Coping with the needs of Clients with Challenging Behaviours in nursing homes Caregiver's Perspective

Possible subheading: Challenging behavior

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Tehtyjen tutkimusten mukaan, on näytetty toteen, että työskentely haasteellisesti käyttäytyvien vanhusten (dementia) parissa vaikuttaa hoitohenkilöstön terveydentilaan, aiheuttaen negatiivisia seurauksia fyysiseen ja psyykkiseen terveyteen. Tämän opinnäytetyön päämääränä on luoda katselmus tutkimustyöhön, jota on tehty aiheesta vanhusten haasteellinen käytös, tarkoituksena löytää keinoja/metodeja helpottamaan hoitohenkilökunnan työskentelyä kyseisesti käyttäytyvien vanhusten parissa ja näin vähentää hoitohenkilöstön kokemaa stressiä, ja sen seurauksena luomaan turvallisuutta ja elämänlaatua vanhuksille hoitoympäristössä.

Opinnäytetyön metodina oli kvalitatiivinen, järjestelmällinen katsaus uusimpiin tieteellisiin artikkeleihin, joita on julkaistu aiheista haasteellinen käytös, dementia ja selviytymiskeinot hoitokodeissa ja niiden sisällön analysointi. Yleisesti toistuvat teemat kategorisoitiin. Tutkimustyön tuloksena tuli esiin ominaispiirteitä tai oireita haasteellisesti käyttäytyvillä vanhuksilla ja keinoja vastata heidän vaativiin tarpeisiinsa. Joitakin ominaispiirteitä haasteellisesti käyttäytyvillä ovat: aggressio, vaeltelu, huutaminen, hamstraaminen, seksuaalinen estottomuus, syömishäiriöt, epäsopiva wc-käytös, jatkuva kysely, itsensä vahingoittaminen ja apatia.

Selviytymisstrategia sisältää ei-lääkinnällisen lähestymistavan, joka helpottaa haasteellisesta käytöksestä kärsivien asiakkaiden kokemaa stressiä. Yhteenvetona, tutkimus ottaa huomioon hoitokotien dementoituneiden asiakkaiden haasteellisesta käytöksestä johtuvan ilmiön emotionaaliset vaikutukset hoitajiin ja muihin ammattiryhmiin, siksi aihe on tärkeä ja siihen olisi paneuduttava, jotta osattaisiin auttaa kohtaamaan asiakkaiden hoitotarpeet.

Avainsanat	*haasteellisesta käytöksestä selviytyminen* tai selviytymisstrategia* aggressiivinen käytös* tai väkivalta* vanhukset* hoitokodit
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Abstract:

According to researches, it has been proven that caring for elderly clients with challenging behavior; (dementia) carries a high cost to care givers' health. And this is associated with negative consequences for physical and mental health status. The aim of this study was to review research on elderly clients with challenging behavior, in order to explore measures/ strategies for caregivers to care for them with ease, without so much stress to caregivers' psychological and mental well-being. This will help foster patients' safety and quality of life.

The method used in this study was: Qualitative, systematic literature review on scientific research articles that were currently published on the subject challenging behavior, Dementia and coping strategies in nursing homes. Content analysis was the method used to analyze the articles. Common themes were grouped into categories. Following the results, the author was able to identify characteristics or symptoms for challenging behaviors and strategies to cope with their demanding needs. Some of the characteristics of these behaviors that challenged are Aggression, wandering, shouting, hoarding, sexual disinhibition, eating disorder, inappropriate toileting, repetitive questioning, self-injurious behavior and apathy.

Coping strategy includes a non-pharmacological approach, which will ease the stress clients with challenging behaviors are encountering. In conclusion, this study considers the phenomenon of challenging behavior perpetrated by clients with dementia in nursing homes, the emotional impacts of assault on carers and other professionals. Therefore, the subject is alarming and effort should be put in order to help assist meet the client's caring needs.

Keywords:	*managing challenging behaviour*or coping strategy* aggressive behaviour* or violence* elderly* nursing homes*
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FORWARD

This thesis work is firstly dedicated to ‘’ALMIGHTY GOD’’ the beginning and the end (Alpha and Omega). I wouldn’t have reached up this this stage without God’s directive. The whole process seamed challenging, but his grace kept me going. Secondly, I owe all my sincere appreciation and gratitude to the family of Mr/Mrs Pastor Linus Anya-mele. God has used you and your family in several ways uncountable. My prayer is for God to continue to bless you and your entire struggle.

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Notwithstanding, I dedicate this work to my sweat daughter Princess Adaugo Salome Uwajimogu and her mother Tiina Tarma. God has used you all to shower my life with blessings. This work is also dedicated to my Parents and entire family for their struggles for a better future for me their son. I pray that God should grant you long life.

If I continue to write, names of whom to appreciate, the pages might not be enough. Therefore, to have it in summary, I appreciate everyone both now and forever in this my struggle. Oh! It would have been a mistake if I don’t appreciate my Queen Elizabeth Chinomso for your love and kindness. God bless you for all.

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Helsinki, August 2012.
Odinakachukwu Philip Uwajimogu.

1 INTRODUCTION

It has been suggested that dementia is more often accompanied by challenging behaviors. These include disturbed perception, thought content, mood or behavior (Finkel, Costa e Silva, Cohen, Miller and Sartorius, 1996) and these are often categorize as (1) behavioral, for example agitation, wandering, aggression and screaming (2) Psychological, for example includes, depression, anxiety, hallucinations and delusions (Finkel et al 1996 see Osborne, H. et al. 2010).

According to researches, it is proven that, not all the people suffering from dementia have challenging behavior. Moreover, it is not only people with dementia who have challenging behavior, and not all people with dementia, shows disturbed or challenging behaviors (Archibald 2003; cp Hazel, H. et al. 2010). Again, on the other hand, it has been estimated by some researchers that between 20% and 90% of people living with dementia will experience at least one form of behavioral disturbance during the illness. According to this figure, it indicates that not all people with dementia display challenging behaviors, the determinants of whether a behavior is thought of being challenging is likely to depend on the context within which the behavior occurs and the meaning that others provide for this behavior.

Consequently, the prevalence of challenging behavior is significant and it is generally agreed that the experiences can impact substantially on quality of life for both people living with challenging behavior (dementia) and the people supporting them (Carers). However, according to John Keady & Lesley Jones 2010; In England and Wales, the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (2006) guidelines for Dementia refers that “Supporting People with Dementia and their Carers in Health and Social Care promoted a biopsychosocial model of dementia”. This is in other words, the interplay between neurobiology, psychology and social environment provides the most holistic way of understanding the lived experience of Dementia and the effects it has on carers and the person’s social/family networks.

On the same note, according to Eloniemi, S.U. et al, (2009), In Finland, 80% to 85% of people living in long term care settings have cognitive decline or fulfill the criteria of Dementia. And caring for Dementia patients has imposed a heavy burden to the economy and the social health care system. Di Mattei, V.E. et al (2008), also talks about the burden and high cost or demands of caring for elderly dementia clients on carers' health and psychological effects nurses pass through at the expense of caring for dementia clients in Italy. In a recent study conducted in Netherlands, by Zwijsen et al (2011), many residents in nursing homes (NH), suffering from Dementia also suffers from behavioral problems (BPs) like aggression, apathy and agitation. Behavioral problems (BPs) were present in 80% of the residents; this (BPs) are associated with high costs, diminished quality of life of residents and a high workload for caregivers and their psychological well-being.

It is also known that advanced age is the most significant risk factor in the development of Dementia (Burns and Iliffe 2009); With Alzheimer's disease, being the most prevalent form of dementia in younger and older people. A significant percentage of older people living in nursing homes (NH) which are likely to have some form of Dementia (Help the Aged 2007) some of these are prescribed an in appropriate antipsychotic medication to help control challenging behaviors such as 'wandering' and 'aggression' (Benerjee 2009). Dementia patients can be admitted in nursing homes mental services for inpatient assessment due to the level of complex patterns of presentation of risk and uncertainty with the meaning of exhibited behaviors, which makes the individuals to be detained under the Mental Act 1983 or care and treatment is delivered under the auspices of the Mental Capacity Act 2005 (Rapaport and Manthorpe 2008 see Keady, J. & Lesley, J. 2010).

Nevertheless, traditionally, challenging behaviors in people with dementia were seen as the consequences of the degeneration of the brain, which assumed a causal relationship between neurology and behavior. However, based on this biologically orientated level of explanation, it appears to have weak theoretical and empirical support (Bird & Moniz-Cook, 2008) and often ignores both the individual with dementia and their sociocultural context (Cheston & Bender, 1999) cited in Osborne .H. et al (2010).

In accordance with World Health Organization (WHO 2007) defines Dementia as: ‘A syndrome due to diseases of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment’. However, consciousness is not clouded. Impairment of cognitive function are commonly accompanied, and occasionally preceded by deterioration in emotional control, social behavior, or motivation. This syndrome is normally seen in Alzheimer’s disease, in cerebrovascular disease, and in other conditions, primarily or secondarily affecting the brain (John Keady and Lesley Jones 2010).

Dementia is often labeled as a progressive condition in that the signs and symptoms will get worst or change in severity and complexity from time to time. Moreover, in England, the National Dementia Strategy (Department of Health 2009) labeled Dementia as a terminal condition with life expectancy from diagnosis to death being around 4.5 years. Dementia is separated into three stages, namely: Mild, moderate and severe. And according to Johns Keady and Lesley (2010),’ it is in any of these three stages of dementia that challenging behaviors occurs.

However, it is usually from the moderate to severe stages that people with dementia exhibits behavior that causes stress and upset to carers and which may lead to the person (dementia patient) admitted to a nursing home or care home (Andren and Elmståhl 2008). In addition, the exhibition of challenging behavior can be a cause of stress for individual and their carers reduce individuals’ quality of life and are reasons for admission to institutionalized care home (Keady, J. & Lesley, J. 2010)

Consequently, according to Osborne et al. (2010) ‘’ There have been psychological interpretation of challenging behavior of the past 20years’’, which have been argued to possess more therapeutic scope, this has offered an alternative to the traditional medical model or ‘standard paradigm’ (Kitwood, 1993). Viewing dementia as a biopsychosocial condition, this rises from an interaction between neurological, psychological and social

factors. However, considering this explanatory framework, behaviors associated with dementia are seen as attempts to seek meaning, express or meet psychological/physical or social needs and are seen as individual's response to or attempt to cope with their world.

The views of standard paradigm of Kitwood, (1993), also concur with Xeniditis et al. 2001's definition of challenging behavior saying ''Challenging behavior is a descriptive concept, which is largely socially constructed, and its meaning is subject to changes in social norms and service delivery patterns over time and across geographical areas'' In other words, challenging behavior is commonly associated with poor quality of life, placement breakdown in service delivery (cp. MacDonald, A. et al. 2010)

The term itself carries no diagnostic significance, and makes no inferences about the aetiology of the behavior. It covers a heterogeneous group of behavioral phenomena across different groups of people with behavioral problems; for instance, oppositional behavior in children, faecal smearing in those with a severe learning disability and deliberate self-harm in adult mental illness.

However, challenging behavior may be unrelated to psychiatric disorder, but can also be a primary or secondary manifestation of it. (Xeniditis, K. et al. 2001)

Notwithstanding, different studies have shown and also argued about the adverse effects or the risk of side effects on the use of medication to treat or take care of clients with challenging behavior especially for patients with Lewy body dementia or additional medical problems. (Barber, Panikkar & McKeith; Coulson, Fenner & Almeida, 2002; Finkel, 1997; McGrath, & Jackson, 1996), ethics (Jackson & McGrath 1996) and its effects on the rate of cognitive decline (McShane et al 1997), Cited in Tuner .S. (2004).

Motivation of Research topic

The author's idea of doing this thesis work came to light after a practical training in a nursing home (Scilla), owned by Helsingin Diakonissalaitoksen Hoiva Oy, during this practical training, clients with challenging behaviors (aggression and complexity in interpretation of mood change in behavior) were seen as stressful and not easy for caregivers to handle. However, the use of some medications was also accompanied, but it was not still successful in all cases of behavior. Therefore, the author made some re-

searches came up with a tip of some coping strategies applied it during ADL (activities of daily living) with a particular client, in which the result of that little activity was productive.

This was then called for discussion with the head of the ward, together with the authors' supervisor during the practical training. With these entire motivations gotten from this, it was commissioned and the author was asked by this nursing home to put down the idea to help caregivers cope with the needs of these clients with challenging behaviors.

2 AIM AND RESEARCH QUESTIONS

The aim of this study is to review the research on elderly clients suffering from challenging behavior, in order to explore measures and strategies for carers or care-workers to provide care for them with ease, without so much stress to caregivers' psychological and mental well-being, been affected. This will help foster patients' safety and quality of life.

Notwithstanding, in order to get the goal of this studies, the following research questions will be tackled, so as to get answers for the aim of this study:

Research Questions

1. What are some of the challenges carers encounter while taking care of patients/clients with challenging behaviours?
2. What are the strategies care-workers can use while approaching clients/patients with challenging behaviours?

In the following chapter, the author looks at different theories that are related to challenging behavior.

3 THEORETICAL BACKGROUND OF CHALLENGING BEHAVIOR

Theories/theoretical frameworks of challenging behaviors are presented in a wide range of conceptualizations of challenging behaviors, including psychoanalytic, sociological theories and learning theories. Nevertheless, the author of this thesis work has decided to base this study on a particular phase/part of Freud's Psychoanalytical theory. However, according to (Loevinger, 1976, p.43; cited in Richters, J. & Waters, E. (1991), says:

''When one considers values in general and moral values in particular from a cognitive standpoint, one is faced with the same problem. Cognition does not offer the principle of determination, of preference, of value.''

3.1 Psychoanalytical perspective

Here, the Freudian's Psychoanalytical theory is divided into three phases, which are:

I. Concepts of Affects and Defense
II. Seduction theory
III. Principles of mental functioning (The Wish Model)

The psychoanalytical theory has central importance of child-parent attachment in Freud's theory of personality is perhaps best captured in his characterization of the infant-mother relationship as ~without parallel, established unalterably for a lifetime as the first and strongest love object and as the prototype of all later love relationships" (Freud, 1940/1949, p.188 in Richters, J. & Waters, E. (1991). This prototype not only forms the matrix on which subsequent personality development builds, according to Freud, but also provides the motivational core of a great deal of behavior throughout the lifespan. Moreover, the conflicts and defenses rooted in early attachment relationships continue to assert themselves throughout life in the form of various prosocial and antisocial behavior patterns.

3.2 Sociological theory

This explores social and economic preference in the environment. Considering the early Parent-child relationships of Freud's theory of attachment, this emphasized more positive motivational core, and suggest that the concept of a child's commitment to prosocial commerce may provide a much needed heuristic view for understanding individual differences in adherence to socially valued standards of conducts (Hirschi 1969 cited in Richters, J. & Waters, E. (1991 p.11).

Nevertheless, Freud's emphasis on the significance of infant-mother attachment for virtually all aspects of subsequent personality development; Its endurance over the intervening decades has been sustained by a wealth of empirical data linking attachment to a wide range of socialization outcomes in both childhood and adulthood (Waters, Hay, & Richters, 1986).

Included among these are patterns of social competence (Waters, Wippman, & Sroufe, 1979), prosocial behavior, antisocial behavior and behavior problems (Erickson, Sroufe, & Egeland, 1985) in early childhood; In addition, the major longitudinal studies of delinquent and criminal behavior have consistently documented links between family factors and subsequent antisocial behavior. Prominent among these have been parental characteristics such as lack of warmth, poor supervision, inconsistency, and poor child-rearing practices - factors that have been demonstrated in more recent studies to be associated with anxious child parent attachment (Ainsworth, Blehar, Waters, & Wall, 1978).

Moreover, attachment, commitment and prosocial behavior which tacitly address a question asked by Kagan (1982), about the implications of child's secured attachment to deviant parents. Saying, ''If a child adopts parental standards, values and norms which are not in accordance to those of the society, will such child not be at disadvantage in later age?'' Certainly, from the standard points of traditional views of identification, according to Freud's psychoanalytical theory, the child identifies with the parents superego, which is the seat of conscience. Thus if a child is raised by criminal or otherwise deviant parents, he or she is also expected to adopt deviant standards and values. More-

over, it has been demonstrated that infants frequently display a great deal of attachment behavior toward individuals who have not been associated with gratification of their basic needs (Ainsworth, 1963; Schaffer & Emerson, 1964 in Richters, J. & Waters, E. 1991).

3.3 Social learning theory

First and foremost, in this context, attachment is viewed within the social learning framework as descriptive shorthand for a learned behavioral pattern originated and maintained by parent-child interactions. Its main defining characteristics are the manifest preference of parent and child for each other's company and the observable influence each has over the other's behavior. A relatively straightforward relation is therefore assumed between the amount of a child's attachment relevant behavior (e.g., proximity seeking, separation distress) and the strength of his/her bond with the parent. And these learned behaviors are carried along even till later age. (Richters, J. & Waters, E. 1991. p.6)

3.3.1 (I) Affect theory and Defense Model

The author has chosen to base this study on Freud's Constancy principle (Affect theory and the Defense Model). This is explaining the idea that Freud's model contains simultaneously a theory of meaning and a theory of mechanism. Constancy principle is first articulated by Breuer but attributed by him to Freud in the studies of Hysteria (Breuer & Freud 1895).

The Constancy Principle states that, it is the aim of the psychic apparatus to keep stimulation as close to zero as possible. Quiescence is pleasant, excitation unpleasant, and we therefore initiate whatever actions (alloplastic or autoplastic) is best suited to reducing the level of stimulations. This study is targeted to older adults suffering from challenging behaviors and their carers in which as a result of psychological, stress and mental drill care-workers pass through in trying to achieve a holistic care/meet the needs of

their clients and patient safety in care homes. Therefore, due to the prevalence of the behavior that challenged, care-givers are not able to meet with the needs of the clients.

And this Constancy principle is applied to the study because according to the studies of Hysteria (Breuer & Freud 1895) and the project for a Scientific Psychology (Freud, 1895a) Despite their vastly different theoretical perspectives, it says that '' Human behavior is best understood to be regulated by the Constancy principle.'' (Greenberg, J. & Stephen, A. 1983)

The constancy principle again also suggests that what matters most to people is to rid ourselves out of stimulation. And this both depends upon and reinforces the most basic assumption of the drive/structure model, which says: ''that there is such a thing as a discrete individual who can be treated both theoretically and clinically, as a closed energy system. Tension build up by this system and must be discharged by it'' And if one channel is dammed up so that discharged through it is prevented, another must be found.

More so, Freud's constancy principle went ahead to narrate that if events become pathogenic when the affect associated with them cannot be adequately discharged, because of internal/external circumstances or because those affects are in conflict with other highly valued states of mind, such as moral and ethical values. The treatment modality suggested in this case, which derived directly from the theoretical assumptions is recovery of the repressed memories will make abreaction possible. Without this full discharged of pent-up affect which was stiffed at the time of the event and which therefore, operated continuously to fuel the consequents neurotic symptoms, illness is inevitable. (Greenberg, J. & Stephen, A. 1983.p.26)

3.3.2 Seduction theory

According to Freud's theory of Psychoneuroses (1896a. p.163) cited in (Greenberg, J. 1983 p.28), says that it is some early occurrence, which ''must consist of an actual irritation of the genitals'' Occurring before puberty. And this is the repressed memory which is evoked by contemporary experience which produces symptoms. However, although the advent of the seduction theory made sex an essential constituent of the neu-

rotic process, it is not on the account of the driving force in all human behavior experiences.

Early seduction provides a traumatic experience precisely because the immature sexual apparatus is not properly equipped to handle the excitations that are stimulated, nor the immature personality equipped to deal with their emotional concomitants.

3.3.3 Principle of the mental functioning (Wished Model)

This is in another word also called the psychic apparatus. This model, offers a more specific statement of the content of human motivational force. However, here, Freud was arguing, stating the constancy principle saying that, ‘’at first the psychic apparatus efforts were directed towards keeping itself so far as possible free from stimuli; Consequently its first structure followed the plan of a reflex apparatus, so that any sensory excitation impinging on it could be promptly discharge along a motor path’’ The ‘’exigencies of life’’ interfere with this function, and Freud states that the first of these are ‘’the major somatic needs’’ This leads to an attempt to discharge the excitation through motor activity, which constitutes an expression of emotion. (Greenberg, J. 1983 p.28)

According to the author, care-givers who intend to care for clients suffering from challenging behavior must come to the understanding of Freudian Psychoanalytical theories. Since as we must not forget that elderly people suffering from challenging behaviors are human beings with emotions like other people on earth. Again, Elderly people suffering from challenging behavior, even suffer so much. But some care-givers cannot understand the signal they are sending. E.g., the same like a child who soils him or herself, the same time crying for attention from anyone around.

Freudian Constancy & Affect model of psychoanalytical theory has been the basis of this study, because the author found it to be full of hope grounded in the experience of despair, anger, depression and mourning for the elderly suffering from challenging behavior and their care-givers who are not able to meet with their needs.

Psychoanalysis occurs alternatively against a background of understandable futility and despair. To paraphrase Freud, 'I take away the neurosis so that people can get on with the ordinary miseries of life' (Clarke, L. 1999, p.88) Furthermore, according to Bettelheim (1983 p.18 see Clark, L. 1999 p.88), says ''Misinterpreting what Freud wrote can we arrive at the comfortable assumption that psychoanalysis, instead of confronting us with the abyss within ourselves and forcing on us the incredibly difficult task of taming and controlling its chaos, would make life easy and pleasurable and permit us, on the pretext of self expression, to indulge our sexual desire without any restraints, risk or price''.

Nevertheless, according to the author, there is little joy and bargain in Freudian Constancy principle and Affect Model of Psychoanalytical theory, as we can see that psychoanalysis as a whole purports to reveal the multi-determined nature of our actions, the complexity of forces that governs our behavior. (Clarke, L. 1999 p.89) For instance, we may swear blind of loving someone, while actually hating him/her. Even altruism can be seen as a mechanism whereby the altruism is self- gratification, e.g. masturbation.

Notwithstanding, the author has come to the understanding that challenging behaviors are behaviors associated with different meaning and interpretation; Therefore, accepting the fact that Constancy principle and Affects models of psychoanalytic theory elicit a serious meaning from a client is correct, the author went ahead to relate the fact that we accept constancy principle and affect model of psychoanalytical precepts that the simplest of actions involves multiple meanings.

In the next chapter, the author looks into challenging behavior, the meaning of challenging behavior and its aetiology. Challenging behavior in elderly clients is a present and alarming issue in the society that we are living in today. Therefore, it cannot be discussed without looking also into the epidemiology of challenging behaviors in older adults. From this chapter, we get a clearer view on challenging behavior in elderly clients, and the factors that influence challenging behavior, which makes it sometimes delicate to handle or meet their needs.

3.4 Challenging Behavior in Elderly Clients

The following chapter looks into challenging behavior as a whole in elderly clients. It gives the meaning of challenging behavior and its aetiology and epidemiology regarding the way it has been used in this study.

Challenging behavior

Challenging behaviors has been given a lot of concerns from experts and its regards on how to manage it. Nevertheless, following the aetiology of challenging behavior, it has been identified that challenging behavior is not a unitary nosological entity, (no single common cause for it can be identified. For instance, the aetiology of self-injury or violence is more likely different from that of disorders of sexual behavior. Moreover, for each individual behavior, the causation is almost invariably multi-factorial (Caused by so many factors). Thus, the causes of challenging behavior are best studied using a biopsychosocial model to examine the different influences on the development and maintenance of challenging behavior. (Xenitidis K. et al 2001).

3.4.1 Definition of Challenging Behaviour

A widely agreed and accepted definition of challenging behaviour is:-

‘’Challenging Behaviour is ‘‘culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities’’ (Emerson, 1995 cp Duff, E. et al, 2006 & Xeniditis K. et al 2001).

Most severely challenging behaviour, ‘‘renders the individual liable to seriously injure her/himself or others and for whom appropriate services are difficult to find’’ (Tarbuck & Thompson, 1995, p. 30. see Duff, E. et al. 2006). In the context of this paper, the author like to accept this definitions above because it deals with the issue at stake as a two edge sword. (Two edged sword in the sense that challenging behaviours are perpetrated against the client to him or herself or to the carers).

3.4.2 Aetiology of Challenging Behaviors

In order to understand very well some of the aetiological factors, the author has decided to categorize them into 3 groups, which are: Biological (Genetics), Psychosocial, and Neurochemicals (Brains) factors.

Biological factors (Genetic studies)

A genetic study has been closely reflected to the determining factors of some challenging behaviors. And in some cases, it is reflected as both genetics and epigenetic factors. (E.g. Violent behavior in people with alcoholic dependence or Psychosis) Also a number of genetic syndromes have been identified that are associated with varying degrees of specific maladaptive behaviors. Examples includes Prader–Willi syndrome (Compulsive over-eating) and Lesh–Nyhan syndrome, Self-injurious behavior (SIB) (Xeniditis .K, et al 2001) Biological explanations have been proposed for behavioral as well as psychological/psychiatric symptoms of dementia: disturbances in circadian rhythm and 'organic restlessness' are possible substrate for wandering behavior, and lowered levels of 5-HT and acetylcholine may be implicated in mediating aggressive behavior (Ballard et al. 2001, see Turner, S. 2005 p. 94)

It has been proposed that study of these disorders may allow further understanding of the genetic contribution to particular behaviors. To this end, the concept of behavioral phenotype has been introduced to describe the behavioral manifestation of a particular genetic make-up (genotype). However, there are a number of methodological problems in the study of behavioral phenotypes, including lack of appropriate instruments, the subjective nature of behavioral observations and difficulties in identifying a behavioral standard.

Nonetheless, the study of some groups of people with genetically determined syndromes, does allows a more fine-grained analysis of genetic and epigenetic contributions to challenging behaviors in that group of people; and may also allow us to understand further the biological basis to psychiatric disorder in the general population. For example, according to Xeniditis K. et al, (2001) People with Velo-cardio-facial syn-

drome (VCFS) have a deletion at Q11 on chromosome 22 (the catechol-O-methyl transferase gene is in this region) and up to 30% of people with (VCFS) have psychosis.

Neurochemicals (Endogenous studies)

Again, according to researchers, it has been revealed that a number of endogenous substances have been investigated by their roles in development and maintenance of challenging behavior. In particular, opioid peptides (β-endorphins), sex hormones, dopamine and serotonin have been studied in relation to their role in mediating human behavioral processes such as aggression, arousal, self- injury and appetite. Endogenous opioids have been implicated in the pathophysiology of (SIB) and a number of aetiological pathways have been hypothesized, for example, the intrinsically rewarding properties of endorphins released by (SIB). Serotonin has been implicated in SIB, aggression, stereotypes, anxiety and behavioral disinhibition. Testosterone has been implicated in the mediation of aggressive and abnormal sexual behavior. In particular, impulsive aggression in personality disorder correlates with tritiated paroxetine binding in the platelet. All the above-mentioned aetiological pathways have been utilized as the neurochemical basis of pharmacotherapeutic interventions.

Neurobiological (Brain structure/ function)

The relationship between well-defined challenging behavior and the abnormalities in particular brain structure and functions are poorly researched. Nevertheless, although there are many studies on neurobiological differences between people with psychiatric disorder and controls, there are relatively few which have related the frequency and severity of individual challenging behaviors to particular biological variables.

However, in order to understand the neurobiological correlates of violent behavior. Lesion studies have implicated a number of brain areas in the regulation of aggression, including the amygdala–hippocampal complex and prefrontal cortex (Mirsky & Siegel, 1994, in Xeniditis, K. et al. 2001). Qualitative computerized axial tomography (CT) and quantitative positron emission tomography (PET) studies have reported anatomical abnormalities, and reduced glucose metabolism, in prefrontal and temporal regions.

However, until recently, nobody had related neurobiological variables to frequency of violence, or used quantitative in vivo techniques to investigate neuronal integrity and brain anatomy of people who are repetitively violent. Thus, we used proton magnetic resonance spectroscopy (HMRS) to study the neuronal integrity of the prefrontal lobe and amygdala–hippocampal complex in repetitively violent adults and nonviolent matched controls. We found that repetitively violent people had reduced neuronal density and abnormal phosphate metabolism in the prefrontal lobe and amygdala–hippocampal complex, and the degree of reduced neuronal density was related to frequency of violence (Critchley et al, 2000, see Xeniditis, K. et al. 2001).

Psychosocial factors

Psychosocial factors here are trying to include the patient's history of learning new skills and its environment. Again, the majority of research into psychological factors dealing with the aetiology of challenging behavior has taken a functional perspective with its origin grounded in learning theory. Nevertheless, in this approach, the emphasis lies on the purpose the behavior serves for the individual, rather than the form of the behavior per se.

On the same note, hypotheses related to the functions of the target behavior are developed (functional assessment) and can be evaluated systematically (Functional analysis). Challenging behavior can also serve or be seen as a means of communication, on the process of avoiding or accessing internal or external events in the environment. ‘*'A single challenging behavior can also be viewed as multi-functional*‘'

Experimental research on challenging behavior has again, been focused on historical reports of people suffering from learning disabilities, seeking to evaluate assessment and treatment procedure. (Ellen D. et al, 2006; Turner S. 2005 & Xeniditis K. et al, 2001). E.g. A large numbers of studies have investigated self-injury behavior (SIB), concluding it to be as often a learned behavior acquired through an individuals' history of interaction with his or her social and/or physical environment. Moreover, studies which have applied the methodology of functional analysis to large numbers of issues or cases comes in the final conclusions to be highly effective in identifying the environ-

mental determinants of self-injured behavior (SIB) depending on the individuals in questions (Individual basis).

According to Xeniditis et al 2001, treatments of challenging behavior are only effective when they match the functions of the target behavior appropriately. And more recently, the methodology of functional analysis has been applied in populations without learning disability, e.g. in diverse conditions like anorexia nervosa, delusional speech and hallucinatory behavior, drinking problems and split personality disorder.

In the next chapter, we will be looking at different definitions of challenging behaviours and its related kinds of violence perpetuated to self or carers, in the context of mental health literature, nursing care scientific articles.

3.4.3 BACK GROUNDS OF CHALLENGING BEHAVIOURS

According to Xeniditis, K. et al. (2001) The term ‘challenging behaviours’ was introduced in North America in the 1980s, and was originally used to describe problematic behaviours in people with ‘mental retardation’ (learning disabilities). Challenging behaviour can, however, occur across the intellectual spectrum being particularly prevalent in populations with psychiatric disorder.

However, some previously used terms for challenging behaviours includes: Behavioural disturbances, problem behaviour, maladaptive behaviour, aberrant behaviour and behavioural abnormalities.

The relationship between psychiatric diagnosis and challenging behaviour is a complex one and it is represented graphically in Fig. 1.

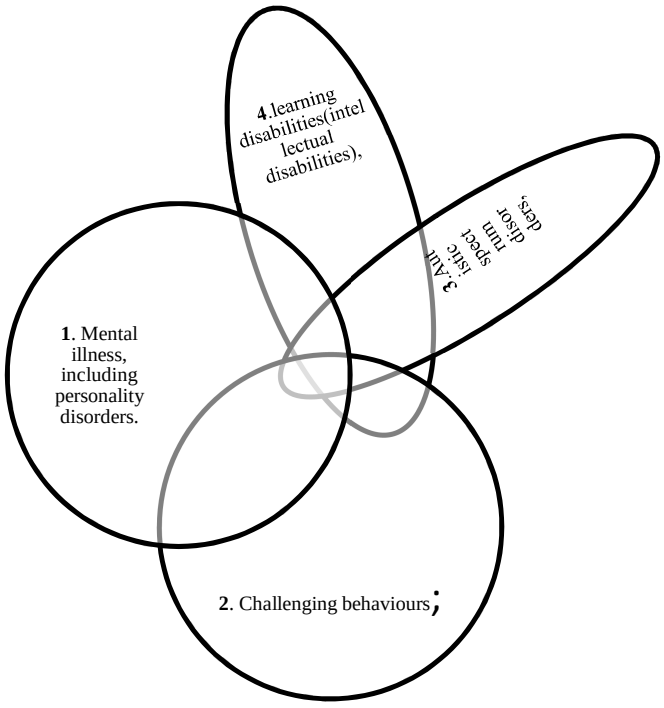

Figure 1 The relationship between psychiatric diagnosis and challenging behaviour in its complex form, By Xeniditis et al. (2001)

1, mental illness, including personality disorder;

2, challenging behaviours; 3, autistic spectrum disorders;

4, learning disabilities

Challenging behaviours can occur in the absence of a psychiatric disorder and not all people with mental illness exhibit challenging behavior. The overlapping area between 1 and 2 represents patients with challenging behavior and psychiatric disorder. In some people, challenging behavior may be an essential diagnostic criterion (e.g. eating disorders, personality disorders, paraphilias, etc.) or a secondary feature (e.g. self-injury in depression, aggression secondary to persecutory delusions in schizophrenia and wandering in dementia). Xeniditis et al. (2001)

On the same note, challenging behavior may simply coexist and often pre-date a psychiatric disorder (e.g. a violent offender who subsequently develops a depressive illness). Learning disabilities and autistic spectrum disorder may also be present in various combinations of comorbidity. The overlap between 1 and 4 represents those with dual diagnosis (mental illness and learning disabilities).The part of 3 that lies outside 4 represents people with high functioning autism and Asperger's syndrome who may or may not have mental illness and/or challenging behavior.

3.4.4 Views and consensus of Challenging behaviours

According to researchers, there is a lack of consensus regarding the definition and measurement of 'challenging behaviour' among persons with intellectual/ learning disabilities (e.g., Lowe & Felce 1995; Joyce et al. 2001, see Sigan, L. et al. 2007 p.519).

Moreover, many researchers argue the fact that behaviours should be defined as challenging not only because they have ill-effects or serve as unreasonable for the person suffering from it or that of intellectual disabilities, but because of their real life impact and consequences for care staff (Kiernan & Kiernan 1994; Lowe & Felce 1995; Elgie & Hastings 2002) cited in (Sigan, L. et al. 2007 p.519).

Again, although the term challenging behaviour encompasses a wide range of behaviours research and practices suggest that it is the degree and/or the intensity of the behaviour displayed that results in it being labelled as ''Challenging'' Nevertheless, Be-

haviours that challenged are therefore subjective and will be influenced by the beliefs and experiences (Bird & Moniz- Cook 2008, see Keady, J. 2010, p. 28).

However, behaviour will be viewed or labelled as challenging if it is viewed as ‘’unreasonable’’ or also challenges the norms and roles of the context in which it occurs. (Keady, J. 2010). A typical example was gotten from (Sigan, L. 2007); Where he narrates that staff report that the ‘’most challenging’’ behaviours of clients with intellectual/ learning disabilities are behaviours that directly affect staff or hinder staff/care-givers from providing services.

These behaviours perpetuated by clients to staff who are caring for them is known as ‘’Staff-averse challenging behaviours’’ which includes aggression, disruptive behaviour, uncooperative, and socially inappropriate behaviours (Elgie & Hasting 2002, cited in Sigan, L. 2007, p.519). And it is in this ‘’Staff-averse challenging behaviours’’ the author is laying the claims of this thesis work.
From the perspectives of staff/ care-givers behaviours which primarily affects clients themselves (e.g. Stereotype or withdrawn behaviours). These are less challenging (Lowe et al.1995; Lowe & Felce 1995; Elgie & Hastings 2002) cited in (Sigan, L. 2007)

3.4.5 Epidemiology of Challenging Behaviours

The little available researches on the prevalence of challenging behaviour has been most extensively focused their epidemiology on learning disabilities/ intellectual disabilities. But the prevalence studies of challenging behaviour in people with intellectual disabilities vary widely in their findings, reporting rates between 5.7% (Qureshi & Alborz, 1992) and 14% (Borthwick-Duffy, 1994: In Xeniditis, K. et al. 2001).

The above probably reflects the different criteria used for case identification (for both intellectual disabilities and challenging behaviour) with the differences in the target populations (hospitals and nursing homes).

Notwithstanding, there is a consensus that: males are more likely to be identified as having challenging behaviour compared to females; and these overall prevalence increases

with age during childhood, and reaches a peak during the age range of 15- 34years, and then declines again. (Xeniditis, K. et al. 2001)

But the prevalence of challenging behaviours such as aggression and self-injurious behaviour (SIB) is greater in people with more severe intellectual/learning disabilities However, in the general adult mental health literature, epidemiological studies of challenging behaviour as a single clinical entity are scarce, owing to the greater heterogeneity of clinical conditions subsumed under the title challenging behaviour.

The prevalence rate of staff-averse challenging behaviours among adults with intellectual disabilities varies depending on the definition of 'challenging'. Nevertheless, studies suggest that 75% to over 90% of adults with intellectual disabilities displays at least one form of staff-averse challenging behaviour to some extent (Eyman & Borthwick 1980; Deb & Hunter 1991; Bruininks et al. 1994; Rojahn et al. 2001) cited in (Sigan, L. 2007 p.520).

Furthermore, when more restrictive criteria are used to determine/ identify only those behaviours that are severely challenging, the prevalence is estimated to be approximately 6-7% (Emerson 1995; Emerson et al 1997; Joyce et al. 2001; see Sigan, L. 2007, p. 520).

However, there are studies examining the prevalence rates of specific problem behaviours in adult mental health settings. For instance, the little epidemiological information that is available shows that 75% of men and 53% of women exhibited aggressive behaviour towards self or others in an acute psychiatric facility in the USA (Steinart et al., 1999; see Xeniditis, K. et al. 2001, p.110; & Duff, E. et al. 2006; p. 476).

A large number of studies have focused on the prevalence of substance misuse in clinical populations, commenting on its particular challenge for services. Regier et al (1993) established a prevalence of 29% for comorbid addictive disorders. More recent studies have established higher rates of substance misuse among patients with severe mental disorder, with 36.3% of patients having comorbid substance misuse, which is associated with greater use of in-patient services. This is of importance because comorbid sub-

stance misuse is associated with an increased prevalence of violent behaviour and criminal offending in people with mental health problems. (Xeniditis, K. et al. 2001; p.110)

Aggression and violence are among the criteria for diagnosis of some mental health problems, including antisocial and impulsive personality disorders and intermittent explosive disorder, and may occur in disorders such as dementia, manic episodes and schizophrenia (American Psychiatric Association (APA), 2000; World Health Organization (WHO, 2003). Self-harm and suicide attempts are other challenging behaviours associated with mental health problems, with 20 – 40% of people diagnosed with schizophrenia attempting suicide during the course of their illness, and there is an increased prevalence of both attempted and actual suicide among people with major depression and some personality disorders (APA, 2000; see Duff, E. et al. 2006).

4 AGGRESSION AND VIOLENCE

Again, we will look further into some definitions of aggressive behaviour and violence perpetrated by people with dementia in residential settings (nursing homes).
Looking at the term ‘’aggression and violence’’ both appear regularly in mental health literatures, and are used in various ways and in different context. According to Pulsford D. et al (2006), A recent initiative, of the national health society, (NHS Zero Tolerance Campaign (NHS 2002) uses the term ‘violence’, and which defines aggression as:

‘’.... ***Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.’’***

This definition can also be applied equally to the behaviour of people with dementia and as to other groups, but the term ‘violence’ often appears in dementia literature. Two possible reasons may be accounted for this: First, ‘violence seems to imply intentionality on the part of perpetrators; this is a concept that is difficult to apply with dementia clients. Then the second aspect is ‘Violence’ implies a degree of severity that again often cannot be applied, though the emotional consequences for the recipients of such behaviour are not trivial (Gates et al. 1999 see Pulsford, D. et al. 2006 p. 612).

4.1 Context and symptoms of aggression/aggressive behaviour

In the context of nursing care, the term ‘challenging behaviour’ is often used to describe people with aggression (Stokes 2000, in Pulsford, D. et al. 2006). Another alternative term that is also used is ‘non-cognitive features of dementia’ (Karlsson 1996; cp Hazel, H. et al. 2010 p.11)

The symptoms of aggressive behaviour by people with dementia, is categorized among ‘behavioural and psychological symptoms of dementia’ with some of the examples as:

- Wandering,
- Agitation,
- Shouting,
- Hoarding,

- Sexual disinhibition,
- Eating disorder,
- Inappropriate toileting,
- Repetitive questioning,
- Self-injurious behaviour (SIB),
- Apathy

(Turner 2005, cited in Pulsford, D. et al. 2006, p. 612)

The incidence of behavioural and psychological symptoms of aggression is high among people with dementia; Ballard et al. (2001, in Pulsford, D. et al. 2006) reported 86% among a UK residential care sample.

Again, a similar report gotten from (Chou et al. 1996; Wystanski 2000), also confirms that aggressive behaviour is more common among people with dementia than among older people who do not have dementia. And this aggression perpetuated against a family member has been a major reason for sending the person into a residential care home. (Gilley et al. 2004, cited in Pulsford, D. et al. 2006, p.612).

Nevertheless, trying to ascertain the specific incidence and severity of aggression is however not straightforward.

4.2 Factors of aggressive Behaviours in dementia clients

Aggressive behaviour in people with dementia has been viewed from so many perspectives, with regards to challenging behaviours. Therefore, aggression in people with dementia is a complex phenomenon, with so many causative factors. Consequently, the author relates some of the features that may lead to aggressive behaviour in people with dementia and even appears in life in general, these might sound minor but then, worth calling for attention. And some of them are: Environmental factors, pain, hunger and so many others to name but few. In other words, aggression may be a way of responding to situation facing the sufferer, or means of sending signals to the carers

Environmental

Situations arising from an individuals' health in the environment he or she finds him or herself may also contribute to aggression. For instance, an elderly person who use to be

so active in sports during his/her youth days, and cannot be active any more due to the effect of accident from falls leading to stroke terns to cry about his or her situation. Moreover, due to stress of unpleasant situation in the environment or some nursing homes, people with dementia are pushed beyond their limit of coping, which makes them to become distressed and behave in ways that demonstrates that they are disturbed.

Moreover, according to researchers, says a situation arising from the person's environment such as change in light level and this affects the person's cognition leading to aggression, thereby the person starts looking for a means to wander to another area of comfort. This brings us to Dewing (2005)'s definition of wandering, which defines wandering as: 'A complex meaningful activity which may take on various forms over time and place in the same person and between people' (see Hazel, H. et al. 2010 p.11)

Hunger and thirst

It is important to understand that aggression or some types of disturbed behaviours are not only seen in people with dementia. But people with dementia shows pattern of aggression for some reasons like hunger, thirst, and therefore may not be able to explain this verbally. Rather, when a carer goes to the corner of this aggressive individual, the aggressive person then explains this with actions due to aggression for being hungry or thirsty (cp Hazel, H. et al. 2010 p.10). This goes with the saying '***A hungry man is an angry man'***

4.2.1 History of Aggressive Behaviour

Here, the sufferer may have a history of aggressive behaviour before him/her contracts a dementing illness. According to O'Leary et al. (2005), he found out that people with dementia who had a history of conduct disorder were more likely to be aggressive towards their partners. Nevertheless, it has not been really clear, the link between premorbid personality disorders and aggressive behaviour in people with dementia (Kolanowski & Garr 1999, Low et al. 2002). In brief, while dementia can cause personality changes. It may also actually serve to alter a person's tendency to behave aggressively (Pulsford D. et al. 2006).

4.2.2 Process of illness

The second aspect here which is as result/consequences of illness process; the traditional perspectives on dementia have tended to regard challenging behaviours as random expressions of neurological damage. Moreover, more recent research has highlighted links between aggressive and other psychological symptoms of dementia. Also correlations have been found between aggressive behaviour and delusional thinking (Gormley et al. 1998, Eustace et al. 2001), and with the symptoms of depression, (Lyketsos et al. 1999, Telerico et al. 2002). Ballard et al. (2001) have also suggested that lowered levels of 5-HT and acetylcholine as mediating aggressive behaviour in people with dementia. (Turner, S. 2005 p.94)

4.2.3 Psychosocial reasons

The third reasoned here according to Pulsford .D. et al. (2006) has been psychosocial. Stoke (2000), adopted Kitwood's person-centred model of dementia (Kitwood 1997), and he regards challenging behaviour as 'poorly communicated needs' Looking at this view critically, according to the author, this view holds that aggressive behaviour perpetrated by a person with dementia is purposeful, and often underpinned by the need to remove a perceived threat. According to indications from researched, it shows that aggressive behaviour happens most often when the person is receiving intimate care (Keene et al. 1999 in Pulsford .D. et al. (2006), also suggesting that the person misinterprets such care for a personal violation by the professional carer.

Again, according to Pulsford et al (2006), says the view of psychosocial, has been reinforced by studies involving observation of interactions between professionals carers and people with dementia during intimate care. Suggesting that, the approach adopted by the professional carer is a factor which determines whether the person with dementia responds aggressively. For example, some researchers found out that people with dementia who were been bathed were more likely to react aggressively if carers communicated with them more negatively or in an inadequate manner.

Implying that, it invalidated their experiences, were too hurried or disrespectful to their clients/ maybe they did not give reasonable explanations before spraying water. Some researchers, in the same way also found out that carers who reported difficulties with challenging behaviours, such as aggressions focused on accomplishing the task in the shortest time, rather than on the process of interacting/ explaining what they want to do, with their clients. Therefore, the notion that care staff can trigger or facilitate aggression in people with dementia has some support from research, and this echoes findings with other groups of people with mental health problems. Duxbury (2002) also reported that patients in an acute inpatient unit felt that the interpersonal style adopted by some nurses was a contributory factor to trigger aggressive incidents.

4.3 Care-givers' reactions to aggressive behaviour

According to researchers, there has been well-known and considerable evidence, that the perception of care-givers about what constitute to challenging behaviour is subjective and they often under-report these incidents of aggressive behaviour perpetuated against them. However, no clear link has been found between the ways professional carers attribute aggressive behaviour and their willingness to help aggressive people with dementia. (Pulsford, D. & Duxbury, J. 2006 p. 612)

This has called for increased attention which has focused in recent year's aggression and violence by users of healthcare services against care-givers or professional care-givers. And the psychological and physical impacts of these kinds of incidents on care-givers have been acknowledged. Moreover, the notion that aggression against care-givers or care staff is unacceptable has been reinforced by government initiatives including the NHS Zero Tolerance campaign (Pulsford, D. et al. 2006).

Nevertheless, these initiatives began with the assumptions that aggression on the part of healthcare service users is deliberate and unprovoked, and this is really the case with people with dementia. And this however is viewed in two perspectives which are:-

- Intentional (deliberate) and Non- intentional (Non deliberate)

Non-intentional

On the reactions of the non-intentional nature of aggressive behaviour by people with dementia, coupled with the likelihood and assumptions that such aggression is only rarely physically injurious to the victims (carers), has brought to the view that it is a relatively trivial phenomenon that should be accepted the way they are by professional carers as 'part of the job' (Gates et al. 1999, see Pulsford, D. & Duxbury, J. 2006). However, this perspective is not always shared or viewed by all.

Nevertheless, researchers suggest that professional carers are ambivalent about the intentionality of acts of aggression carried out by people with dementia. And some caregivers are prepared to accept aggressive behaviour as non-intentional while others also hold the view to be a deliberate act (Oser 2000, Astrom et al. 2004; Pulsford, D. & Duxbury, J. 2006, p. 613).

Intentional (deliberate)

Aggressive behaviour being an intentional or deliberate act has been viewed by some researchers that it helps some professional carers who believed that it is to be intentional to create channels of helping clients with aggressive behaviours. E.g. Todd & Watts (2005, in Pulsford, D. 2006) found out that professional carers, who believed that people with dementia were being aggressive deliberately, were no less likely to express positive views towards helping aggressive clients; than professional carers who believed that aggression was seen as unintentional act.

However, a more significant findings shows that professional carers experience considerable stress, negative feelings and burn-out as a result or consequence of being victims of aggressive behaviour (Gates et al. 1999, Oser 2000, Rodney 2000, Evers et al. 2002, Astrom et al. 2004: see Pulsford, D. 2006 p.613). Nevertheless, perceived threat leads to raised stress, and continuous physical aggression which can result to emotional exhaustion.

Again, the negative reactions of professional carers to these kinds of assaults, may also lead to perpetuation of aggressive behaviour in those they care for. This, therefore, also

brings to mind the points of Gate et al. (2003) in Pulsford, D.& Duxbury, J. (2006), that the emotional toll on caregivers of repeated assaults will have an impact on the care they give, which this may lead them to respond to clients of aggressive behaviour either by being aggressive or abusive themselves. However, this appears that in some cases, caregivers can get into a vicious circle which triggers aggression by them responding in a negative manner if they are facing that aggressive behaviour at that point in time.

Notwithstanding, according to Gate et al. (2003), different care settings, can experience widely differing incidences of aggressive incidents, and may reflects in different ways of handling the problem of aggressions. And their care staff or caregivers may respond/interact with their residents of aggressive behaviours in different ways, depending on how the incident occurs. (See Pulsford, D. & Duxbury. 2006, p.613)

According to researchers, current approaches of managing challenging behaviours have followed the same path of managing aggression and violence. Therefore, the author of this thesis work has decided to discuss them following some philosophical bases of aggressive behaviour by people of dementia.

5 MANAGING CHALLENGING BEHAVIOURS

According to Duff, E. et al. (2006), current approaches of managing challenging behaviour, especially aggression and violence, has taken the form of seclusion, restraint, medication and time out; but all of these approaches have serious drawbacks and side effects. However, seclusion has been termed unpleasant and untherapeutic, therefore, should not be used with suicidal or self-harming clients.

Restraint is ethically controversial and potentially risky. Its use with people who suffer from self harm (SIB) can be counter-therapeutic (Johnstone & Harrison, 1994). Again, clients or patients who have suffered abused before, can be traumatized, and even without a history of abused, therefore, being restrained commonly provokes a range of unpleasant feelings (Naber et al. 1996; Sequeira & Halstead, 2002, see Duff, E. et al. 2006 p.476).

On the aspect of time out, this can be therapeutic, provided it is used in accordance with an agreed care plan which is linked to the functions of the behaviors and this should not be allowed to become an unofficial seclusion.

On the other hand, there has been evidence for the effectiveness of medication in reducing extreme behaviors, such as violence towards others or towards self, suicidality and serious self-injurious behaviour (SIB), in both learning disabilities and mental health populations (Meltzer & Okayli, 1995; Reis & Aman, 1998; Spivak, Mester, Wittenberg, Maman & Weizman, 1997; see Duff, E. et al. 2006 p.476).

Nevertheless, according to researchers, there has been contradictory evidence suggesting that the effectiveness of medication in managing challenging behaviour is very poor and weak, and so much of the support is coming from researches that are methodologically complicated. More so, in addition to this inconclusive evidence, many of the drugs used to curb challenging behaviors are associated with a range of mild to life threatening side effects (Baumeister et al. 1998; Emerson, 2001; cp Turner, S. 2005 p.93). And this life threatening side effects can occur relatively frequently (see Duff, E. et al. 2006).

Furthermore, the significant risk of the side effects without a strong evidence-based indicates a need for continuous caution. But the recent guideline on the short-term management of violence, produced by the British National institute for Health and Clinical Excellence (NICE, 2005) recommends that all of these methods of managing challenging behaviors should be used as a last resort (Duff, E. et al. 2006 p. 476, cp Keady, J. & Lesley, J. 2010).

According to the author of this thesis work, in order to understand the strategies/approaches of managing challenging behaviors as a complex entity, with a diverse and complex approach to treat and assess, there has been proved from researches that the management approach of challenging behavior should follow a systematic multifactorial and disciplinary/approach (Zwijsen et al. 2011, McDonald et al. 2010, Turner, S. 2005). However, knowing this together with the Constancy principle and Affect Model, which demands that human being should be treated either by clinical means or theoretical means.

Therefore, the author has grouped them into 5 conceptual philosophical approaches namely, Pharmacological/ physical approach, psychotherapeutic approach, environmental approach, behaviour modification approach and person-centered approach. However, there has been argument concerning which approach is the best and most effective. But research evidence for the effectiveness for each approach has been considered where it is appropriate.

5.1 Pharmacological/Physical approach

This is grounded from the ‘standard paradigm’ of dementia care, viewing challenging behaviour as the more or less random consequences of neurological damage, which considers that the best response to behaviors is to minimize its occurrence and effects by using tranquilizing drugs and/or physical restraints. Nevertheless, according to Pulsford, D. & Duxbury, J. (2006), Anti-psychotic drugs have been used with people of dementia, exhibiting aggressive behaviour, in order to reduce psychological symptoms that may

lead to aggression, such as delusional thinking, and also to sedate them, thereby reducing their aggressiveness.

But the research evidence for this approach is however, mixed. On the bases of this, some studies found evidence for effectiveness of pharmacological interventions in reducing aggressive behaviour, while some other studies also found limited positive effects of neuroleptic drugs (Schneider et al. 1990, Lee et al. 2004, Sink et al. 2005). But the major concerns when using these drugs on people with dementia are side effects; which more especially, affect people with Lewy Bodies dementia (Barber et al. 2001). However, according to McShane et al. 1997), all anti-psychotic drugs have been linked with quickened cognitive decline, and also recently with increased risk of adverse cerebrovascular events/effects (Committee on Safety of Medicines 2004 in Pulsford, D. 2006).

In conjunction to the above mentioned problems, according to Pulsford, D. & Duxbury, J. (2006), says, these problems have prompted the Royal College of Psychiatrists (2004), to propose that: -
..... 'Non-pharmacological management approaches should be considered always first for people with dementia'.

5.1.1 Physical approach

This method is the physical means of holding e.g. arms and bodies of aggressive clients during personal care activities, through the use of mechanical or manual devices like restraining chairs/or cot sides or by employing control and restraint techniques to prevent the individual attacking other persons or self. (Pulsford, D. & Duxbury, J. 2006)

However, there are not enough evidence baselines, on this approach on people with dementia who display aggressive behaviour. But according to Kirkevold et al. (2004), it seems highly likely that ad hoc holding of limbs or body to facilitate personal care is common .But Shaw (2004) revealed that some caregivers/ care-staff in United States adopted a method they called '***Bull-dozing***', in this practice, two or more care staff or

caregivers would team up to forcibly carry out personal care with client that is not co-operative (see Pulsford, D, & Duxbury, J. 2006 p.614).

Nevertheless, from the look of things, it seems likely that mechanical restraints are still been used on people with these challenging behaviors despite their ethical values and reports that have highlighted their potential abusive nature of their use. Again, according to researchers, the available evidence literature suggest that mechanical restrains should be used with those who are inclined to falls, or have physical problems, rather than as a means of managing challenges occurring from behaviors.

In overall, little has been written concerning the use of restraint strategies in managing challenging behaviors, other than a general warning to take physical decline into consideration, if restraining older adults (NIMHE 2004, see Pulsford, D. & Duxbury, J. 2006). Nevertheless, the area of physical restraints as a means of tackling challenging behaviors, is undoubtedly grey and unclear, with little evidence base literatures to guide health care practitioners in the use of the strategies, also the possibility for it being used in an abusive manner is therefore very high.

5.1.2 Behavior Modification Approach

This approach is grounded from the suggestion that challenging behaviour in people with dementia may have been originated from operant conditioning. To explain briefly in technical terms, like variable intervals, intermittent reinforcement schedules produces behaviour that is most resistant to extinction Pulsford, D. & Duxbury, J. (2006). This means that inconsistent responses by caregivers to aggressive behaviour clients may lead to that behaviour becoming entrenched and resistant to intervention.

However, this behaviour modification models, hold the fact that if people with dementia can learn aggressive behaviour, therefore, learning theory principles can be adopted to extinguish such behaviour. But according to Pulsford, D. & Duxbury, J. (2006), say some writers such as Wells & Wells (1997), suggest that analysis of antecedents and consequences of aggressive behaviour can lead to care staff devising interventions that

may or will deny positive reinforcements to such behaviors. But if this interventions are consistently applied, then that behaviour will be reduced or eliminated.

Nevertheless, despite the behaviour modification approach, may be appropriate or feasible with dementia, other researchers, such as Stoke (2000), points out that the research evidence for the effectiveness of behaviour modification techniques in altering the behaviour of people with dementia is sparse, therefore, holds that the underlying philosophy of behaviour modification, which implies that behaviour can be changed by selectively manipulating reinforcers does not agree with person-centered values of respect and understanding the emotional world of the person. Therefore, behaviour modification consequently remains the most controversial and least used strategy for managing/curbing challenging behaviors (Pulsford, D. & Duxbury, J. 2006).

5.1.3 The Person-centered approach

This approach focuses on attempting to understand the poorly communicated needs being expressed by the aggressive person, thereby finding individualized ways of meeting those needs. Such strategies may include individualized care plans for assisting clients/residents to complete activities of daily living (ADL), without provoking aggressive responses.

Another focus is the use of individual or group activities to relieve boredom, dispel energy and engender a sense of well-being participants. However, research evidence for the effectiveness of person-centered approach in managing aggressive behaviour partly from evaluating studies of a particular phase of psychosocial therapeutic techniques, and partly from studies of training programmes which teaches person-centered principles to professional carers. And such programmes aims at increasing caregivers understanding of the causes of aggressive behaviour, and also their skills in managing such behaviors, by responding more individually and creatively to their needs (Turner 2005).

However, a number of case studies have also appeared in scientific literatures, describing creative strategies for managing aggressive behaviour in individual clients/residents, deriving from understanding the person's life history, how it influences present ways of

reacting to situations (e.g. Innes 1996, Stokes 1996, James et al. (2006, 2007) and Cohen-Mansfield (2000, 2008; cp Keady, J. & Lesley, J. 2010 p.27).

According to Pulsford, D. & Duxbury, J. (2006), the proof for the effectiveness of specific individual/group activities has been reviewed by Turner (2005) and Verkaik et al. (2005). And the intervention strategies include validation, multi-sensory stimulation, psychomotor therapy (sports and physical games) and aromatherapy.

Nevertheless, both of these reviews concludes that the methodological quality of the literature is rarely high, and that the few rigorous studies offer limited effective evidence of these intervention for the reduction of challenging behaviors such as aggression. However, the evidence for the effectiveness of person-centered care principles has been compromised by practical problems, on implementation of such principles in residential care settings. While training programs have been criticized for being focused more on bringing of awareness, than on equipping care staff with new skills (James 2001, see Pulsford, D. & Duxbury, J. 2006)

According to the author, researchers have made it clear that changes in care shift/regimes, as a result of training have been proven difficult to sustain. But Turner (2005), came with the suggestion that this may be as a result of high staff turnover, or to the desire of caregivers to eliminate challenging behaviour, coupled with their discouragement and reversion of old ways of doing things, when things do not work following changes in patterns of care. On the same note, Gates et al. (2005) in Pulsford, D. & Duxbury, J. (2006) also found out that a training programme only led to a reduction of aggression against caregivers who had previously experienced few assaults, suggesting that some caregivers who are frequently recipients of aggression may not be open in considering new ways of interacting with the clients or residents.

5.1.4 Environmental management approach

This approach is derived from two related assumptions, which are: - (1) the suggestion that people with dementia are very sensitive to stress-provoking factors within their physical environment. Therefore, may react to these factors with challenging behaviors

such as aggression. (2) the assumption that providing an environment that takes an account of cognitive disabilities of dementia, allows some behaviors such as wandering to be reframed from being challenging, thereby, becoming non-challenging.

Under this approach, Stokes (2000), in Pulsford, D. & Duxbury, J (2006), observed that aggression in people with dementia, being almost invariably reactive, cannot be viewed outside the person's physical or social environmental context. However, the evidence has developed regarding the optimum living environment for people with dementia, who may be prone to challenging behaviors, and this has embraced fundamental principles like aesthetic (homely furnishing and decoration; color and lightening that aids perceptions); minimization of stress-provoking environment/background noise; space for people who do not feel overwhelmed by others; and a safe and stimulating areas for the person to walk about in.

Furthermore, in regards to this approach, Pulsford, D. & Duxbury, J. (2006) says Calkins (2002) discussed ways of reducing aggressive behaviour during personal care activities, which comprises: providence or relaxing and enabling or reassuring environment within the bathroom, downplaying institutional features and highlighting homelike features; thereby minimizing loud echoing noises that can be highly stressful to a dementia client; also accompanying the activities of playing music which the person likes best, and also providing pleasant or good smells.

But in as much as current thoughts are being speculating about the physical environment, it appears to have common sense validity, there is no specific research evidence for the effectiveness of these measures/strategies in reducing challenging behaviour such as aggression among people with dementia

5.1.5 Psychotherapeutic Approach

This approach aims at fostering the uninhibited expression of feelings and emotional awareness that shapes the clients'/patients' future behaviour (Alpert & Spillman, 1997 see Duff, E. et al. 2006 p. 476). But the methods employed for achieving this psycho-

therapeutic approach includes; ***behavioral*** and ***cognitive techniques***, ***and group therapy***. Although there is no evidence effectiveness of this approaches.

However, according to Cremin et al. (1995) psychodynamic intervention for self-harm behaviour (SIB), has been developed for this approach; based on Freud's (1923) theory of repression and transference, by which in order to act out a real or imagined traumatic childhood events, a patient(client) projects roles on to members of staff/caregivers. stating that caregivers must resist responding in a way of this project role, but instead put the situation into words, thereby making the client to feel understood and allowing the repressed experience into the conscious mind to be considered rational act. But the result of this, was however, quite discouraging, with levels of self-harm, been seen again to baseline levels after a weak. Moreover, this approach was not readily accepted by care staff. (Duff, E. et al. 2006)

5.1.6 Cognitive therapy

This therapy intervention for violent behaviour designed for implementation during restraint was developed by (Hibbs, 2000) in Duff, E. et al. (2006), based on Novaco's (1975) cognitive model of anger. The interventions consist of developing awareness, learning alternative coping strategies and using reality testing and problem solving. But there is no concrete evidence data currently available for this treatment. Though Cognitive Behaviour Therapy (CBT) is currently a popular treatment for a range of psychiatric disorders (Xeniditis et al. 2001), but there is little evidence to support its effectiveness in managing challenging behaviour.

Nevertheless, on the same note, according to Duff, E. et al. (2006) says Bazzoni et al. (2001) used group (CBT) with clients experiencing acute psychosis, found out that violent episodes were almost halve and escaped attempt were almost diminished totally following this treatment. But unfortunately, there is no strength to these results, because of lack of an experimental group.

Furthermore, there is increasing interest in Acceptance and Commitment Therapy (ACT), but the problem with this treatment is that it has not yet been tested in relation to

the treatment of challenging behaviour. Duff, E. et al. (2006) says Chapman et al.'s (2006,) Experiential Avoidance Model (EAM) proposes that people should self-harm to avoid unpleasant emotional experiences. However, according to Duff, E. et al. (2006), says using this model as a basis, (ACT) would be the best and logical treatment option for this particular form of challenging behaviour. But the effectiveness of this approach of treating self-harm/or any other form of challenging behaviour, has not been tested yet.

5.1.7 Behavioral Techniques

Applied Behaviour Analysis (ABA), this is a general term, referring to methodologies and interventions based in operant conditioning theory (Erickson, Swiezy, Stigler, McDougle & Posey, 2005, see Duff, E. et al. 2006).

According to operant conditioning theory (Skinner, 1938 in Duff et al. 2006), says the environment provides ''cues'' that act as antecedents for behaviour, thus setting the conditions for behaviour to occur. Therefore, the consequences of behaviour make it more or less likely for behaviour to occur in the future. And this is described as the three-term contingency (Antecedent, Behaviour, Consequence; A-B-C), the basic unit of the analysis of behaviour. Nevertheless, this Operant conditioning theory concur along side with the Constancy and Affect Model of Freud (alloplastic or autoplastic). Thereby letting us to understand that there must be a reason to act outward or inward.

5.1.8 Three-term contingency of behaviour

This assessment framework, was also put together by Stokes (2000), in order to understand the reasons for the change in behaviour, so as to offer appropriate support to clients suffering from challenging behaviors, these are explained as follows:-

- A- Antecedents or triggers: what was happening before the behaviour occurred, who was present, when and where did it occur?
- B- Behaviour, describes exactly what the behaviour was like, be specific; is this new behaviour, what form did it take, how long did it last?
- C- Consequences of the person's behaviour.

(Hazel, H. et al. 2010 p.11)

Notwithstanding, Operant and classical conditioning have been cited as relevant for some challenging behaviors. Again, the interactive cognitive subsystem model (ICS), has also been elaborated by James (in Ballard et al. 2001) to provide a rationale both for understanding how negative memories can be established and how therapies based on sensory or emotional input could work in tackling challenging behavior (see Turner, S. 2005 p.99).

It is also suggested that memory traces be established by non-language-based systems (pattern recognition), and once distressing memories (e.g. embarrassment), are linked with sensory input (e.g. sound or smell). Therefore, can be triggered by these sensory cues, this model, has been useful, and has been proposed as a mechanism to underpin individual therapeutic work, such as validation of therapy (Woods, 1999 in Turner 2005), and for non-verbal therapies, such as aromatherapy, snoezelen, music and exercise.

However, according to the author, the application of these scientific principles to matters concerning socially significant behaviors, led us to what is now known as Applied Behaviour Analysis (ABA), which is defined as:

'***The science in which procedures gotten from the principles of behaviour are systematically applied to improve socially significant behaviour to a meaningful degree, and to demonstrate empirically the procedures employed were responsible for the improvement in behaviour'***. (Baer, Wolf & Risley, 1968) in Duff, E. et al. (2006)

Nevertheless, the main objective of (ABA) is to establish lawful relationships between the observable features of an environment, and the observable behaviors of an individual in that same environment (Samson & McDonnell, 1990). Nevertheless, the functional assessment of behaviors let us to identify the consequences in individual's environment, maintaining their unwanted behaviour. Some changes can then be made, so that challenging behaviour is reinforced less, while looking for desirable alternatives of reinforcement (Duff, E. et al. 2006).

According to Duff, E. et al. (2006), there has been an increase evidence from a large number of literatures for the past 40years demonstrating the effectiveness of approaches based on (ABA) principles in reducing challenging behaviour, especially in relation to people with learning disabilities. A considerable number of meta-analytical studies have consistently shown approaches to be more effective in reducing challenging behaviour in clients with intellectual disabilities compared to any other non-behavioural interventions, including medications.

There are also suggestions of evidence that the approach of (ABA) can be applied into mental health settings, e.g. for reducing bizarre vocalizations in schizophrenic clients (Wilder, Masuda, O'Connor, & Baham, 2001). Program for behavioral treatment designed and implemented following functional analysis have also been found to be more effective compared to therapies in reducing incidents and inpatient days in parasuicidal patients/clients (cp Turner, S. 2005 p.101)

According to Duff, E. et al. (2006), the Royal College of Psychiatrist (1995) agrees with other writers (e.g. Alpert & Spillman, 1997; Lerman & Vorndran, 2002) in recommending that strategies for treatment should be based on functional analysis and should focus on adaptive behaviours reinforcement.

However, these evidences together with the constancy principle which is the universal nature of behavioral principles, has brought to a large extent of intervention of behaviour being accepted as 'best practices' in curbing challenging behaviour in both intellectual/learning disabilities and in mental health settings.

6 METHODOLOGY

6.1 Method and Materials

Qualitative research method was used in data collections, whereby the method facilitates study of issues in depth and details. Approaching fieldwork without being constrained by predetermined categories of analysis, contributes to the depth, openness, and detail of qualitative inquiry (Patton, 2002 p.14)

Qualitative methods typically produce a wealth of detailed information about a much smaller number of people and cases. This increases the depth of understanding of the cases and situations studied but reduce generalization (Patton, 2002 p.14). Thereby it is oriented towards exploration, discovery and inductive logic; which its evaluation approach is deductive.

Qualitative content analysis was the basis on how the research articles were going to be analyzed, when collecting data. However, qualitative content analysis according to (Patton 2002 p. 453) is defined as:-

‘’Any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings’’

Qualitative content analysis goes beyond merely counting words or extracting objective content from text to examine meanings, themes and patterns that may be manifest or latent in a particular text. It allows researchers to understand social reality in subjective but scientific manner. But qualitative content analysis does not need to exclude deductive reasoning (Patton, 2002).

The analyst looks for quotations or observation that links together, that are examples/similar of the underlying issue, idea or concept. But sometimes, this involves pulling together all the data that addresses a particular evaluation question. For instance, a

question in a process evaluation might relate the nature of staff/caregivers' perception/reactions to challenging behaviors. The evaluation analyst will first of all pull together all the related data to this issue, and then subdivides that data into coherent categories, patterns and themes.

During the research, published studies related to challenging behaviors were targeted. Since this research is based on elderly people, the age range targeted was elderly people of 65 years and above. With the main diagnosis being 'aggression' and 'violence'

A systematic search of the electronic databases EBSCO host and Google Scholar was conducted for the papers published between 1999 and 2012, using the following key words: *challenging behaviors*, aggressive behaviour* or violence* dementia* or intellectual disabilities* nursing homes or *residential settings* elderly and caregivers*

6.1.1 Problems Encountered In the Study

The comprehensive identification of main concepts is one of the challenges encountered at the data analysis stage. Combination of the deductive and inductive coding logic approaches, together with repetitive cycles of coding procedure until no new concept is identified, aims to address this issue successfully. In the study, it was difficult to acquire books that have discussed the methodology used for this work in details. It was also difficult to get books that have discussed content analysis in depth. However, there were several books that have discussed the method briefly, then from there; the author was able to get a general overview of the basis in content analysis.

6.1.2 Validity and Reliability

Reliability of content analysis study is the extent to which an experiment, test, or any measuring procedure yields the same result on repeated trials. Without the agreement of independent observers able to replicate research procedures, or the ability to use re-

search tools and procedures that yield consistent measurements, researchers would be unable to satisfactorily draw conclusions, formulate theories, or make claims about the generalizability of their research. In addition to its important role in research, reliability is critical for many parts of our lives, e.g. manufacturing, medicine, and sports (Howell, J. et al. 2005). Reliability is also concerned with accuracy of actual measuring or procedure.

The validity of content analysis study refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher is attempting to measure. Validity is also concerned with the study's success at measuring what the researcher sets out to measure (Howell, J. et al. 2005).

In this study, the author cautiously studied the published articles that were chosen for this study. The results that were closely connected or appropriate and corresponding to the research questions were grouped into different categories, as already explained in the methodological part of this work. The categories were according to different themes which were gotten from the articles that were relevant to the study. The categories were named according to the subject that the different categories were focused on. The author felt the naming was consistent with the units in the categories, and this was contributing to the structuring of the work to reach the answers to the research questions. The naming and classification of categories could defer if another researcher is to do the work, but the results will most likely end up being same.

The published articles that were used in this study were retrieved from trusted and reliable a database that contains scientific research work that has been done by professionals in the field.

The results found in the study have all emerged from the scientific articles used for this study, and the author has not included any other sources for the results. The author has

never used neither past experiences nor the author's knowledge to influence or to alter the results.

The method that was used to analyze the articles to arrive at the answers of the research questions was the best method to be used for this kind of study and was conducted to the best of the author's knowledge.

6.1.3 Ethical Considerations

The author studied thoroughly and understood the Declaration of Helsinki World Medical Association (WMA) – Ethical Principles for Medical Research Involving Human Subjects prior to writing the report.

The scientific research articles that were used as the bases of this study were reported in truth throughout the study.

Quotations also gotten directly from the articles and books that were used for this study have been quoted and also written in italics format. The author has also documented fully, sources for ideas, words, and pictures used in the study properly.

6.1.4 Sample Process

At the beginning of the search, a trial was made finding data about challenging behaviour, aggressive behaviour and by using the database EBSCO host. The subject term used was 'Challenging behaviour' and 'aggressive behaviour' and this yielded 8551 references, while applying finding my entire search terms, apply related words, and also search within the text articles and year of publication from 1999 to 2012.

The author then conducted another search in EBSCO host database. The subject terms used in the search then were elderly to stand for older adults who are above 65 years old. The key terms used in the search were *managing challenging behaviour*or coping strategy* aggressive behaviour* or violence* elderly* nursing homes*

The search yielded 960 articles which were then limited more by getting the ones with full text available and full text. The author was interested in getting recent articles, therefore restricted the search to the past twelve years that was 2000 to 2012.

This then yielded 57 articles, from these, the author selected 10 articles that were relevant to the interest of the study, because they were providing useful information contributing to the growth of the study. The author was also interested in getting the articles that had discussed coping with challenging behaviour from non pharmacological perspectives.

A search in GOOGLE SCHOLAR with managing challenging behaviour in the elderly living in nursing homes yielding Results **1 - 10** of about **17,300**. (**0.17** sec). The author went through the search, but majority of the documents in this database, need to be purchased; moreover, some of the articles were already gotten free from EBSCO. Therefore, only two was selected.

Table 1. Sample process

Database	Search terms	Year range	Results	Selected articles	Articles used
Academic Search Elite (EBSCO)	Challenging Behavior and Aggressive Behavior	1999-2012	8551	0	0
Academic Search Elite (EBSCO)	Managing Challenging behavior or Coping, aggression or violence	2000-2012	960	57	10
GOOGLE SCHOLAR	Managing Challengingbehaviors	2000-2012	17,300	10	2

6.1.5 Content Analysis

Content analysis is a research technique for making replicable and valid inference from texts (or other meaningful matter) to the context of their use (Krippendorff, 2004).

Content analysis usually refers to analyzing texts (scripts, journals, diaries, articles, interviews or documents), rather than observational-based field notes (Patton 1990). However, this concur with the definition above in parenthesis, (Krippendorff, 2004 p.19), says it may include works of (art, images, maps, sounds, signs symbols and even numerical records) may be included as data, that, which may be considered as texts-provided they speak to someone about phenomena outside what can be sensed or observed. However, generally, content analysis is used to refer to any qualitative data reduction and sense making efforts that take a volume of qualitative material and attempts to identify core consistencies and meanings (Patton, 1990).

According to Patton, (1990), the main central part found through the content analysis is called patterns or themes. And the process of searching for patterns or themes can be distinguished respectively as pattern analysis or them analysis.

However, owing to the fact that the method used for this study was content analysis, the author grouped the results of the common themes that emerged from these articles into different Categories. These Categories were divided into sub categories, generic categories and main categories.

The reason for these whole processes was to elaborate briefly the categories and link the sub category, main idea to the research question for the study, which is the main category.

Summary of the Selected articles for the Study

Tabell 2

Authors/Source	**Title**	**Year of Publication**	**Aim of the article**	**Results**
Duff, E. et al. EBSCO- academic search Elite	Challenging Behavior in Mental Health Services	2006	To review evidence on the causes and management of Challenging behavior in mental health services and its impact on direct care staff, and report on an innovative approach that integrates different bodies of and psychological theories to provide coherent approach to training and supporting staff	The result shows sufficient evidence, recommending psychological approaches that addressing the problem of challenging behaviour in mental health services. These are based on functional analysis and address staff motivation as a central concern for which BAITS is one of such approaches.
Di Mattei, V. E. et al. EBSCO academic search Elite	The burden of distress in caregivers of elderly demented patients and its relationship with coping strategies	2008	Is to investigate which socio-demographic and clinical variables are significantly associated with higher level of distress	The study samples 112 caregivers of demented patients, admitted to the department of Neurology of San

			in caregivers, and the relationship between caregivers' level of distress and coping strategies they adopt.	Raffaele-Turro Hospital (Milan, Italy). Caregivers were asked to the CBI and COPE. Results show that caregivers with highest level of distress are characterized by an impaired physical health status.
Eloniemi-Sulkava, U. et al.	Family Care as Collaboration: Effectiveness of a multicomponent support program for elderly Couples with dementia	2009	To determine whether community care of people with dementia can be prolonged with a 2year multicomponent intervention program and to analyze effects of the intervention on total usage and expenses of social and health care services.	At 1.6years, a larger proportion in the control group than intervention group was in long-term institutional care (25.8% vs 11.1%, p=.03)

Hazel, H. et al.	Improving quality of care for people with dementia in general hospitals	2010	Improve care environment and supporting increased independence for people with dementia through a range of measures including improved signage and removal of potential hazards	Results shows that environmental, communication, bright light therapy, sound care practices, rehabilitative and supportive approaches and multi-professional team work are effective in meeting the needs of clients with dementia.
Keady, J. & Lesley, J.	Investigating the causes of behaviors that challenge in people with dementia	2010	explore ways of understanding behavior that challenged in person with severe dementia in nursing homes	Results show that multi-disciplinary team approach was used to curb challenging behaviors, which enhance quality of life and alleviate suffering.
MacDonald, A. et al.	The use of multi-element behavior support	2010	Review articles on work done with individuals	Indicates that behavior support program

	planning with a man with severe learning disability and challenging behaviour		and care staff team which helped reduce challenging behavior and provide improved service and better quality of life.	enables people with learning disability and challenging behavior to live long and reduce challenging behaviors.
Osborne, H. et al.	The Relationship between Pre-morbid and Challenging Behaviour in People with Dementia.	2010	Examine the studies of relationship between pre-morbid personality and challenging behavior in order to conduct systematic review.	Result indicates 72% of studies reported significant relationship between pre-morbid personality and behavior. In terms of specific relationships, the strongest evidence was found for a positive relationship between pre-morbid neuroticism and mood, aggression and overall behavioral acts
Pulsford, D. & Duxbury, J.	Aggressive Behaviour by Peo-	2006	to review researches on ag-	Finding shows that the emo-

	ple with Dementia in residential care settings		gressive behavior by people with dementia in residential settings	tional impact of assaults on caregivers and other professionals is alarming.
Sigan, L. & William, E. M	Staff-Averse Challenging Behaviour in Older Adults with intellectual Disabilities,	2007	To review articles on age-related change in prevalence rate of challenging behavior among older adults with intellectual disabilities	From the results, there was an intra-individual decline in the frequency and severity of challenging behavior using both lenient and more restricted definition of challenging behavior.
Turner, S.	Behavioral Symptoms of Dementia in Residential Settings: A selective review of non-pharmacological interventions,	2005	To review the evidence for alternative treatment of the recent ruling that Risperidone and Olazepine should not be used to control behavioral symptoms in	Improvement in behavior and of staff attribution of it, which to improved handling of residents and quality of life/job satisfaction.

			dementia.	
Xeniditis, K. et al. GOOGLE SCHOLAR	Management of people with challenging behaviour.	2001	Assess/treatment relationship between psychiatric diagnosis and challenging behaviors	Shows both assessment and treatment should consist multi-agency, multi-disciplinary involvement.
Zwijsen, S. A. et al. EBSCO academic search Elite	Grip on challenging behaviour: A multidisciplinary care program for managing behavioral problems in nursing home residents with dementia	2011	Evaluate the effectiveness and cost-effectiveness of an evidence and practice base care program for managing challenging behavior in (NH)	Increase of quality of life for residents, lower costs and decrease of behavioral problems, which comes from a good care plan.

6.1.6 Inductive content analysis

According to (Burnard 1991, 1996, Hsieh & Shannon 2005 in Elo, S. & Kyngäs, H. 2008) says, if the researcher has chosen to adopt inductive content analysis, the next step is to organize the qualitative data. This process includes open coding, creating categories and abstraction. Open coding means that notes and headings are written in the text while reading it. The written material is read through again, and as many headings as necessary are written down in the margin to describe all aspects of the content, and this is shown in (Table 1, 2 & 3) explaining the results.

The tables below illustrate briefly, the three categories in which the results found from the articles were classified into. However, it gives a clearer view of the main ideas behind the three categories, whereby the elements in each category where classified into groups that have the same idea.

Then the two research questions are linked with each research question having an answer to main categories.

RESULTS: Question 1: What are some of the challenges caregivers encounter while caring for clients with challenging behaviors?

Tabell 3 Challenges Caregivers encounter

SUBCATEGORY	**GENERIC CATEGORY**	**MAIN CATEGORY**
Exhaustion-leading to absenteeism, Not willing to discuss it with other professionals/Psychologist Pressure- leading to chronic stress-Burnout. Emotional detachments and also perhaps absenteeism and denial of their problems/quite the job. (Some may pretend) Difficult to speak of their anxiety, depression, not making time for themselves/ones' self. Negative feelings.	**Stress** **Burnout**	Threat to psychological well-being

Psychological imbalance, mood deterioration.	**Mental health problems**	

Table 4 Categories of challenges

SUBCATEGORY	**GENERIC CATEGORY**	**MAIN CATEGORY**
Hurting self or caregivers Making mockery of care-giver, (Socially offensive behaviors)- physical injury to self or others	Destruction-harmfulness Assaults,	Physical threat (challenges during ADL)
Poor social support frequently associated with higher level caregiver's distress and burden Severity of behavioral disturbances, psychotic symptoms of (AD), depressive features gotten from their clients leads to most distressful in caring.	**Burden of distress**	**Psychopathological** Threat to mental well-being.

Table 2

Question 2: What are some of the strategies/approaches caregivers can use while taking care of clients with challenging behaviors?

This follows the categories of systematic multi-factorial and disciplinary approaches (Zwijsen et al. 2011, McDonald et al. 2010, Turner, 2005) .Non-Pharmacological interventions.

Table 5 Strategies of managing challenging behaviours

SUB CATEGORY	**GENERIC CATEGORY**	**MAIN CATEGORY**
Strategic decision making, e.g., if there is noise in the environment, try to stop every distraction. Providing soothing or sensory stimulation. Taking resident/client out for a supervised walk, Use of sights and sounds of nature also reminiscence Good communication practices, no bridge in communication (communication gab. Two or more caregivers, forcibly carrying out ADL-practices (restraints-mechanically/manually)	Positive programming/planning (Physical intervention)- To reduce agitation(aggression), wondering, Stimulated environment (lost memories prevention) Wonderers, agitation Apathy 'Bull-dozing'(Sense of humor)	Proactive strategy-changing clients' behavior

SUBCATEGORY	GENERICCATEGORY	MAIN CATEGORY
Visual daily planner ADL Activity board Structured week (ABA-applied behaviour analysis)-to neutralize ABC Recognising the future of social environment. (i.e., when there is time to play and sing with the client) Good oil with nice smell provides relief from pain and distress. Bathing and during all the caring process.	Antecedent control Neutralising routines (Therapeutic environment) Bright light therapy. Snoezelen, music (stimulated presence therapy)-tapes and recorded stimulated voices. Aromatherapy**.**	Ecological strategy (prevention of more behavioral cues).

SUBCATEGORY	GENERIC CATEGORY	MAIN CATEGORY
Counter-(rehabilitating staff/caregivers) attributes and attitude (perception) towards the clients and their challenging behaviors. Conducting sessions focusing on particular clients presenting significant challenges	Training of staff/caregivers (person-centered framework) Behavioral training Providing 'refresher' courses.	Reactive Strategies (Stressors prevention)

SUBCATEGORY	CATEGORY	MAIN CATGORY
Support-provision for support to caregiver (from every sphere of life) mentally, physically and otherwise. Comprises of training, support and change of attitude programs) Feelings and actions.	**BAITS** (Behavioral analysis, intervention, training and support) approach. Sensitizing, Educating, Encouragement.	Stress and burnout prevention

Table 3. Bellow talks about 'Active and Avoidance coping strategies': - The predominance of one type of strategy over another is determined by personal characteristics (e.g. some caregivers can cope more actively than others) and also by the type of stressful events (potentially controllable or uncontrollable problems). People use both strategies to combat stressful events or stressors (Di Mattei, V. E. 2008)

Tabell 6

SUBCATEGORY	GENERIC CATEGORY	MAIN CATEGORY
Behavioral or emotional, being active to deal with stressful events. Caregivers, looking for help on how to cope. Acceptance of problematic situations	Activeness. Nervousness(Avoidance) Laziness(Adaptive)	Coping strategies

In addition, the fundamental building block of 'BAITS'- educating caregivers about challenging behaviors or person-centered care, and making modifications to the living environment could prevent problems and improve the way caregivers, respond to these behavioral problems. Generally, a structured model of intervention can be proposed to clinicians' decision making about how and whether to intervene with behavioral challenges.

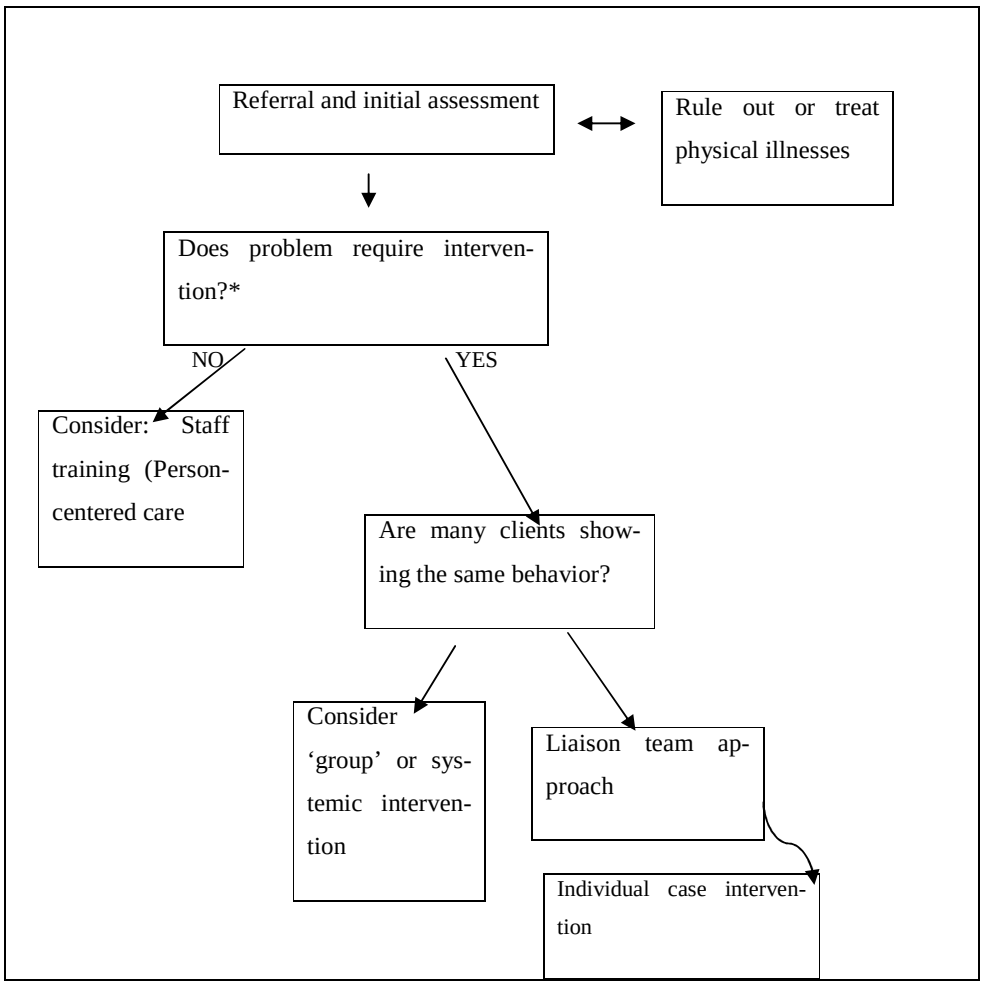

Figure 2

(Turner, S. 2005)

Fig.2, this is a structure model for deciding on how to care for clients with behavioral problems, which are challenging.

Criteria for interventions here, includes distress to resident, distress to other residents, harm to other residents, harm to staff. If low on distress and harm, then consider evi-

dence for effectiveness of interventions should be viewed with potential for achieving any improvement with available resources.

7 RESULTS

The results that emerged from the articles used in the study are further discussed below, and these results are divided into two parts according to the research questions as seen below.

7.1 Caregivers' burden with Challenging Behaviors

(Results of Research Question 1)

According to researchers, there is strong evidence that caring for dependent elderly people suffering from all sorts of behavioral challenges, comes at a very high risk cost to caregivers' health. And this affects caregiver's health both physical, psychological and mental well-being and these are seen with negative consequences. However, these challenges are highlighted bellow as they occur.

Psychological Challenges

Stress and burnout

This comes with a high level of distress and burden to caregivers' health. And a more significant findings is that carers experience considerable stress, negative feelings and burnout as a result of being a victim of aggressive behavior or challenging behavior melted on them (Gates et al. 1999, Oser 2000, Evers et al. 2002, Astrom et al. 2004) and perceived threat leads to raised stress, which results to emotional exhaustion, (see Pulsford, D. & Duxbury, J. 2006).

According to Di Mattei, V. E. et al. (2008), some characteristics of both clients of Alzheimer's disease or any form of dementia and of their caregivers are associated with a higher risk of developing stress and the most distinctive features are:

- ***Gender,*** It has been highlighted that women who take care of demented clients are at higher risk of getting stress than men carrying out the same caring assis-

tance role. And this can be due to different reasons such as:- Social and gender issues makes them more likely to assume a fuller role as caregivers; moreover, women caregivers, tends to spend more time with the patient/client during ADL, which leads them to feel more burdened and stressed up.

- ***Caregivers' physical and mental health status:*** Some studies pointed out that poor physical and mental health status can put caregivers at risk of stress and depressive symptoms.
- ***Caregivers' age:*** Caregivers at the retirement age are at risk of getting stressed up more easily than younger ones. Such vulnerability could be explained both by difficulties in assuming such a demanding role and by caregivers' own physical and psychological problems.

Physical Challenges

A high rate of hurtful harm, destructive, disruptive behavior, socially offensive behavior and uncooperative behaviors, physical assaults like physical aggression, bullying sexual harassment (clients with aggressive abnormal sexual behaviors), this high level of physical injurious harm and exposure to severe psychological trauma elicit negative reactions to caregivers.

Mental Challenges

And over time, these negative effects are thought to accumulate and lead to decrease, psychological and decrease mental well-being. Caregivers' stress and burnout and other forms of assaults to their mental well-being, has a major impact and affects the quality of care/service.

However, as a result of all these challenges coming from clients of challenging behaviors, caregivers, then resort to absenteeism and so many other ways so as to escape their heavy work load. A possible explanation for this discrepancy comes from burnout literature, which states that when healthcare job pressures reaches a critical point, caregivers may respond with emotional detachment, perhaps leading to absenteeism and denial of their problems, and not wanting to discuss their anxiety or emotions

7.2 Strategies of managing challenging behaviors

(Results of research question 2)

There has been great evidence from researchers based on the effectiveness of non-pharmacological approaches in coping with challenging behaviors. This non-pharmacological intervention approach follows a systematic multi-factorial disciplinary measure, which are:

Ecological Strategies

This involves changes in the clients' environment, by applying the use of therapeutic environment. Aromatherapy, Snoezelen, music (simulated presence therapy)-tapes and recorded simulated voices are played to clients, and exercise. Bright light therapy, all these aims at bringing about change in the clients behaviour, providing soothing or sensory stimulation (Burns et al. 2002) and invoking the interactive cognitive subsystem model (ICS), with the hypothesis that pleasant memory traces are evoked by stimuli.

A-B-C (antecedent-behaviour- consequences) the use of A-B-A, (Applied Behaviour Analysis, this is made available to neutralize the cues for behavioural antecedents, which would create enabling environment and sense of humour for the client, thereby stopping other kinds of distractions that would evoke aggression or other forms of behavioural challenges.

Proactive Strategies

This involves, positive decision making, like taken the client out for a walk, in order to influence positive change in the clients behaviour, like for some of the clients who are wonderers, they always like to walk around their vicinity, therefore, making decision, and finding out time to take them even around the corridors of the building helps relief pain and distress. Moreover, for aggressive clients, ensuring that the environment is more quite and not noisy, and also more structured with some colourful background, helps get them in contact with their world.

Reactive Strategies

This strategy aimed to ensure that care-staff are reinforced in order to get rapid and safe control over the challenging behaviour. Nevertheless, BAITS (behaviour analysis, intervention, training and support) this is an optimistic approach to supporting and training caregivers who work with people with challenging behaviours, it is strongly oriented towards positive change and personal development, rather than just managing the problems.

Intervention, training and support, all these three aims of BAITS' target is to give caregivers the knowledge to view challenging behaviour from a behavioural perspective, and also to provide skills necessary to develop understanding based on observation and analysis, rather than on assumptions. However, this knowledge and skills are designed to allow caregivers to deal confidently, with the challenges they encounter daily.

CRITICAL ANALYSIS

The whole process of writing this thesis project has been very challenging, and as the name of the thesis topic narrates that challenging behaviour is very complex due to the nature and mood of presentation of different forms of behavioural problems. So many researchers have been discussing the topic under pre-morbid personality disorder, and it was difficult to get articles which have discussed challenging behaviour and its methodological frame work in details.

Another limitation the author faced was that some researchers argued the fact that different types of research methodology for behaviours are appropriate for different studies concerning different forms of behaviours; therefore, there is still too little evidence to provide guidelines. Again none of the reviews has been able to provide best and concrete method of curtailing challenging behaviours. On the other hand, considering the fact that Finnish being the mother tongue, while English language was the only language used in searching for articles, this implies that useful articles written in Finnish language could not also be accessed. This brings to the limitation of important and useful articles that could have added more validity and reliability to be left out.

8 DISCUSSION, CONCLUSION AND SUGGESTIONS

The aim of this study was to review the research on elderly clients or patients suffering from challenging behavior, in order to explore measures and strategies for carers or care-workers to provide care for them with ease, without so much stress to caregivers' psychological and mental well-being, been affected. This will help foster patients' safety and quality of life. And also on the other hand grant job satisfaction to caregivers.

Strong evidence has been shown from researches that the distress of challenging behavior to caregivers' health is an alarming issue to the society and a great burden to the society at large, Looking into socio-demography, challenging behaviors have been mostly the major reasons for an elderly client entering into a nursing home, just for the fact that, the family are no longer able to cope with the situation of the behavior that challenged, therefore, some family see nursing homes as a place where their hopes could be curtailed.

According to Freud 1895's Affects theory and Defense Model (Constancy principle), is a theory of meaning and theory of mechanism, identifies that human being is a discrete entity, who can be treated both theoretically and clinically, the mind is constructed like a machine driven by the flow of energy forces. Alloplastic or Autoplastic is best suited to reduce the level of stimulation, and therefore, tension build by it must be discharge by it. And we find that this theory is consisted with the findings from this study. Reasons for a behavior being labeled as challenged are due to human nature of mechanism and meaning. And which suggest that what matters most to human being is to rid ourselves out of stimulation either outwardly or inwardly, which is autoplastic or alloplastic (Greenberg, J. & Stephen, A. 1983).

Following the current research articles that were used in this study, aggression and violence has been established as characteristics of challenging behavior in older adults. Older people with aggression and violence express worries of restlessness and agitation, which comes as stress to caregivers' health and burden to the society. And this is seen as a result of looking for means to meet with their needs, communicate an unmet need,

which is fuelled by impaired ability to express desires and wants (cp Keady, J. & Lesley, J. 2010). And this correlates with Constancy principle of Freud 1895, which talks about looking for meaning and desires.

Conclusion

In conclusion, the aim of this study which was to review the research on elderly clients suffering from challenging behavior, in order to explore measures and strategies for carers or care-workers to provide care for them with ease, without so much stress to caregivers' psychological and mental well-being, been affected. This will help foster patients' safety and quality of life. And also on the other hand grant job satisfaction to caregivers. This study contributes greatly to the well-being of elderly people and their carers; more so, the study has been able to find answers to the research questions that were set as the basis for the study. Again, this study has been able to identify some of the challenges caregivers encounter as a result of caring for elderly clients with challenging behaviour which was connected to the 1st research question. Therefore, the author believes that this study will contribute immensely in the management of challenging behaviour which was connected to the 2nd research question, and hence reducing stress and encouraging job satisfaction.

RECOMMENDATION FOR FURTHER STUDIES

According to researches, it has been proven beyond reasonable doubt that challenging behaviors are the most inarguable reasons for moving clients with dementia to nursing homes, due to the complexity of the challenges arising from behaviors. And they are often burdensome for residents, nursing staff and even the family or relatives of client. Therefore, it will be good to investigate which of the practices or methods will be best to curtail, reduce stress and burnout for both caregivers and also improve quality of life/care for clients.

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APPENDICES

Summary of findings/results gotten from the articles

Summary of the findings are grouped according to the two research questions that were used as a back bone to this thesis work. This is to enable us get a concrete understanding of the articles which answers the research questions.

Q. 1. What are some of the challenges caregivers encounter while caring for clients with challenging behaviors?

Authors & Year of Publication	***Challenges discussed***
Di Mattei, V. E. et al. 2008,	According to the results gotten from this article, it was gathered that taken care of elderly clients suffering from challenging behaviors comes with a high cost to caregivers' health, and which is seen as psychological and mental health break down, which is associated with negative consequences with burden of distress to caregivers of elderly demented clients.
Sigan, L. & William, E. M. 2007,	Results gotten from this article summarizes the physical challenges which is known as staff –averse challenging behaviors, and these challenges are those which are directly or indirectly hinders staff from providing services, which includes hurting of staff, aggression from clients, disruptive behaviors, uncooperative behavior and socially inappropriate offensive behaviors.
Pulsford, D. & Duxbury, J. 2006,	Elaborate on the increased attention of aggression and violence perpetrated by clients to their caregivers. Perceived threat leads to raised stress and persistence physical aggression and injuring results in emotional exhaustion of caregiver
Osborne, H. et al. 2010,	The prevalence of challenging behavior adds greatly to the reduction of quality of life for both clients with dementia and their carers. Reduction in mood behavior which comes from the experience of being victimized.

Question 2: What are some of the strategies/approaches caregivers can use while taking care of clients with challenging behaviors?

Authors and Years of Publication	*Strategies or approaches*
Duff, E. et al. 2006,	**Reactive strategies:** Results from this article recommends psychological approaches that addresses the problems of challenging behaviors rather than just managing them, which are based on functional analysis and staff motivation as a central concern and which **BAITS** integrates them.
MacDonald, A. et al. 2010,	**Proactive strategies:** Enabling change in clients behavior, and which involves creativity on the side of the care-staff, for instance wanderers and clients whom are always shouting needs the staff to employ critical and creative thinking at any given point to care for them, like taken a wanderer out for a walk.
Keady, J. & Lesley, J. 2010.	Person-centered approach: Using case study, understanding why the behavior is demanding and therefore, trying to alleviate suffering and improve quality of life.
Eloniemi-Sulkava, U. et al. 2009,	
Zwijsen, S. A. et al. 2011,	Results from these three articles are explaining briefly multi-factorial and disciplinary approaches to manage challenging behaviors like snoezelen, music (stimulated presence therapy)-tapes and recorded stimulated voices and pet therapy etc.
Turner, S. 2005.	
Xeniditis, K. et al. 2001	
Hazel, H. et al. 2010	**Ecological strategies:** Great evidence in the change of clients environment by providing therapeutic environment, with the use of aromatherapy, sensational stimuli from good smells, drawing and nice pictures on the wall of the clients environment