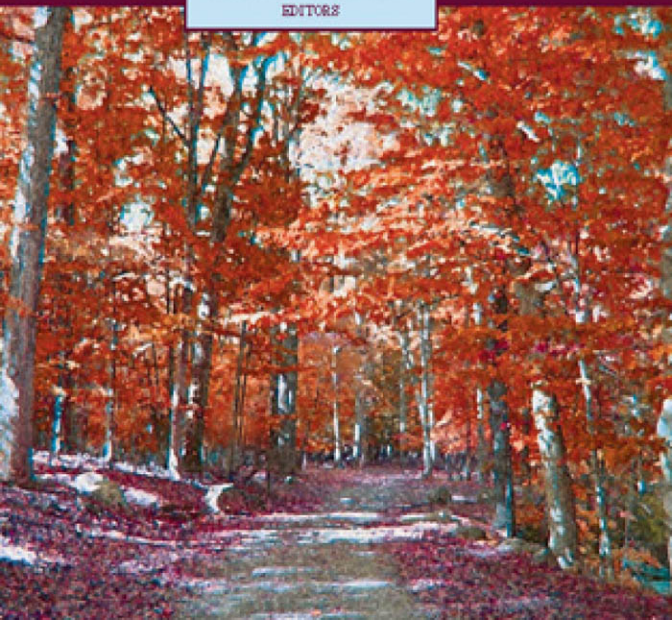


GEROPSYCHOLOGICAL INTERVENTIONS IN LONG-TERM CARE

LEE HYER
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SPRINGER PUBLISHING COMPANY
New York

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Springer Publishing Company, Inc.
11 West 42nd Street, 15th Floor
New York, NY 10036-8002

Acquisitions Editor: Helvi Gold
Production Editor: Print Matters, Inc.
Composition: Compset, Inc.
Cover design by Mimi Flow

06 07 08 09 10/5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Geropsychological interventions in long-term care/[edited by] Lee Hyer,
Robert C. Intrieri.

p.; cm.

Includes bibliographical references and index.

ISBN 0-8261-3845-4 (hardcover)

1. Geriatric psychiatry. 2. Older people—Long-term care. 3. Older people—Mental health.

I. Hyer, Lee, 1944— II. Intrieri, Robert.

[DNLM: 1. Long-Term Care—psychology—Aged.

2. Dementia—therapy—Aged. 3. Homes for the Aged.

4. Psychotherapy—methods—Aged. WT 31 G3773 2006]

RC451.4.A5G495 2006

618.97'689—dc22

2005049530

Printed in the United States of America by Bang Printing.

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Preface

You cannot depend on your eyes when your imagination is out of focus.

Mark Twain

We are in a remarkable time; 40 years ago, the only anxiety disorders that were considered untreatable were obsessive-compulsive disorder and panic disorder. Things have changed and we had to endure that time, that science, and that conclusion to reach this point. We offer a book that is also captured somewhere in time, one that will certainly change more rapidly than this example, because studies in long-term care (LTC) are now more informative and more evident.

Across the past decade, the typical LTC resident has become frailer, as well as more physically, cognitively, and psychologically vulnerable. Many believe this phenomenon is largely due to a change in the system. Specifically, they highlight the emergence of the Prospective Payment System (PPS) for Medicare hospital expenses. At the time of its inception in 1984, the goal of PPS was to reduce health care costs. Examining its success in achieving this goal, Estes et al. (1993) analyzed the impact of PPS on community-based LTC systems. Their results suggest that PPS leads older adults to return to the community from acute-care settings or to posthospital rehabilitation in LTC facilities “quicker and sicker” than ever before (Estes et al., 1993). Fischer and Eustis (1989) argue that not only does PPS influence the margins of hospital care but it also influences the interactions between acute and LTC facilities. More importantly, Fischer and Eustis (1989) state that PPS has altered the nature of family care. Families are expected to provide care services for increasingly longer periods, often until the family system can no longer sustain the caregiving burden.

The impact of this social policy has been gradual and harmful, especially in relation to the LTC resident’s ability to maintain autonomy and dignity within the LTC system. The typical resident suffers from a dizzying array of complicated medical, cognitive, and psychological issues that are agonizingly slow to unravel. For the practice of mental health in

LTC especially, we believe that we are in a borderland between the day-to-day, in-your-face practice in these facilities and empirically supported treatments. Perhaps clinical practice is still too disparate and primitive as a science to be ready to establish best practice guidelines, but we, in this book, argue that we have an improved direction and validated technologies to practice alongside medicine. We offer a book then that examines extant practices, supports or challenges these, and points the way for better care.

We are aware of something else, the complexity of LTC resident him or herself. In the past 5 years, the typical resident in nursing homes has become older and more physically fragile. In fact, there remains much variability in nursing homes. On the one side, 25% of all deaths occur in nursing homes. On the other side, we can assess and treat problems with greater ease and better outcomes. In the middle, we are able to define stability and change among residents and to provide an outlook that allows us to handle these “complex systems,” striking a balance between the need for order and the respect for inevitable decline. We are grasping the difference between help and ineluctable loss better, and the creative management of both. In the science fiction novel, *The Lost World*, Michael Crichton commented:

Complex systems tend to locate themselves at a place we call “the edge of chaos.” We imagine the edge of chaos as a place where there is enough innovation to keep a living system vibrant, and enough stability to keep it from collapsing into anarchy. (Crichton, 1996, p. 4)

At present, we have much to go on. Theories of the behavior of residents in LTC now exist and explain the relationship between the aging individual and behavior in these settings. The work of Lawton and Baltes especially has explicated the complexity of this social system and the compensation required of the resident, and provided a guidepost for dialog. These and other theorists address the whole person in a “complete” environment and request us to push the limits of our technology to have a better vision and offer better care. We attempt to accomplish this in the book.

Now more than ever, there is progress and energy in LTC settings. We believe that we have captured this here. We have assembled a group of health care professionals who are dedicated to the care and research of these residents. This group pushes the treatment envelope and opines for the improved use of professional input, time, and effort. Interventions range from the organizational to the personal; psychosocial to the medical; and the theoretical to the practical. This group recognizes that, in our modern information economy, a far higher level of knowledge,

education, and skill is required for LTC treatment than in the past. They realize too that this effort demands a much higher level of commitment of human concern and scientific rigor.

To turn a phrase used by Art Linkletter, “long-term care is not for sissies.” Working in LTC requires commitment, guile, patience, and knowledge of what works and what does not. To that end, the goal of this book is to provide insight into the psychosocial issues confronting older LTC residents as well as information regarding strategies that are most effective based on the evidence to date. *Who should read this book?* We believe this book provides valuable resource information for physicians and geriatricians who care for older adults in the LTC system and may want to supplement medical treatments with effective psychosocial interventions. Further, we think this book will provide valued and needed information for registered nurses, geriatric nurse specialists, social workers, activity coordinators, as well as physical, occupational, and speech therapists that operate within the LTC setting who are seeking ways to explain behavior and empower the residents that they care for. Finally, psychologists and psychiatrists whose practice focuses on older adults will gain valuable information about the process of working with people in the LTC environment will hopefully further facilitate their effectiveness within the LTC setting. *Who will take care of Mom and Dad when they can no longer take care of themselves?* We hope that it will be someone who understands that maintaining autonomy, respect, and dignity through the end of life is critically important.

We (Lee and Bob) also have our own energies and beliefs. This book was begun under the quixotic skies of hope and change, against the noxious fumes of LTC practice everywhere. No one is at fault. As in health care everywhere, we are strapped to the mast, knowing what can be done and most often helpless to alter practice. As health care providers, we practice in LTC facilities in this country with a rigid, record-based technology that often leaves the resident alone and misunderstood. We know that there is a better way. We believe that this book allows us to look in a clearer way into the cosmos and entrails of LTC facilities, at what we are doing, at bringing awareness to what we are doing, and at explicating our choices and responsibilities. As you peruse the table of contents, and as you complete the book, we hope you agree that you also are more skilled and challenged.

Most of all we believe in and like what we are doing. We can make a difference. “Blessed is he who has found his work. Let him seek no other blessedness.”

Thomas Carlyle

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Introduction

To add spin on a phrase, it takes a village to adequately understand and maximize the quality of life in residents placed in long-term care (LTC) facilities. The natural events of a failing health, general debility, a social milieu that fosters inactivity and lack of control, and an intervention focus on the medical model conspire to prevent adults in LTC to thrive or even adjust marginally. Changing the quality and zeitgeist of care in such a setting requires much effort and some theory. In fact, there are many theories and much speculation on the causative agents involved. Barton, Baltes, and Orzech (1980), for example, proposed specific mechanisms that whereby institutions foster excess disability and a “dependency script.” Brandtstadter and Renner (1990) too indicated that a central task of coping for living well is flexible goal adjustment, meaning the view of seeing a positive aspect, or meaning in the failing to achieve one’s goals or lower one’s level of aspiration.

Applying the one model of care in such settings, Baltes and Baltes (1990) hold that compensation efforts, such as acquiring substitute means to maintain one’s level of functioning, indeed do provide a way out, a way to improve quality of life. This is the SOC (selection, optimization, and compensation) model. It takes the global view that every stage of development individuals seek to master life through the application and orchestration of three components—selection, optimization, and compensation. In the action-oriented formulation of SOC (Freund & Baltes, 1998), the focus is on proactive and agentic strategies of life management. It is thereby adaptive to set clear goals, acquire and invest means into the purpose of these goals, and do so persistently even in the face of setbacks and losses.

Perhaps ingenuously, we take the global view that at all stages of development individuals seek to master life through assimilation/accommodation. In LTC this can be seen through the lens of three components—selection, optimization, and compensation. Sometimes this involves an action-oriented formulation of SOC (Baltes & Freund, 2003) where the focus is on agentic, self-regulated strategies of life management; at other times, the focus is elsewhere, on the environment.

In this book, we address the challenge of LTC—how to allow residents to thrive in an environment at the end of life, one with one exit. We have divided the book into five sections; *Overview, Basic Care, “There Is Still a Person in There,” Training, and Interventions.*

Overview: We start the book (Chapter 1) with an overview on aging, with a special focus on the lifespan perspective as it assists in an understanding of the “care” in LTC. Behaviors are viewed as the result of the assimilation/accommodation of the whole person and the social environment. We highlight the SOC model in a fluid but closed system, the nursing home. Our concern is the decline progresses, the person usually accommodating by a downward adjustment. How we can undo this is our challenge.

In Chapter 2, a perspective on the care is given by Collins and Smyer. They focus on the ecology in the environment that sets the stage for LTC. Older people are entering nursing homes later, and sicker, than ever before. An understanding of the ecology of LTC allows for a grounding to facilitate optimal aging. The authors initiate the discussion by providing a perspective on the background and modifiable variables that lead to a person to LTC. The authors then examine LTC from an ecological perspective and illuminate the interactions among multiple levels, including the disabled individual and his or her physical and social environment. Their discussion of a hierarchical model of functional assessment implies that level of functioning requires physical, psychological, and social skills. Disabled individuals must manage losses and promote gains based on their individual profiles for risk. Individual characteristics like age, gender, race, marital status, education, and health influence level of risk for disability and the ability to manage disability once it occurs. Finally, the authors discuss Medicaid as an example of a successful program that empowers disabled individuals to choose care based on their changing personal needs.

Basic Care: In the section on medical care, Heath, Gartenberg, and Beagin (Chapter 3) discuss how the family practice physician responds to medical issues in a “nursing home.” The import of this chapter is psychosocial care of a human being with multiple medical problems. Importantly, the authors discuss how does the physician overcome the shackles of the medical model in a “nursing” home. Reviews of medical and psychosocial issues related to LTC from a medical perspective set the table for a typology of LTC—actively dying, actively rehabbing, and surviving. The authors finish with typical medical diagnoses and red flag issues, as well as a discussion of the usual models for mental health delivery as inadequate.

In Chapter 4, Shah and Reichman discuss effective psychiatric evaluation and the importance of the contributions of biological,

psychological, and social factors to the expression of mental illness. When these are carefully considered, affected residents experience a heightened sense of personal well-being, engagement in the environment, competence, and purpose. The authors provide the reader with a geropsychiatric view that allows for a melding of medical and psychosocial in order to best allow the integrative benefits for residents in LTC. Practical suggestions from medication limits to care interventions are addressed.

In the last chapter of this section (Chapter 5), Duffy and Karlin review the treatment methods for depression in older adults, emphasizing several methods (including exercise), both those that are common to therapy and those that devolve from behaviors. They “push the envelope” to examine a taxonomy of psychological dynamic patterns that exist “within” the depressive symptom profile. Depression at the symptom level then is a “final common pathway” for many distinct dynamic patterns. They discuss depression through the prism of a growth, adaptability, and change model of behavior, the SOC concerns. These authors seek an estimate of the person’s available unused psychological and physical capacity to optimize change.

“*There Is Still a Person in There*”: In this new section, constructs in LTC related to SOC are considered. These include personality, self-identity, and emotion, as well as the need for ethical deliberation and care in dementia. Molinari, Kier, and Rosowsky (Chapter 6) highlight the importance of personality in LTC. They examine personality and its relationship to the SOC model. Using both research and clinical examples they evaluate how the SOC model meshes with personality factors in the LTC environment, as well as consider the practical implications of the model for enhancing the quality of life of LTC residents.

Next, Parpura-Gill and Cohen-Mansfield (Chapter 7) argue for the persistence of self in older adults, even in LTC. They discuss the provision of activities in LTC facilities is planned without significant attention to their effects on individuals with dementia. Group activities are then based on “general templates for a range of cognitive abilities, while activities for one-on-one interactions are mostly based on trial and error.” In effect, these positions fail to recognize the sense of self. Knowledge of such persons and their roles has practical value for the design of interventions.

Goodwin and Intrieri (Chapter 8) address the important issue of passion in life, emotion. After clearing terminological confusion, they see emotion as referring to the individual’s biologically based multi-dimensional response to a stimulus, leading to changes in physiological functioning, behavior, and subjective experience. Interestingly, this model does not negatively impact on age. The authors find few changes

in functioning. In fact, older adults are most capable of intense emotions, despite some decline. Emotion regulation, for example, is suggested as the mechanism through which individuals achieve their emotional goals, specifically, the maximizing of positive affect and/or the minimizing of negative affect. There appears to be an influence of age on emotion regulation, with older adults reporting greater effort to control the experience of emotion in their daily lives. Age differences in mood states then finds older adults enjoy a more positive mood profile with higher levels of positive emotion and lower levels of negative emotion.

In sum, Goodwin and Intrieri suggest that in late life the interaction between the individual and their environment is positive with an adaptive balance between security and autonomy. This can be done modifying the social context to achieve a desired affective state. Importantly, the authors suggest that older adults are adaptive: as personal resources decline, the individual may select a reorganization of emotional goals, emphasizing the construction of a personal environment that limits exposure to negative affective experiences. The nursing home is after all a reservoir of debility and unmet needs.

In the last chapter of this section, Volicer and Simard (Chapter 9) outline the necessity of the SOC model in advanced dementia. The selection of care is based on the knowledge of the burden and benefit of different treatment strategies, and on previous wishes of the individual with dementia or his/her best interest. The ethical mandate to make advanced care plans as early as possible allows for the best care plans to prevent or minimize behavioral symptoms of dementia. This care should be optimized according to the remaining functional abilities of the individual with dementia. The intricate plan of how to prevent an escalation of negative behavior (resistiveness) is discussed. Compensation allows for both habilitation strategies to maintain remaining functions for as long as possible, and executive function interventions to allow for reasonable activity and meaningful activities to occur. The author notes that by paying attention to the SOC model, it is possible to improve dementia care and maintain quality of life throughout the course of the disease.

Training: Staff training is required in LTC facilities and is often offered as an avenue for improving the care and quality of life of nursing home residents. Unfortunately this has not always been the case. The general goal of such interventions is to provide staff with the knowledge and skill to identify and address the unmet needs of residents, particularly residents with dementia.

Gould and Stevens discuss two models that maximize the possibility of staff input, embedded care, and overall satisfaction. Gould and Hyer (Chapter 10) apply an organizational model that specifies steps in the application and process of bottom-up training. They discuss in detail the

guiding conception of the individual and organizational competencies of behavior management.

In a similar way, Stevens and Hochhalter (Chapter 11) articulate a general model of staff development called Informed Teams. This model considers the unmet needs of residents and staff. The authors conclude by discussing a project to increase staff member use of care skills that are known to reduce need-driven behaviors, as well as to increase communication about the most effective care strategies for individual residents across shifts and levels of the nursing staff, and to continue this process.

Interventions: In the last section, we have two chapters on care; two methods that, we believe, can make a difference in LTC. First, Snow and colleagues (Chapter 12) discuss the most applied psychotherapy technique in LTC, cognitive-behavioral therapy (CBT). They make a case for its use with persons with dementia for a variety of theory-based and evidence-based reasons. CBT is after all based on the principles of learning and their accommodation to cognitive disability. CBT allows the therapist to flexibly address the range of presenting problems common in dementia, from those that are more common in persons with mild dementia to those that tend to only affect persons with severe dementia.

In the last chapter (Chapter 13), Camp focuses on Montessori-Based Dementia Programming™, a method applied with severely dementing residents. Camp discusses the mechanisms responsible for effects produced by the intervention; in effect, the characteristics of successful activities programming for dementia. The authors discuss the inevitable disconnection between an individual's environment as making demands and the capacity of the person to accommodate these. When environmental press and competence are not in balance, negative affect and maladaptive behavior result. They argue for the Montessori-Based Dementia Programming™ in LTC environments. This program has been implemented at several nursing facilities with success. Interestingly, at the end Camp discusses seven rules for dissemination of innovations within the context of health care delivery systems.

CONCLUSIONS

Increasingly, we can see that the face of LTC is both complex and changing. Nursing homes are now typically filled with residents who are either very impaired or in for a short stay (subacute stays). As such, the health care professional is targeting people who have very different problems. Making glib statements about “residents” is very risky. In fact, it can

easily be argued that residents in assisted living facilities also could be considered as targets for the chapters in this book. We are aware then that some chapters will apply to various settings in more or less apt ways, depending on the facility.

We seek to make things better. Psychological well-being is often the goal and it is elusive. This is so because it is hard to define. There is also much heterogeneity at late life, even in LTC. Well-being clearly is a superordinate construct that involves the reaction of a resident to his/her situation. It exists on a continuum. Internal variables that detract from positive well-being include a reduced ability to alter goals, little self-acceptance for who one is and what one has done, inadequate self-protective psychological processes (unable to see perspective or to make favorable comparisons), poor assimilation/accommodation, a lack of emotional regulation, and little capacity for wisdom (Blazer, 2005). Add to this, economic distress, physical diseases, functional impairment, and little social support can make life problematic indeed.

As we shall see, mental health problems are pervasive. They are also added to a sea of physical dilemmas. In fact, if truth is told, mental health is the new kid on the block. Cardiology, for example, has clear mechanisms of pathophysiology and has evolved interventions to address these; psychiatry has the DSM, a symptom-based mechanism for care that is both inappropriate and primitive, especially for LTC needs. A resident who has mild dementia and depression, for example, is one who is both mentally and physically ill. The brain of this resident is different from another resident who has dementia but no depression. Additionally, this depressed resident may have little insight into the state and, for reasons of neurological insult or personological fixity or both, may have “depression without sadness” or depression executive dysfunction (DED) syndrome. This resident may or may not have social support, may or may not like the facility, may or may not be able to negotiate their environment with friendly helpful staff, may or may not. . . . Our mission here is to know as much as we can about such states, appreciate the complexity, and pursue change. To date, we are using a technology that is not sophisticated or in many cases not even helpful.

Swimming against the tide, this book then challenges the reader with the idea of the treatment-refractory resident. All are. We really have “treatment-refractory treatments” and ideas for care. This is truly a challenge. Change almost certainly will not involve cure, but will address the removal of those elements in the care process that interfere with survival-oriented interventions. The reading of *Clinical Applied Gerontological Interventions in Long-Term Care* hopefully will prove worthwhile in better understanding of this condition.

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PART I

Overview

Perspective on Long-Term Care

Necessary and Unnecessary Practices

Lee A. Hyer and Robert C. Intrieri

The over-65 population of the United States is projected to reach 70 million in 2030. At that time, one in five Americans will be 65 years or older (Older Americans 2004, 2004). Although data indicate rates of chronic disease have not declined, improvements in health care allow for less disability and better quality of life (QOL). The gap between the total life span and healthy life span has narrowed considerably, with the result that people are living longer and enjoying it more.

Despite these facts, the course of aging still tends to be characterized by decline. Heart disease, stroke, and cancer account for 60% of deaths among those 65 and older. Further, over 40% of older people can expect to spend some time in an LTC facility (Hyer & Ragan, 2002). Currently, about 2 million adults are admitted to 17,000 United States nursing homes annually (Rhoades & Krauss, 1999). In a recently published study, Porock et al. (2005) found that 24% of all US deaths occur in nursing homes.

Given the increasing presence of nursing homes in our society, greater attention is being focused on the needs and problems of older people in LTC facilities. Older LTC residents have varied and intense problems and have traditionally received support that under-represented or over-represented those problems. Increasingly, the focus of researchers

as well as practitioners is how best to assist older adults so that they may thrive in LTC settings.

There is a stereotypical link between age, aging, disease, and decline. The presence of this stereotype is probably strongest for the LTC environment. But, how accurate is this association? In other words, is aging within an LTC setting truly one of universal decline? At the individual level, aging can be conceptualized as a series of “adjustments.” For the most part, age-related diseases are accompanied by meaningful accommodation or the emergence of dysfunction. When stress and loss naturally unfold, a “learned dependence” results where the older person downwardly adjusts and settles for lower life satisfaction. Late in life, psychological and physical resources are increasingly devoted to the regulation and management of decline or loss. How the aging person makes decisions regarding the allocation of increasingly limited psychic and physical resources, as well as how developmental processes assist in this decision-making process, will be a central focus of aging research across the 21st century.

The focal point of this book is the application of clinical interventions in LTC. The “progenitor” of this work is Lawton’s Environmental Press Model (Lawton, 1982; Lawton & Nahemow, 1973). From Lawton’s perspective, as an individual’s environment places demands that cannot be met (environmental press), the individual’s (personal capacity) level of competence falters, and problems result. In effect, Lawton believes the well-being of older adults depends on their ability to adapt and modify the social and environmental context to re-establish some degree of equilibrium between their personal competence and environmental demands (Lawton, 1996).

A more recent addition to the field is Baltes’ conceptualization of selection, optimization, and compensation (SOC; Baltes & Baltes, 1990). Baltes and colleagues have modified the traditional conceptualization of successful aging, particularly within the nursing home environment. The authors argue that any model which attempts to explain successful aging in LTC must view success as adaptive functioning irrespective of the environmental context (Baltes, Wahl, & Reichert, 1991). The challenge for the LTC resident is to minimize the impact of age-related losses by maximizing potential environmental gains. In an LTC setting, the resident seeks a best-fit interaction between self and environment, one that maximizes strengths while limiting weaknesses. Both Lawton and Baltes believe an adaptive balance between security and autonomy achieves this. In general, the goal of this book is to examine how each resident achieves this balance, as well as identification of the mediators and outcomes of this process. More specifically, this book seeks to encourage practitioners to rethink their beliefs regarding what constitutes successful aging and QOL within the LTC setting so that they may intervene in a more appropriate manner.

QUALITY OF LIFE IN LONG-TERM CARE

Actions in an LTC facility are never solo events that affect one person. They are dynamic and context-specific properties that speak to the concern and philosophy of individual development. In addition to the LTC setting itself, resident characteristics also influence QOL in the LTC environment.

Setting

Over the past few decades, a number of trends have characterized the long-term care environment. First, increased life expectancy has led to an increase in demand for nursing home care. Second, rising health care costs have led to staggering increases in the cost of nursing home care. Third, and perhaps most importantly, regulatory bodies have assumed increasing control over resident QOL. Measures to assess QOL in LTC are now abundant. The Centers for Medicare and Medicaid Services (CMS) contract provides constructs and measures for the evaluation of QOL (Kane, 2001) via quality assurance and regulatory processes as well as internal quality improvement efforts. Indicators of QOL can be found within facility-level structural and process factors that relate to the outcomes of interest, or through the aggregation of resident data, as is done with the minimum data set (MDS). The idea is that nursing homes have some degree of responsibility for QOL and do have the capacity to influence residents' lives for better or worse.

The criticism of attempting to improve QOL through increased regulation stems from the reality that outcomes such as meaningful activity, relationships, etc., are often strongly influenced by social factors outside the control of the home. Further, QOL is also influenced by the nursing home case mix, particularly the physical and mental health, functional and cognitive abilities, as well as sensory abilities, of residents. Although nursing homes can influence factors like pain, functional status, and social interaction, as well as general medical care, they may have difficulty influencing other factors, such as who will be admitted and when.

In the past 15 years, entire industries, as well as federal and state regulatory commissions, have emerged to monitor the application of what is perceived to be quality care (Colenda et al., 1999). To many, this is anything but caring or efficient. Under the direction of CMS, state mandates typically emphasize necessary basic care and prevention of poor care. The result has been the codification of a subtle but powerful stance that is regulation-based, with nursing homes increasingly conforming, antiseptic, and risk averse. "Quality management" often refers to the minimal requirements of state and federal agencies. More cynically,

it can be argued the canons of care are profit or maintenance. Most often, the goal of care is to manage residents and appease staff. Penrod, Kane, and Kane (2000) caution that the state can be unforgiving, creating a risk-averse environment in which the desire for perfection is driving out the good, especially when innovations do not correspond to surveyors' criteria. In other words, interventions may be "resident limiting" and "system comforting." Erving Goffman's (1959, 1961) concept of the "total institution" seems to apply. Goffman defines the total institution as one that becomes "a place of residence and work in which a large number of individuals, who are cut off from the wider society for a relatively long time together, lead an enclosed, formally administered round of life."

Research clearly indicates that "usual care" in the nursing home does not seriously address mental health problems (e.g., Binstock & Spector, 1997; Borson, Reichman, Coyne, Rovner, & Sakauye, 2000). Even the thrust of care, once given, is askew. For example, psychological assessment evaluates weaknesses while providing little information regarding an individual's potential for optimal functioning (Camp, Koss, & Judge, 1999). More precisely, the typical psychiatric evaluation seeks to type dementia and evaluate the potential of psychopharmacologic intervention to address problem behaviors. This does not necessarily translate into good care.

Additionally, in a situation that is less than ideal, in LTC the nursing assistant (NA) or licensed practical nurse (LPN) typically provides day-to-day care. LPNs and NAs hold the majority (88%) of full-time positions in hospitals and well over half of all positions in geriatric long-term care (Brannon et al., 1988; Kasteler, Ford, White, & Carruth, 1979). NAs outnumber LPNs 4 to 1 and LPNs outnumber registered nurses (RNs) 3 to 2 (Kasteler et al., 1979). Additionally, turnover among NAs is high, costly to the institution, and has considerable effect on quality of care (Brannon et al., 1988; Kasteler et al., 1979; Waxman, Carner, & Berkenstock, 1984). Turnover rates have been found to be as high as 75% per year (Kasteler et al., 1979). As a group, NAs suffer from low morale, burnout, and stress (Baillon, Scothern, Neville, & Boyle, 1996; Karuza & Feather, 1989). A majority is disenchanting with the understaffing and overwork, along with organizational problems such as poor supervision and communication (Kasteler et al., 1979). In other words, although NAs are heavily involved in difficult patient care, they often feel isolated, ignored, and neglected. Training in this context is often pro forma and perfunctory. In fact, Cohen-Mansfield (2004) labeled most training in LTCs as "placebo," suggesting it is minimally effective and is only offered to satisfy state requirements.

Finally, nursing home administrators are rarely involved in resident care in active and compassionate ways. As system monitors, they look

to the bottom line first. In an attempt to change this administrative tendency, motivational systems have targeted the skills of supervisory staff. Performance-based training (Snyder-Halpern & Buczkowski, 1990), competency-based training (del Bueno, Barker, & Christmyer, 1981), mastery learning (Pinkney-Atkinson, 1980), and total quality management (TQM) (Deming, 1986) are popular examples. For example, TQM emphasizes the inter-relatedness of individuals and systems that make up the care setting, as well as customer satisfaction. TQM emphasizes five caring factors: a written statement of philosophy, a structured problem-solving approach including measurement, use of employee teams for the analysis and improvement of processes, assessment of resident satisfaction, and empowerment of employees to identify and respond to quality improvement opportunities. Unfortunately, the system hierarchy within LTC (DONs, RNs, LPN, and NAs) often contradicts these objectives, with all going about their business as if there were no TQM (Burgio & Burgio, 1986; Burgio & Stevens, 1999).

Resident Characteristics

Clearly, characteristics of the LTC setting (e.g., staffing) influence resident well-being and development. As noted previously, characteristics of the resident exercise an independent influence on well-being and QOL within the nursing home. The phenomenology of the LTC facility has changed. In general, LTC residents are both sicker and declining more rapidly than in previous decades. Residents spend less time in the facility, are more ethnically diverse, more likely to be widowed, more likely to suffer from dementia, require more assistance with ADLs, and generally have more choices for care prior to entering the facility. Many have a chronic illness (about 10%), and will iterate through an LTC facility two or more times. The typical resident is more likely to be female (women outnumber men 3:1), more than 50% are cognitively impaired with an additional 19% experiencing a mood or anxiety disorder. The prevalence of mood and anxiety disorders remained relatively stable across approximately 10 years (17% in 1985; 19% in 1997). About 30% of all residents have visual problems despite the use of glasses while a little less than 10% are blind. About 25% of all residents have some difficulty hearing while approximately 5% are completely deaf. The mean number of ADL impairments rose from 3.8 (1985) to 4.4 (1997), although the typical resident's ability to use the phone and secure personal effects (IADLs) remained stable from 1985 to 1997. In sum, older adults' desire to remain in their community for as long as possible has led to a nursing home population that is more disabled than in previous decades (Sahyoun, Pratt, Lentzner, Dey, & Robinson, 2001).

Not surprisingly, resident physical and/or mental impairment has a significant effect on their ability to adjust successfully to life in the facility. Cognitive impairment sufficient to influence physical function affects more than 50% of LTC residents (McConnell, Pieper, Sloane, & Branch, 2002). In a longitudinal analysis, McConnell et al. examined the linear effects of cognitive impairment on admission and the trajectory of dependence in activities of daily living, adjusting for demographic status. Results showed that on average ADL dependence worsened 0.84 points per year. Among long-stay residents, cognitive status had a clinically significant effect on ADL dependence. Using depression as a marker, Hybels, Blazer, and Pieper (2001) applied the Center for Epidemiological Studies–Depression scale (CES-D) and found that subthreshold depression exists at high levels in LTC, especially among women and unmarried residents, and influences physical health, use of psychotropic medications, disability days, and social support.

In a prospective study examining nursing home admissions, Rovner, Steele, Shmueli, and Folstein (1996) noted that after 1 year 50% of residents did not participate in facility activities. In general, this appears to reflect the low social cognitive functioning of LTC residents. Specifically focusing on social cognitive ability, Washburn, Sands, and Walton (2003) assessed 40 residents with and without cognitive decline on 11 social cognition tasks across two occasions. The measure used in this study is unique in that it assesses a collection of cognitive abilities that enable people to make sense of their social world and interact with others. Not only did the measure predict social functioning in the LTC facility, but also residents who scored lower on this measure tended to have more problems. It may be that only with an understanding of the social cognitive abilities associated with cognitive functioning (e.g., affect recognition, social reasoning) a full understanding of social interaction in LTC can be achieved.

Examining the link between illness and social functioning, Binder et al. (2003) used a prospective design to follow residents treated for an acute illness. Of 781 residents, those who survived 30 days of nursing home-acquired lower respiratory tract infection developed new functional declines and were at risk for further decline across 90 days. Doraiswamy, Leon, Cummings, Marin, and Newmann (2002) examined the prevalence of comorbid medical illness in Alzheimer's disease at different severity levels among 679 outpatients. Across patients, 61% had three or more comorbid medical diseases. Medical comorbidity tended to increase with dementia severity and poorer cognitive status.

Problems both physical and mental appear to influence cognitive decline. One interesting study suggests the care equation of the logical lets-get-everyone-active stance may not be generally successful or

appropriate. Carstensen, Fisher, and Malloy (1995) assessed social withdrawal and cognitive impairment in nursing homes. Given their belief that social withdrawal in residents reflects cognitive deficits that interfere with the ability to interact with others, they were surprised that social withdrawal was not contingent on intact cognitive functioning. In other words, cognitive deficits do not preclude social activity.

Other studies also indicate resident adjustment in LTC is complex. Residents tend to adjust in ways that reflect their setting, cognitive status, and personality (see Goodwin & Intrieri, 2005). What seems clear is that most residents can make input into their care and do so with some rationality. Feinberg and Whitlatch (2001) found that persons with MMSE scores between 13 and 26 are capable of consistently responding to questions about preferences, choices, and their own involvement in decisions about daily functioning, and can provide accurate demographic information. While it is true that as cognition declines (based upon MMSE scores) choices become more truncated, decisional capacity remains viable until late in the disease process.

The prevalence of disruptive behaviors in LTC is variable and high. Reports of pacing and wandering range from 3 to 59%, rates of noisy and disruptive behavior range from 10 to 30%, while the prevalence of aggressive behavior ranges from 8 to 91% (see Cohen-Mansfield, 2000). Rovner and Katz (1993) indicate that approximately 80–94% of residents have some dementia. Of these, about 40% have psychiatric symptoms that cause behavioral disturbances. Depressive symptoms among residents may be as high as 50% and are strongly associated with increased staff time and resident mortality. Finally, as many as 50% of residents spend more than 50% of their day in bed, especially in homes with low staff ratios (Levy-Storms, Schnelle, & Simmons, 2002).

MODELS OF CARE

Less a theory than a perspective, life-span psychology serves as a framework for a number of promising theses regarding the process of aging. For example, the maturity/specific challenge model of aging (Knight & Satre, 1999) highlights individual differences in the aging process. From this perspective, aging is viewed as a more mature time that brings sociocultural and personal circumstances that require considerable effort and resources to manage. Generally, it is argued that whatever the nature of cognitive deficits, especially regarding memory and fluid intelligence, the performance of older people is sufficient for most tasks including those related to therapy and normal adjustment (Knight & Satre, 1999). Further, older adults appear to utilize emotions in more

integrated and complex ways (Carstensen & Turk-Charles, 1994) and can demonstrate intelligence that appears more wise and deliberative (Tornstam, 2000).

Within the context of LTC, theories of aging tend to morph into theories of competence—ecological (Lawton & Nahemow, 1973) and person–environment (Kahana & Kahana, 1982)—underscoring the significance of the match between the person and the environment. In other words, optimal functioning occurs when environmental demands are manageable. From this perspective, models of care within LTC emphasize the practical understanding of how problems emerge and how they can be addressed. In addition, models attempt to identify those factors influencing effective person/environment fit—sound, videos, light, touch, social interaction, to name the more assessed ones.

Medical Model

The most frequently used model in LTC is the medical model, which argues there is a pathogen that can be corrected or alleviated through medical intervention. Becker and Kaufman (1988) suggest the medical model is appealing for LTC because aging is primarily characterized as a physiological event. As such, “medical care” is seen as the appropriate response and is acted upon vigorously and doled out by “nurses” while custodial care is provided by NAs. Given the nature of LTC residents, this is certainly an appropriate response as almost all have multiple medical diagnoses (average number = 4) and are on multiple medications (average number = 6). From the perspective of the medical model, behavior problems are seen to reflect a chemical imbalance and are treated in a prescriptive manner. Highlighting this point, the percentage of residents on psychotropic medication has risen measurably in the last 5 years.

A medical response to psychiatric problems is increasingly the norm in LTC. Use of cholinesterase inhibitors (ChEIs) and selective serotonin reuptake inhibitors is clearly on the rise in LTC (Smyer, Shea, & Streit, 1994). A summary of these medications is given in the accompanying box (Hyer, Carpenter, Bishmann, & Wu, 2005).

- Safe to use, reduce, or stabilize the decline in cognition for 1 year, especially for mild/moderate dementia
- In few studies, ChEIs lead to improvement or delay deterioration in ADLs
- Moderately effective for total problems on behaviors
- Mild effects sustained in severely impaired patients
- Administer early, rather than late

- Equal efficacy but differ somewhat on type of outcome and range and type of dementia
- Efficacy among agents is largely equal as between comparisons cannot be reasonably made as methodology of studies differ.

Caution should be exercised before drawing firm conclusions based on this data. There are large differences in study parameters when placebo groups have been compared with ChEI groups. For example, the percentage of dropouts and adverse reactions is highly variable for both experimental and placebo groups. Often the placebo group exceeds the experimental group with greater than 4 points on standard measures (e.g., ADAS-Cog). It is noteworthy that the level of improvement on standard cognitive, adjustment, and behavioral measures is not translatable to day-to-day gains. An arguable “substantial improvement,” a 7-point gain on the ADAS-Cog, occurs in about 20% of donepezil hydrochloride (e.g., Aricept) subjects, and only 3% of subjects when using the CIBIC (the clinical trials gold standard for adjustment over baseline). This occurs only at higher doses for one of the ChEIs (Reminyl [Galantamine]; Reisberg et al., 2003). In sum, findings on the reported data (of ChEIs) are “only suggestive” (Anand, Hartman, Sohn, Danyluk, & Graham, 2003).

Additionally, ChEIs do not appear to be effective for psychiatric symptoms of dementia. In a review of pharmacological treatment of neuropsychiatric symptoms of dementia, Sink, Holden, and Yaffe (2005) conclude that extant medications are not particularly effective for the management of neuropsychiatric symptoms of dementia. Two meta-analyses (Olin & Schneider, 2002; Trinh, Hoblyn, Mohanty, & Yaffe, 2003) and six additional RCTs (Courtney et al., 2004; Erkinjuntti et al., 2002; Holmes et al., 2004; McKeith et al., 2000; Tariot et al., 2001) of various ChEIs for the treatment of neuropsychiatric symptoms have been published. Five of the eight studies report statistically significant benefits for neuropsychiatric symptoms. However, the magnitude of the effect is small and of questionable significance (Sink et al., 2005). These findings also apply to memantine (Reisberg et al., 2003; Tariot et al., 2004), where results indicate nonclinically significant changes.

Problems related to medication are not unique to the cognitive enhancers. Prevalence rates for depression in the nursing home are high, especially in relation to affective symptoms, dysphoria, and mixed depression and anxiety. In outpatients, the SSRIs and SNRIs that address depression and anxiety generally have a 50–60% rate of remission on acute trials with placebo rates at 25–35% (Blazer, 2003). Currently, no RCT studies on depression in LTC residents exist. It should be emphasized that the nature of depression is different in LTC populations characterized by medical comorbidity, multiple medications, failure to thrive, and

an inability to act or assert control. In fact, the use of the DSM in LTC as it applies to depression requires rethinking (Hyer, et al., 2005).

There are also issues concerning the use of major tranquilizers. According to the psychiatric model (Tariot, 1999), disturbed behaviors are modal and require a careful diagnosis prior to intervention, most frequently medication to calm the resident and alter brain pathology. Grossberg and Desai (2003) review the use of medicaments with dementia, suggesting they be considered for all psychiatric and cognitive problems. In a meta-analysis of 33 controlled studies of patients with dementia, Olin et al. (1996) identified a response rate of 59% for drug treatment and 41% for placebo. In another meta-analysis of 16 controlled studies, Lanctot, Bowles, Herrmann, Best, and Naranjo (2000) found these rates to be 64 and 38%, respectively. Discussing a consensus panel on treatment guidelines for dementia, Rabins (2000) states meta-analyses indicate neuroleptic medications are better than placebo by 19%. Sunderland (2000) notes that although neuroleptics are more beneficial than placebo, only 20% of patients derived significant benefit.

As noted in Rabins' (2000) summary of the consensus panel on treatment guidelines, current efficacy literature suggests psychotropic medications show only a weak effect. However, this group could not determine whether agents were effective for the treatment of hallucinations or delusions. Nonpharmacological agents, on the other hand, were considered nonefficacious. That said, the panel noted that combining data on a variety of treatments of noncognitive, behavioral, and psychiatric symptoms is important. Therefore, treatments like music therapy, pet therapy, and activity therapy may be modestly effective in specific contexts.

All agree that nonpharmacological interventions are the first line of defense—if only they worked. Mintzer et al. (1997) note that after a thorough review of the medicaments that subserve dementia, nonpharmacologic interventions constitute the basis for care of this disease. The issue is how to have a care plan that is clear, accepted, monitored, and consistently applied. Perhaps psychopharmacology has not fully appreciated the fact that their science is one of complexity, with variance found mostly in the individual and not in the compound. The real world of psychotropic drugs works against a pure deterministic science since not all brains are equal and brains of frail residents are already compromised. Nowhere is this more evident than in LTC.

Psychosocial Models

Perhaps the most appropriate model for the LTC setting is the biopsychosocial model, particularly person–environment interaction models. Kahana and Kahana (1982) warned that we must attend to individual differences

or we may unintentionally increase the disparity between person and environment, causing further distress. Carp and Carp (1984) also emphasized that we must acknowledge the role the person plays in the dynamic interplay between individual and context so as not to encourage debility.

As noted above, the seminal understanding of the LTC resident comes from Powell Lawton. Lawton (1999) argued that assessment of residential settings of older adults must fulfill three standard functions: maintaining competence, providing stimulation, as well as offering a sense of security and support. Further, he suggested the goal of LTC should be to keep residents independent and autonomous in a comfortable environment. Therapeutic models should be designed that stabilize and build on the competencies of residents but are challenging enough that the potential for prolonged functioning exists. Parmelee and Lawton (1990) characterized this pivotal issue in terms of a need for balance in LTC, represented by the autonomy-security dialectic. Although both are essential for well-being, it is easier to stress security over autonomy in nursing homes.

More recently, several more general models have been developed to explain the cause of challenging behaviors in LTC settings (Cohen-Mansfield, 2001). The “unmet needs” model proposes that challenging behaviors occur when there is a deficit in the environment. This deficit may lead the resident to become bored, lonely, or deprived of sensory stimulation. As a result, the individual may behave in a challenging way in an attempt to fulfill unmet needs. Cohen-Mansfield (2001) further classified challenging behaviors into four broad categories: physically aggressive behaviors, physically nonaggressive behaviors, verbally aggressive behaviors, and verbally nonaggressive behaviors. Specific to dementia, behavioral symptoms stem from an unmet need or goal of the individual (Algase et al., 1996). Unmet needs have also been linked to several mental health correlates, not limited to depression and aggression. Finally, Talerico, Evans, and Strumpf (2002) suggest aggressive behavior among nursing home residents may be a symptom of inadequately treated depression. In fact, depression in Alzheimer’s disease is often undertreated because its detection is difficult in this population.

A second psychosocial model reflects a behavioral or learning perspective in which reinforcement contingencies are seen as the best explanation for behavior (Teri & Gallagher-Thompson, 1991). Teri and colleagues have given us perhaps the one technique that has been evaluated and matches mainstream psychological skills; applied behavioral analysis. This method has merit when it is applied in a validating environment with a motivated staff (Teri et al., 2000). A variant involves the STAR method (Teri et al., 2003), an A-B-C (e.g., antecedent, behavior, & consequence) analysis of a situation and identification of conditions that merit change. As behavior is influenced by a specific antecedent and

maintained by a specific consequence, trained staff can apply behavioral principles.

Another model that emphasizes environmental vulnerability/reduced stress threshold as the cause of challenging behaviors is Hall and Buckwalter's (1987) Progressively Lowered Stress Threshold (PLST) model in which people with dementia (as noted previously, rates of dementia among LTC residents is extremely high) become progressively more stressed during the day and more likely to engage in dysfunctional behavior in the evening. According to this model, individuals with cognitive impairment suffer from progressively lower stress thresholds (e.g., a continually decreasing ability to cope with stress). As environmental stress begins to exceed this threshold, individuals become agitated and exhibit challenging behaviors. A reduction in environmental stimulation (e.g., low lighting, quiet, predictable events) is recommended in conjunction with relaxation exercises.

Several authors have advocated for a holistic model. Kitwood (Kitwood, 1995; Kitwood & Benson, 1995) calls for a new culture of dementia care, replacing the medical model with a rehabilitation focus. He proposed a model ($D = P + B + H + NI + SP$) where D is dementia, P is personality, B is biography and personal history, H is physical health, NI is neurological impairment, and SP is social psychology. He notes, "In a general way the symptomatic presentation of dementia in any individual arises from a complex interaction between all five factors, while the progression of the illness depends primarily on the interplay between NI and SP, and this interplay . . . may properly be characterized as dialectical" (p. 274). This model accounts for a good deal of variance in dementia, complexity of dementia, some with rapid declines, some with slow trajectories, and some with unusual phenotypes of the disorder.

Volicer (Volicer & Hurley, 2003) also argues for an encompassing (holistic) model of dementia in which deviant responses of residents with dementia require assessment and qualification. Primary problems involve functional impairment, delusions, and mood disorders, which in turn lead to secondary problems (inability to initiate activity, ADL dependence, spatial disorientation, and anxiety). Peripheral symptoms, like agitation, vocalization, apathy, food refusal, and repetitive behaviors, develop as a consequence. Interventions should emphasize primary problems first, as these will alleviate secondary and peripheral problems. For example, agitation, a modal response of residents with dementia, should be limited to behaviors that occur outside of caregiving activity and that are not accounted for by other problems. Agitation then is an unpleasant state of excitement unrelated to known physical needs of the person. In contrast, opposition to care occurs when an individual with dementia obstructs caregiving efforts in active care. In effect, they oppose care as provided.

Several writers emphasize the use of continuing abilities. For example, Sifton (2000) suggests that interventions need to focus on how the caregiver can best assist the person with dementia by supporting and reinforcing habitual skills (like humor, emotional memory/emotional awareness, sociability, sensory appreciation, motor function, music responsiveness, and long-term memory). Camp and Stevens (1990) also advocate for the application of these areas, as in errorless learning and spaced retrieval. Others have proposed the introduction of environmental cues to assist in maintaining competence such as memory books (Bourgeois, 1991).

Interventions that emphasize specific and validating responses by the caregiver for the declining resident are plentiful. For example, Feil (1999) posited a method of treatment that maximizes validation. Persons with dementia are attempting to resolve earlier developmental issues in order to die in peace. Zgola (1999) notes the care provider–care recipient relationship is the centerpiece of the caregiving process. From this perspective, a positive environment cannot be cultured without an adequate relationship between the care provider and care recipient. Zgola believes that providing good-quality care to the care recipient is not only positive for the care recipient but also fulfilling for the care provider.

Finally, some consider rehabilitation an option for LTC residents (e.g., Camp, 2000). West, Welch, and Yassuda (2000) summarized the results of several studies on cognitive rehabilitation with older people. Generally, older adults can learn memory strategies (even complex techniques) and this training can lead to lasting memory improvements, although it tends to be task-specific with little or no transfer. In a much-cited meta-analysis of this area, Verhaeghen, Marcoen, and Goossens (1992) endorse training and its effects. This group noted that four factors enhance training: pretraining, group sessions, shorter sessions, and younger participants. They also note modest effect sizes due to training. Hyer and Rebok (2005) argue for a “mild” rehabilitation approach involving the care recipient–care provider dyad. Memory retraining is applied in a problem-solving paradigm where supports are introduced over time. Use of effective communication, validation of emotions, functional assistance, maintenance of social skills, acting to decrease confusion, and a constant effort to understand the person are also beneficial.

INTEGRATING MEDICAL AND PSYCHOSOCIAL CLINICAL INTERVENTIONS

Practicing within an LTC setting does not diminish our obligations as professionals. In relation to any particular resident, the clinical task is to establish and articulate a clear problem list or diagnosis, educate the

resident and caregiver regarding prognosis and disease stage, discuss the resident's present state and treatment options, assemble a comprehensive treatment plan (medical, social, financial, legal), establish caregiver support, and confirm the presence of ongoing support across the course of illness. In clinical staff meetings, discussion usually centers on the medical problem, medication effects, presence or absence of cognitive impairment, presence or absence of mental syndrome as well as history and causes, and environment or change in environment.

The idea that any mental health professional can attend to, and oversee, all of the above clinical tasks may strike some as quixotic. Undoubtedly, the multidimensional nature of clinical practice within the LTC setting appears to increase the difficulty of effectively prescribing and monitoring the use of medications. Since OBRA, the established rule of thumb in LTC is that the first intervention should be nonpharmacological. Should psychotropic medications be necessary, they must be justified, monitored regularly, and tapered if possible. Unfortunately, very few health care practitioners really practice this "ideal" care strategy. The reality might be better described as "medicament thinking," in which staff input is biased in the direction of medication. Once a target behavior has been identified, medication is prescribed, and a medication watch ensues. Side effects are considered eventful as the medication is "working." If problems arise, the belief is that the wrong drug was chosen, the dosage was too high or too low, or the trial duration was inadequate. In other words, all attributions of change or lack of change is viewed as a product of the medication. This bias has the unfortunate consequence of shutting down or at least altering dialog about psychosocial intervention.

A second area of concern regarding clinical practice within LTC is the applicability of DSM (a standard in community settings). The DSM is not effective for modal diagnosis and is truly fuzzy in an LTC setting. Volicer and Hurley (2003) note that in LTC, the psychiatric model attempts to overcome shortcomings of the DSM by using a psychobehavioral metaphor that reflects or approximates diagnosis. In effect, a psychological space of clustered behaviors that are considered clinically related is created, similar to a drug-responsive system (Nelson, 1998). According to this perspective, signs and symptoms are identified, classified, and then matched to medications that have the potential to reduce and weaken symptom intensity and frequency. Again, this method of reasoning regarding medication choice is based on poor scientific reasoning and often nondeliberative team discussions.

Mental health professionals are often uninformed about the LTC milieu and associated practice rubrics. When dealing with frail elders, mental health treatment is strikingly different than with younger, reasonably healthy adult patients. The standards of mental health practice

in LTC vary not only in the way care is provided and bills are generated, but also in the application of outcomes. One recommendation for improving clinical care within LTC is to provide practitioners with knowledge regarding psychobehavioral models as well as training on their content. The outcome should be a fuller discussion of treatment issues, as well as the use of psychosocial technologies for better care (Hyer & Ragan, 2002).

Strictly speaking, data regarding which interventions are most effective for which persons manifesting which behaviors do not exist. Despite the paucity of efficacy data, failure to provide mental health services is not an option as neuropsychiatric disturbances afflict almost all patients with dementia as well as many without. A “best practice” approach includes a perspective on what to expect and how to predict decline. Extrapolating from current outpatient mental health treatment efficacy data, it is our assumption that nursing home residents will benefit from a combined approach that includes both medication and psychosocial intervention. The key to management is meticulous assessment, conscientious case formulation, interdisciplinary team collaboration, and caring clinical experimentation with clinically informed technologies. At present, medical and nursing care can reasonably address limits in several areas of functioning, including pain, sensory problems, sleep problems, and limits on autonomy.

The following box outlines these concerns.

Practical Considerations for Meds

- Consider use of medication more to stabilize function than to improve cognition/mood.
- Consider meds as an adjunct to psychosocial treatments.
- Consider who is a robust responder, not the mean group effect (it is too modest).
- Do not “medicament think.”
- Treatment occurs throughout the entire course of illness and reassessment is ongoing.
- Efficacy relies heavily on team’s and caregiver’s “clinical global impression.”
- Danger: Advanced Management Medication treatment.

Practical Considerations of Psychosocial Therapy

- Integrate care and look for all causes and possible solutions.
- Assemble a team that addresses the person and not the symptom.
- Instruct team on value of meds and psychosocial input.

- Know psychosocial data, models, and behavioral techniques.
- Measure, measure, measure with psychological indices.
- Experiment with best combination of meds and psychosocial treatment.
- Work at multidisciplinary team.
- Consider limits of DSM.
- Know when not to treat.
- Appreciate end of life issues.

TRAINING AND QUALITY OF LIFE

Any discussion of the application of psychobehavioral models in LTC must include attention to the topics of training and QOL. In general, training programs emphasize simple assessment techniques, communication methods, and skills to intervene. Training is typically entrenched within clinical care. A number of scholars argue that training has become reified, taking on a life of its own. The United States Congress passed the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), legislation that discouraged nursing homes from using pharmacological interventions for the management of challenging behaviors. Prior to this legislation, the use of pharmacological interventions, as well as physical restraints, was common. In 1990, the U.S. Health Care Financing Administration (1990) responded to OBRA 87 by recommending staff training and behavior management as first line interventions for challenging behaviors in nursing homes. This recommendation resulted from a growing awareness that a resident's behavior could be influenced by environmental factors (Burgio et al., 2001, 2002).

As noted previously, resident QOL is receiving increased attention. In general, QOL depends on the goodness of fit between a person's unique needs and the facility's ability to meet those needs. In other words, QOL is interactive. Post (2000) argues that caregivers condition the QOL of a dementia victim. If true, enhancing resident QOL cannot be accomplished without attention to the caretaker. Lawton (1991) and Kane et al. (2004) have specified taxonomies, as well as measures, for the construct of QOL. Lawton (1999) outlined six caveats in the measurement of QOL.

1. Documentation indicators of quality: If QOL is limited to what is measurable, then we are impoverished.
2. Incorrect citations have a cost: Surveyors must be trained in new concepts if QOL is to be represented in a broader fashion.

3. The absence of an obvious ultimate validity criterion: Typically, we are rating “hard stuff”—death rates, morbidity rate, etc. Many of the criteria for QOL are process criteria.
4. By whose perspective is QOL to be judged? If the emphases are on the consumer (the resident), there will be problems, as only a few will rate the condition; if only the environment is evaluated, we also miss something.
5. Representing both positive and negative QOL: Most surveys are centered on identifying the negative—deficits, risks. The opposite is the essence of QOL.
6. Does QOL vary by user group? Residents in LTCs are highly variable.

Clearly, QOL is a difficult issue to apply, measure, and optimize. A large body of research suggests that resident QOL is improved by the ability to control, and make autonomous decisions regarding, their environment. However, many residents have basic needs that require a level of assistance that limits autonomy and environmental control. Some research suggests that nursing home staff have an unwitting tendency to provide more help than necessary, leading to even greater declines in autonomy and control (Agich, 1993; Dowd, 1975). Faulk (1988) evaluated QOL using the Life Satisfaction Index with 124 residents in 40 board and care homes. Results demonstrated that once lower level needs were met life satisfaction was enhanced with the meeting of higher level needs. More importantly, if only minimum life satisfaction needs were met, there were no gains in life quality. Improvements in QOL occurred when social integration needs were developed. In summary, it appears that autonomy and control are highly valued by residents and if attained are likely to produce correspondingly high levels of life quality. At the same time, Baldwin (1993) noted that although most LTCs have interventions for the fostering of autonomy, they also have policies that restrict the implementation of these interventions, such as limits on staff time.

Finally, Lawton (1991) and Kane et al. (2004) found that state and federal regulation of nursing homes was associated with better QOL in a number of areas, including social integration, safety, and presence of supportive features. Licensure alone was found to be effective in ensuring that nursing homes provided care at or above state required minimum threshold levels. However, nursing home regulation had no effect on other variables believed to influence resident life quality, like staff training, staff knowledge in any number of areas, availability of licensed nurses, and cleanliness and attractiveness of homes.

The “Holy Grail” of long-term care is to provide a positive residential environment for a declining older adult—in other words, provide

a setting that allows for positive QOL. Attempts to identify objective markers of quality care, as well as efforts to appreciate and understand what may be best for a person, are legion. Fortunately, there are increasing efforts to assess QOL beyond that mandated by formal state agencies. QOL as seen from the perspective of the resident (Logsdon, 2000) is being pursued more aggressively. Perhaps the models of intervention advocated in this book, especially SOC, can assist here.

THE POTENTIAL OF SOC FOR CLINICAL INTERVENTION IN LTC

The potential strength of SOC within an LTC setting is its ability to understand the interaction between the individuals and their environment by emphasizing the multiple ways that a context can shape behavior as well as outcomes. Specific to LTC, Baltes, Wahl, and Reichert (1991) argued that nursing homes function as an institutional proxy for SOC. SOC acknowledges that residents may not be physically equipped for extended old age in LTC, but that both the resident and the environment can make adjustments. Baltes and Freund (2003) suggest that a state of “permanent incompleteness” is inevitable as we seek personal change and growth. There are few fixed end states. Baltes and Freund (2003) indicate that the goal of human development is construction of competencies that allow the individual to navigate effectively a changing world. They argue the regulatory processes that are fundamental across the life span are SOC. These processes occur at various levels of analysis or integration ranging from the macrolevel (e.g., society) to the microlevel (e.g., cells). Utilization of these processes can assist in the facilitation of higher levels of functioning, even within LTC.

SOC (Baltes & Baltes, 1980, 1990) represents a holistic view of aging: Aging successfully is reflective of doing the best with what one has. The emphasis is on coping and a positive view of the inevitable consequences of aging (e.g., problems, disease, and loss). The use of SOC to respond adaptively to everyday demands and functional decline in later life is associated with better functioning. Undoubtedly, utilization of SOC requires the use of resources. The more resources an aging individual has, the better is their ability to engage in the use of SOC. Given frailty and ever-increasing morbidity and debility among LTC residents, the challenge is application.

SOC represents a belief in adaptive development. More specifically, SOC provides a framework for understanding processes of developmental regulation across the life span. In an LTC setting, *selection* in everyday life is defined as actively or passively reducing the number of

activities, goals, or domains in order to focus on those areas that are most important in one's life. This is a "loss-based selection." *Optimization* is defined as enhancement of the means to refine one's resources in a selected domain. It refers to adaptive processes or strategies where indirect aging losses have occurred and where an actual amelioration or maximization of means can be found. Investing more time and effort in specific tasks or activities that provide meaning as opposed to those that are less salient is most reflective of optimization. Finally, *compensation* involves the use of new and alternative means to reach a goal or to maintain a desired state once a loss has occurred. Compensation emerges when there has been a loss. People may intensify or expand routines once a functional loss has resulted. Again, this occurs best when there are resources available.

Within the LTC setting, selection largely consists of loss-based problems and includes focusing on the most important goals, reconstructing a goal hierarchy, adaptation of standards, in addition to a search for new goals. Optimization involves distinct means-action—attentional focus, seizing the right moment, persistence, acquiring new skills, practice of skills, time allocation, and successfully modeling others. Compensation is the means used to counter a loss—substitute means, use external aids, use therapeutic intervention, acquire new skills and resources, increase effort and energy, increase time allocation, and activate unused skills (Freund & Baltes, 1998). Given the constraints and demands of LTC, implementation of SOC requires creativity.

There is an emerging body of supportive data in relation to SOC. For example, Lang, Rieckmann, and Baltes (2002) found that resource-rich people (e.g., those individuals with positive sensorimotor-cognitive functioning as well as social-personality resources) demonstrated the use of SOC more frequently in their everyday lives and were more likely to survive after 4 years, as compared to resource-poor people. Specifically, resource-rich people were more active in everyday life. It is not surprising that older people with greater resources were more resistant to aging compared to adults with fewer resources. More specific to frail elders in LTC facilities, Brandtstädter and Greve (1994) proposed that older adults use a combination of active, assimilative strategies and passive, accommodative strategies. This dual process model asserts that advancing age results in a shift away from active adjustment of life situations to meet personal preferences (assimilation) and a parallel shift to the accommodation or adjustment of personal preferences to fit situational constraints, making fewer psychological demands on the person's resources. Older adults who replace lost activities with less physically or psychically demanding activities may be viewed as successfully accommodating. If activity levels become unfeasible, accommodative strategies should allow for a change in focus to alternatives.

Using a longitudinal design, Duke, Leventhal, Brownlee, and Leventhal (2002) followed 250 community-dwelling older adults to examine activity loss and replacement due to an important illness episode. In line with the SOC metamodel, reductions in activity were predicted by physical factors. Individual resources like social support and optimism increased the likelihood of taking action to replace lost activities. Conversely, a belief in the need to conserve physical resources reduced the likelihood of replacing activities. Accordingly, older adults who replaced a lost activity experienced higher levels of positive affect 1-year after illness onset in contrast to those who did not replace activities. Physical incapacity was less important for activity replacement than were social factors that influenced the motivation to seek alternatives, like optimism and conservation.

Generally, older people, including those in an LTC setting, manage their own aging process. This self-regulated dependency is an integral part of successful aging (Baltes & Wahl, 1992). SOC proposes that dependency and/or other forms of passive and nonengaged behavior may be considered adaptive within the context of the nursing home. The older person experiencing some form of loss has several choices: (a) give up the activities hampered by functional loss; (b) compensate for them by searching for a means to maintain activities; or (c) become increasingly dependent in the weakened domains to free energy for other more personal areas. In this last strategy, the person recognizes the loss and delegates control to others as a form of proxy control. In effect, only the initial option causes problems.

In other words, SOC makes the intriguing suggestion that lowered performance and behavioral dependency can be adaptive. When effectively coordinated, the three processes (SOC) promote successful aging, even in the presence of losses and reduction of resources. Selection requires age-related losses be identified and compensated for with a wide array of environmental aids which assume a high priority. This often involves a convergence of environmental demands, individual motivations, skills, and biological capacities. Optimization is characterized by the maintenance of high levels of functioning in selected domains through practice and acquisition of new bodies of knowledge and technology. Compensation becomes important when life tasks require a capacity beyond that of current skills. At the risk of repetition, in an LTC facility, even dependency can be self-selected and an outcome of active selection and compensation.

Baltes and Baltes (1990) add one more term here, wisdom. They define human strength as wisdom or knowledge about fundamental pragmatics of life and the implementation of that knowledge through the life management strategies of SOC. The concept of human adaptation is contextually dynamic, because the function of the expression of a person is a function of context (and outcomes). Age, gender, ethnicity,

social group, among many others, determine context. Baltes and Freund (2003) point out that the ensemble of multidisciplinary, contextual, and normative factors and perspectives that need consideration when delineating notions of adaptation are legion. This requires a theoretical orientation such as SOC. It is a wisdom-related knowledge that is acquired and translates into developmental-enhancing behavior directed at oneself as well as others. It is then the interplay between SOC and wisdom that determines adjustment.

ADJUSTMENT TO AGING IN LTC

Aging well, especially in LTC settings, requires a series of personal adjustment be made. Fortunately, as humans, we appear to be programmed for growth and change. Over 20 years ago, Block (Block & Block, 1980) noted that one personality dimension, ego-control or ego-resiliency, was moderately consistent across the life span. Research that is more recent indicates that personality, as a trait, is reasonably consistent (Costa & Widiger, 2002) even in the presence of individual differences (Vaillant, 1976). It now seems clear that even into old age, individuals continue to be open to new experiences. We change, but with consistency, and aging allows for unique challenges.

Aging is best characterized as a gradual and natural process, a period of life evaluation and increased freedom, but also a period associated with physical decline and concerns regarding health and loss (Keller, Leventhal, & Larson, 1989). Steverink, Westerhof, Bode, and Dittmann-Kohli (2001) found the aging experience is best represented by physical decline, social loss, and continued growth. Highlighting the importance of individual differences, subjective health, higher income, loneliness, and hope all influence these components. In a sense, aging is an empty variable, a multidimensional construct best accounted for by other factors, particularly those that influence the perception of change.

Philosophically, older people do best when they are self-organizing, proactive, self-reflecting and self-regulating, not just reactive to external events (Bandura, 1999). Usually interactionism involving the person, behavior, and environment is in effect. Perhaps the most parsimonious and realistic view about human actions is that the person is neither driven by traits nor automatically shaped by the environment: They are producers and consumers of their own behavior (Lerner, 1982; Lerner & Busch-Rossnagel, 1981). In addition, this change is not random: It is guided by a person(al)ity system that mediates the relationship between types of situations and the cognitive/affective/behavior patterns of the person (Shoda & Mischel, 2000). Thus, there are predictable,

characteristic patterns of “variation” in the person’s behavior across contexts and age. Organisms self-organize and do so naturally, consistently, and holistically.

The transition to old age is accompanied by increased awareness of what one cannot do in the context of what one can do. This transition influences the type of goals selected in late life. Since the central task of later life is facing decline, one’s possibilities adjust accordingly. The choice is probably most often a function of health, identity (personal characteristics), and attachment (social relationships and positive contacts). One example is the concept of possible selves (Markus & Herzog, 1991). Possible selves are defined as highly personal, hoped for and/or feared images that function to encourage the individual towards or away from action (Markus & Herzog, 1991). Using a group of older participants from the Berlin Aging Study (BASE), Smith and Freund (2002) examined the influence of specific hopes and fears regarding health maintenance on the view of possible selves. Their results indicate that possible selves are both stable and discontinuous into old age, suggesting “possible selves” are dynamic throughout the aging process. The importance of this is that as we age, our possible selves adjust to reflect a recreation of “past and anticipated future selves.”

In LTC, the operative variables for positive adjustment center on the person and the context. While we have discussed SOC variables, several related constructs also make this point. For example, a sense of control has repeatedly been identified as an important factor in successful aging and emotional well-being. In general, by adulthood, and particularly later adulthood, perception of control has stabilized (Seeman & Lewis, 1995). As a global personality trait, high internal locus of control has been found to be related to greater life satisfaction, more positive self-concept, better ratings of health status, and greater participation in activities among the elderly (Eizenman, Nesselroade, Featherman, & Rowe, 1997; Rodin, Timko, & Harris, 1985). The few studies that have attempted to enhance and examine perceived personal control in residential care settings have found greater levels of choice and internal control are associated with better resident well-being, less reliance on facility services, and greater participation in community activities (Langer & Rodin, 1976; Timko & Moos, 1989).

In the LTC setting, the critical issue concerns enhancing control or at least maintaining the illusion of control. This may involve the use of secondary control strategies, a higher dependence on the environment, as well as accommodation to problems. Schulz and Heckhausen (1996) have suggested successful aging is linked to the development and maintenance of primary control throughout the life course via control-related processes that optimize selection and compensation functions. Primary control is directed outward and targets the external world while

secondary control targets the self and attempts to achieve changes within the individual. Although both can involve cognition and action, primary control always involves action. With age, the ratio of gains to losses becomes less favorable and secondary control becomes more important. The person must manage trade-offs across domains and sequential life phases and recognize that resources are a key consideration, as they must be juggled to maintain balance.

However, the reality is that with age, primary control may decrease while secondary control may be more stable and malleable. Elderly individuals who continue to emphasize primary control may experience poorer adjustment to the aging process than those who shift paradigms and gradually increase their reliance on secondary control. When conceptualized in this way, poor adjustment (e.g., general distress, depression, anxiety) may reflect frustration associated with continued attempts to control aspects of one's life that are no longer within the person's control. Put another way, individuals may poorly adjust to changes associated with aging because they continue to place a high priority on controlling their environment, when their ability to control their environment has declined as a function of their life stage. Elderly individuals who accept the declining control that comes with age, and who focus on their ability to control internal states and behaviors, may demonstrate more successful adjustment to aging.

Altering of one's expectation of life in LTC can then be positive. This also applies to a realistically pessimistic perspective, found to be associated with better adaptation to negative life events among older adults, in contrast to typical findings with younger participants (Isaacowitz & Seligman, 2001). Schulz, Bookwala, Knapp, Scheier, and Williamson (1996) followed 238 cancer patients receiving palliative radiation treatment for 8 months. Controlling for site of cancer and level of symptomatology at baseline, the authors examined the independent effects on mortality of pessimism, optimism, and depression. Results indicated that endorsement of a pessimistic life orientation is a more important risk factor for mortality among middle-aged (ages 30–59) than it is among older individuals. For older individuals, endorsing pessimism may simply reflect a coping strategy that has become adaptive in the face of declining ability to control important life outcomes such as health.

CONCLUSIONS

As aging unfolds, the person must adjust to maintain a positive QOL. Evidence suggests this adjustment is not a singular event but continues over the lifetime. Evidence also suggests adjustment can be “for better or

worse.” The main path to aging adjustment or dysfunction is shaped by imbedded risk factors (behavioral, psychological, and biological factors) and mediated, we believe, by the regulatory processes of SOC. We believe the SOC metamodel is sufficiently cogent and specific to address problems of adjustment in LTC. These involve lifestyle and behavioral actions, as well as appropriate psychosocial attitudes and environmental changes. The burden is on the caregiving to optimize this.

As noted, age itself is best construed as an empty variable. It is not the passage of time alone but various biological and social events that occur with the passage of time that have relevance for change. Unfortunately, the negative consequence of the increased life span is an increased risk for LTC placement. Successful aging within the LTC context requires the individual continuously adjust choices in life via the regulatory mechanisms outlined by the SOC metamodel. Regardless of the model used, however, the many constructs noted above articulate the use of alternative resources and, we believe, a better state of being.

In many ways, this is what occurs in psychotherapy, the psychosocial methodology applied for change. In therapy, internal and external events influence and recreate conditions for positive or negative outcomes. Much of what goes on involves an attempt to shift people’s focus to view themselves in their daily lives in different ways. All psychotherapy is an assault on truth. In this way change is a function of having people respond differently to new situations or in response to new contingencies. Optimism-generating, support-assisting, and control-enhancing interventions make a difference in the context of the person. In effect, successful outcomes are represented by altering goals and adjusting to the “new person” they have become. This is what can occur in LTC.

In sum, decline does occur. It has something to do with the disease and something to do with the person with the disease. Finding the “right” intervention and structure is not logically obvious. It is clinical, interactive, and demands a feedback loop of many parties. A resident in bed 18 hr/day, for example, can be gotten up and made to sit in the dayroom. That may be 50% of the battle. The real difficulty comes in the applied behavioral activation in the dayroom. This involves thinking, thoughts about who the person is and what the psychological constructs that can be “SOC-ed.” It is here again that our models enter. We may never know the real outcome as defined by satisfaction of the person. Nevertheless, we must persist. The greatest challenge in LTC involves devising strategies for maximizing independent functioning. This should remain a priority for researchers, service care delivery professionals, and policymakers alike in the first decade of the new century (Ory, Yee, Tennstedt, & Schulz, 2000).

ACKNOWLEDGMENT

We thank Dr Paige E. Goodwin for her reading of the manuscript and instrumental editorial suggestions.

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