal?

It's just a setting on the dryer, honey.
Exploring Sexuality in Older Adulthood

American Sexual Health Association, “Understanding Sexual Health” http://www.ashasexualhealth.org/sexual-health/
Actually, you can have a healthy sex life well into your later years. Assuming you can stand the sight of people your age naked.

I want to grow old with you.
But not too old.
Old people are gross.

They're adult diapers in a thong...I told you I was bringing sexy back...

Sweet angel of death please take me now.

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What does that mean for LTC?

• Face taboos of aging and sexuality
• Paternalistic, judgmental view of older adult sexuality
• LTC may feel like “giving up” on having a private life
• Everyone is affected by negative imagery about older adults
• Creates uncomfortable, silent space
Discussing challenges of sex-positive thinking in LTC

• Stereotypes and taboos
• Ageism
• Discomfort with open discussion of sexuality
• Paternalistic/judgmental view of the elderly
• Focus on a medical model
• Personal issues/beliefs influencing how we support the lifestyles/beliefs of others
Healthy Sexuality and Aging

• Human sexual interactions are normal & natural
• Emotional & physical intimacy is important in the lives of many older adults
• The ability to engage in sexual activity is considered a human right
• The need for sexual expression & intimate relationships does not diminish with age
Sexual Needs in LTC

- Support sexual needs in LTC - with or without partners
- Have easy access to sexual resources
- Create policies for supporting sexual health in your facility
- Promote more information/discussion on the topic
- Also ensure safety for all residents & their right to NOT engage in sexual encounters

LGBT – Important Considerations
Building Inclusive Communities

• Being aware of the potential needs & preferences of residents – & helping meet those needs in a caring way – helps create genuine, trusting relationships

• Fosters a more open, sex-positive, connected community

• Needs & preferences will be changing significantly in LTC over the next two decades
Challenging behavioral expressions & needs
How do we determine what’s challenging?

&

Who gets to decide what’s appropriate?
Assess the Situation

1. Identify Issue
   - Identify what the issue is - is it: Physical safety? Avoidance of harm? Personal discomfort? Violation of social expectations?

2. Identify Risk

3. Review Policy
   - Review existing policy for your facility, using it as a guideline for intervention

4. Problem Solving
   - Employ creative exploration & problem-solving techniques using person-centered care principles

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Sexual behavioral expressions

Note: dementia often results in a DECREASE in sexual expression or interest

Common reasons for increased sexual expression:

- Disinhibition – lack of a “filter”
- Same desires present, but unable to comprehend changes (executive function impairment)
- Brain changes to emotional or pleasure centers
- Medication side effect

More Common Expressions

Types of challenging sexual expressions that may occur:

- Increased libido
- Actively seeking out a partner, with potentially limited ability to comprehend consent
- Role confusion with staff/care
- Increase desire for physical stimulation
- Masturbation not occurring in private
- Less commonly, sexually aggressive behaviors

Non-Pharmacological Approaches

- Adjust Caregiver Approaches
- Change the Environment
- Use evidence-based interventions
Person-Centered Problem Solving – Behavioral Expressions

- Behavior not dangerous, but persistent, or distressing?
  - ✓ IDT Review & develop action plan

- What else?
  - ✓ A mental health evaluation – guide the team, provide additional interventions, support for the resident

- Non-pharmacological approaches not working?
  - ✓ Psychiatry consult – as a LAST RESORT!
Developing Person-Centered Approaches
Who is Responsible for Person Centered Care?

- Clinical staff
- Direct care staff
- Administrative staff
- Support staff
- Physical environment must support
- Daily schedule & activities
Community-Wide Responsibilities

• Encourage creative problem solving by all staff
• Empower staff to utilize creativity, compassion & relationships
• Interdisciplinary Teams provide creative, individualized care planning
• Care planning must take into account:
  – Personal history & preferences
  – Functional & cognitive strengths
  – Behavioral expressions
Creating a Plan

• Gather information from observations, chart review, known issues, etc.:
  – Diagnoses
  – Medication review
  – Staff observations & experiences
  – Review behavior logs

• Discuss above with team members

• Strategize interventions & suggestions

• Create a written plan
Support Plans

Development
- Utilize MH professionals, Behavior Specialists, etc.
- IDT – create if not in place

Structure
- Evidence-based approaches & interventions
- Readable across disciplines – know your audience

Implementation
- Create an organization-wide system for distribution
- System for observation, follow-up, revisions
Organizational Approaches

- Creation of specific policies:
  - Dementia
  - Sexuality
  - MH support

- Develop and/or enhance person-centered approaches to behavioral expressions

- Education, Education, Education!

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Supporting the Aging Process
PREPARING FOR A NEW GENERATION
Moving Forward

- Customer Service – prepare early!
- Evaluate attitude & environment – will it support the next wave as-is?
- Does your environment send the messages you want it to?
- Are your staff comfortable with carrying out expectations?
- Do you need to increase involvement from your community?
Supporting Healthy Expressions

• Dementia
  – Create a dementia-friendly environment
  – Foster independence, purpose, meaningful experiences
  – Person-centered focus, not pathological

• Mental Health
  – Sensitivity training for staff
  – Consider in-house clinicians, or consultants, to guide IDTs
  – Get into compliance with BH 483.40

• Sexuality
  – Seek to normalize sexuality & aging in the environment
  – Create policies to address; train ALL staff
  – Partner with local advocacy/educational organizations
Encouraging development of sex-positive policies in LTC

- Set expectations & reasonable limits/boundaries for sexual activity
- Sexual health & education (Sex Ed for Seniors)
- Recognize changes due to new generation(s) of older adults
- Need to establish boundaries & expectations regarding consent & capacity

Setting up for Positive Outcomes

Approaching sexuality & challenging issues in LTC is a complex & dynamic process. Consider:

• Staff training
• Behavioral interventions
• Support for healthy sexual expression
• Organizational policies
• Consultation of psychological and psychiatric professionals when expressions are challenging
What does the future hold?

As we continue to change cohorts of older adults, many things will evolve:

– Residents who are more customer-service oriented
– People who are more comfortable with liberalized social views
– More “non-traditional” support systems
– Awareness & expectations for MH care increase
– Sexuality will likely become a more important factor
– Expectations for approach & available resources will increase significantly
Age should not have its face lifted, but it should rather teach the world to admire wrinkles as the etchings of experience and the firm line of character.

– Clarence Day
Assessments & Resources

**Cognition/dementia:**
- Montreal Assessment of Cognition
- Functional Assessment Staging of Dementia (FAST)
- Brief Cognitive Assessment Tool (BCAT)
- Quality of Life in Alzheimer's Disease Patient and Caregiver Report

**Mood:**
- Geriatric Depression Scale
- Geriatric Anxiety Inventory
- Cornell Scale for Depression in Dementia
- Confusion Assessment Method (CAM) - delirium
Sexuality Resources

• **Sexuality & Dementia: Compassionate & Practical Strategies** (2014): Douglas Wornell, M.D.

• St. Andrew’s Sexual Behaviour Assessment Scale (SABSA)


QUESTIONS?
For More Information, please contact:

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