

Chapter 6

CARING FOR THE CLIENT WHO IS CONFUSED OR MENTALLY ILL

What You Will Learn

- Two general types of confusion
- Characteristics of clients who are confused
- Three causes of confusion
- Examples of the three types of responses to confusion
- The difference between delirium and dementia
- The four stages of Alzheimer's disease
- Correct methods of dealing with severe behaviors (catastrophic reaction) resulting from confusion
- Correct approaches for the client who is confused
- Other nervous system disorders
- Types of mental illness

Understanding Mental Confusion

Some of the clients you take care of are confused. It is important for In-Home Aides to understand confusion and how to care for these clients. The client who is confused may have problems with their memory of recent and past events. They may have forgotten how to perform well-learned skills such as dressing themselves. Loss of orientation to person, place, time, language problems, visual and motor problems are also common. Some clients may have trouble problem solving and use poor judgment.

Characteristics of Clients who are Confused

Clients who are confused have changes in their actions and behaviors. A common memory problem is the inability to remember recent events. A confused client may not remember that he just had breakfast. Personality changes including mood swings, suspiciousness, and delusions may be seen. Disorientation is another common symptom. The confused client may have difficulty remembering the day of the week, season, or even the time of day. They may not be able to find their way around their home or neighborhood and may not remember the names of people whom he has not seen for awhile. The confused client may stop socializing with others and neglect established friendships.

Language problems called aphasia are frequently seen in confused clients. The client with aphasia may have a hard time understanding what is said to them or following directions. They may also have problems with speaking and repeat words over and over.

Some clients have problems with judgment and may lose their social skills and make unsafe choices.

Many confused clients have problems with everyday activities. They may need help with dressing, bathing, and meals. Bowel and bladder incontinence may develop. Changes in sleep patterns are also common.

Sexually aggressive behaviors may be caused by nervous system disorders, medications, fever, and dementia. The client may confuse the In-Home Aide with his partner. Many clients are not able to control this behavior because of changes in mental function. Touch may be an attempt to get the In-Home Aide's attention and may be misconstrued as sexual. Consistent with in-home provider policy, the aide should protect herself from harm and leave the home if necessary.

Causes of Confusion

Confusion may be caused by physical, sensory/emotional, or environmental factors. Table 6.1 lists examples of factors that can cause confusion.

Table 6.1: Factors that can cause confusion

<i>Physical factors</i>	<i>Sensory/emotional factors</i>	<i>Environmental factors</i>
Diseases of the central nervous system	Lack of stimulation or over stimulation (sensory overload)	New surroundings
Lack of oxygen to the brain	Misinterpretation of sensory input	Isolation; decreased contact with other than confused people
Fluid, electrolyte, and nutrition difficulties, dehydration	Depression	Restraints
Undetected infections, temperature elevation, UTI, pneumonia	Hallucinations, delusions	Misinterpretation of the environment
Elimination difficulties, constipation		
Effects of drugs – past or present		
Alcoholism		
HIV		

Responses to Confusion

Some clients do not appear to be bothered by their confusion. They are pleasant and agreeable when care is being given. Other clients have a hard time dealing with their confusion. They may respond in a physical, behavioral, or functional manner. Table 6.2 lists examples of each of these types of responses.

Table 6.2: Examples of confused responses

<i>Emotional or physical responses</i>	<i>Behavioral responses</i>	<i>Functional responses</i>
Being suspicious	Having difficulty remembering how to do simple tasks or not finishing something started	Unable to dress himself
Being rude, angry or insulting	Forgetting what day it is; what time of life; who they or others are	Unable to feed himself
Being constantly restless or talkative	Losing, hiding, or misplacing things and looking all over for them	Unable to bathe, shower, or shave himself
Seeing things that are not there, hallucinating	Wandering or getting lost	Incontinent of bowel or bladder
Hearing voices from the past		
Reliving situations from the past		
Not responding to anything		

Delirium or Dementia

There are two general types of confusion, delirium and dementia. Delirium is an acute form of confusion that starts suddenly. The client has fluctuating levels of alertness. Delirium may be caused by illness or medications. This type of confusion usually goes away when the medication is stopped or the illness is treated.

Dementia has a slow onset and becomes progressively worse. Dementia is usually permanent. Dementia can be the result of a stroke, brain injury, Parkinson’s disease, multiple sclerosis, or AIDS. Alzheimer’s disease is the most common form of dementia. The client with dementia is usually alert. Depression in an older person can mimic dementia. The emphasis in dementia care should focus on the person, not on the disorder. The In-Home Aide must view someone with dementia as a person and not just a confused client.

Alzheimer's Disease

While dementia may be the result of other nervous system disorders, Alzheimer's disease is the most common form of dementia. Alzheimer's disease (AD) is one of the most common causes of chronic confusion in the elderly and is currently incurable. It is a progressive disease of brain cells in which the client loses mental and physical ability. In AD, the confusion and the loss of functional ability are caused by brain cell death (tangles) and interruption in communication of brain cells (amyloid plaques).

The symptoms and progression begin slowly and worsen in each of the four stages of the disease. Symptoms may vary in clients; some clients progress quickly through each stage, whereas others may live for years without completely deteriorating.

In Stage 1, mild dementia, the client may appear normal. He can function with minimal assistance and supervision, and usually is still living at home. Symptoms of Stage 1 include:

- Gradual short-term memory loss
- Difficulty concentrating
- Poor judgment
- Decreased interest in environment and social affairs
- Moodiness
- Blaming others for mistakes and problems

In Stage 2, moderate dementia, the client continues to be in good physical health but memory loss is apparent. Symptoms associated with this stage are:

- Obvious memory deficits, hesitation in verbal response
- Disorientation to time
- Forgetting normal routines, appointments, and significant events
- May begin wandering or pacing, very restless
- Complaining of neglect; may accuse caregivers of stealing or failing to provide care
- Losing personal belongings
- Agitation, anxiety, depression, combativeness

In Stage 3, severe dementia, the client cannot function alone and becomes increasingly more dependent on caregivers. This stage involves greater mental deterioration and decline in motor ability. Symptoms include:

- Disorientation to person, place, and time
- Inability to recognize family, friends, or staff
- Inability to read or write
- Immodesty
- Severe difficulty communicating
- Catastrophic reactions, hallucinations, delusions, and sun downing are common
- Requires assistance with all ADLs

In Stage 4, the terminal stage, the client becomes totally dependent upon others for care and develops severe physical problems. Death usually occurs due to complications of immobility or respiratory infections. Symptoms of stage 4 include:

- Incontinence
- Difficulty in swallowing
- Inability to communicate
- Sleep disturbances
- Little or no response to stimuli
- Severe weight loss
- Inability to walk
- Increased susceptibility to infection

Family members whose relatives have AD face a variety of challenges. They may have feelings of denial, anger, frustration, resentment, fear, guilt, hopelessness, depression, and loneliness. Legal challenges include the need to deal with ethical issues of life-prolonging interventions. Financial issues are also a concern to family members. They may have to pay for healthcare costs directly and handle insurance. The financial impact on the family of a client with AD can be devastating and they need to know where to go to obtain help.

Family members may need help when caring for relatives with AD. The In-Home Aide may help to meet the client's physical needs. The client may need assistance with exercise, safety, comfort, grooming, and appearance. Clients with AD also have emotional, social, and spiritual needs. They need to feel loved and cared for.

Communicating with the Client who is Confused

Communicating with the client who is confused can be challenging. Validation therapy is a method of communication developed by social worker Naomi Feil. It uses empathy to help people regain dignity, reduce anxiety, and prevent withdrawal. It also assists caregivers to communicate and to avoid burnout and depression.

The foundation of **validation therapy** is based on the following beliefs:

- All people are unique and valuable
- There is a reason behind the behavior of the disoriented person
- The disoriented client cannot be forced to change his/her behavior and must be accepted non-judgmentally
- When recent memory fails, older adults restore balance to their lives by retrieving earlier memories
- When an empathetic, trusted listener validates feelings, anxiety diminishes, trust is built, and dignity is restored

Before validation therapy, most health care workers used a method of communication called reality orientation. Reality orientation was developed in 1964 by James Folsom, a psychiatrist who worked with veterans with schizophrenia and mental retardation. The goal of reality orientation was to return these individuals to the community.

Reality Orientation is based on the following ideas:

- Confusion can be prevented
- Therapy should begin as early as possible
- People feel better when they are oriented to the present time and place

In some situations it is more appropriate to use reality orientation to help a person to become more aware of his surroundings. This would be used successfully with the client who was previously alert and oriented and has experienced temporary confusion due to an acute illness such as pneumonia.

In working with the client who is in the more advanced stages of Alzheimer's disease or other forms of dementia, validation therapy merely confirms a client's feelings without feeding into his confusion.

Listed below is a situation and examples of responses that reflect validation therapy and reality orientation principles.

Situation: Glenda, a 92-year-old client with severe dementia, is wandering around the house calling for her mother. She is very distraught and wringing her hands as she looks in every room.

Reality Orientation: "Glenda, this is 2001 and you are 92 years old. Your mother is no longer living. This is your daughter's home where you live now and I am your In-Home Aide."

Validation Therapy: "Glenda, why are you looking for your mother? Can you tell me about her? Do you need someone to do something for you?"

Note that in using reality orientation, trying to reorient this client to person, place, and time will most likely be unsuccessful because she is unable to remember current information. It is very likely that this method of communicating with her will result in her becoming increasingly agitated. If she does not remember that her mother has died, this may upset her. By using validation therapy, the caregiver validates the client's need to find her mother and explores the reason she is looking for her. This method is kinder and will usually result in the client communicating his or her needs to the caregiver.

The service plan for a client should reflect the appropriate method of communicating with him. Effective communication takes practice. It is important to remember that when validating the client's feelings, you should not feed into the confusion by making statements such as "I saw your mother a few minutes ago" or "I'll help you find your mother." It is believed that the confused client may be able to realize that he is confused and by taking part in his confusion, the caregiver undermines the client's trust. Box 6.1 contains additional tips for communicating with a confused client.

Box 6.1: Tips for communicating with a confused client

- Treat the client with dignity and respect. Respond to feelings, display empathy, interest.
- Know the client as an individual (his past, likes, and dislikes).
- Always introduce yourself, call the client by name, and explain what you are doing as you approach the client. Speak softly, in a low-pitched voice.
- Approach the client from the front, moving slowly and gently and without startling him. Establish and sustain eye contact with the client.
- Speak in short, direct statements and repeat key words to help promote understanding.
- Always get the client's attention before commenting or asking a question. As soon as eye contact is made, begin speaking because the client with Alzheimer's disease has an attention span that may last only a few seconds.
- Explain each task by providing short, one-step directions. Ensure that all tasks are simple and manageable. Show the client how to begin a specific task (e.g., brushing hair).
- Ask questions that are short and to the point. Only ask one question at a time. When repeating a question, ask it exactly the same way as you did the first time.
- Use nods, pats, gestures, and smiles, and other means of nonverbal communication. Be consistent with gestures. It only adds to the client's confusion if you use a gesture to mean one thing one time and something else at a different time.
- Provide sensory stimulation if appropriate using music or touch. Encourage clients to talk about their families and past experiences if they desire.
- Observe and report signs of infection, including an elevated temperature.
- Observe and report changes in thinking or memory.

Managing Severe Behaviors (Catastrophic Reactions) Resulting from Confusion

Catastrophic reactions occur when confused clients cannot cope with the stress around them. Unable to understand what is happening and respond appropriately, the client becomes distressed and may strike out in anger or fear. During a catastrophic reaction, the client cannot control his behavior.

The best way to deal with a catastrophic reaction is to try to prevent it from happening. Look for signs that the client is getting upset. Ensure that the client is comfortable and has rest periods throughout the day. A client that is tired is more likely to become upset. Speak to the client calmly and quietly, never argue with him. Always treat the client with courtesy and respect. If the client had a previous catastrophic reaction, try to determine its cause.



If a catastrophic reaction occurs, you can help to calm the client by:

- Trying to determine the cause of the behavior. Check for physical causes, (e.g., swollen gums, sore teeth, infection, and pain).
- Remaining calm and quiet
- Trying to soothe the client
- If the client allows it, touch him and hold his hand
- Do not ask the client questions at this time
- Speak in simple, short sentences
- Slowly move the client to a quiet private place
- Using simple distractions, such as, “Let’s go get a drink”
- Feeding the client. Food was used in many homes as a sign of nurturing. Sweets may have a condition of being a special treat.

Clients usually calm down as quickly as they flare up and typically do not remember what just happened. Therefore, do not take the catastrophic reaction personally; it is a reaction to the situation, not the caregiver.

Other Nervous System Disorders

A stroke (CVA, cerebrovascular accident) is due to hemorrhage or loss of blood supply in the brain. Symptoms can include loss of sensation or movement in the extremities, inability to speak, dizziness and loss of consciousness. A transient ischemic attack (TIA) has symptoms similar to those of a CVA. The symptoms may be transient, lasting for only a short period of time.

Spinal cord injuries or damage to spinal cord result in paralysis that is often permanent. Paralysis of the legs is called paraplegia. Paralysis of the arms and legs is called tetraplegia or quadriplegia.

The client with Parkinson’s disease has a disease of the brain cells that control movement. Symptoms include slow, short steps or a shuffling gait; a stooped posture, hand tremors, and a tendency to fall.

Multiple sclerosis is a progressive disease that causes degeneration in the brain, spinal cord, and nerves. Symptoms include numbness, paralysis, and incontinence and there is currently no known cure.

Types of Mental Illness

A client with paranoid disorders or reactions usually has a single life theme or connected themes of being conspired against, cheated, spied upon, followed, poisoned, drugged, etc. The slightest thing may be exaggerated. Common features include resentment and anger, which may lead to violence.

There are several types of anxiety disorders, including phobic disorders (phobias or irrational fears), panic disorder (panic attacks), obsessive-compulsive disorder

(obsessions or compulsions), or generalized anxiety disorder. Although people show anxiety in a variety of ways, generally the signs are restlessness, irritability, and fear.

Mood disorders (previously called affective disorders) are a disturbance of mood accompanied by manic and/or depressive symptoms. When individuals are in the midst of an adjustment disorder, they are having difficulty coping with a stress-producing event. The stress can be single, as in having a loved one die, or it can be multiple, as in having a family member sick and work problems at the same time.

Hypochondriosis is diagnosed when the individual is overly concerned with health complaints not related to physical symptoms.

NOTE: ALWAYS REPORT ANY OF THE ABOVE BEHAVIORS TO YOUR SUPERVISOR/NURSE.

A confused state of mind may be very frightening and upsetting to both the client and the caregiver. Sometimes caring for the confused person is difficult and frustrating because a “cure” is not always possible, and then the confused person cannot or will not say “thank you” for your work. Although they are as vulnerable as children, the confused clients are not children and should not be treated that way. Clients may have a form of mental illness, so it becomes very important to be able to identify the basic types of this illness. Your care can make the difference between good days and bad days.

It is important for the In-Home Aide to realize that the client may feel threatened and not understand what is happening in his environment. The In-Home Aide can communicate concern, acceptance, and reassurance. This can be done both verbally and nonverbally. The confused person often responds to nonverbal communication when memory and language fail.

Chapter Review

1. What are two general types of confusion?
2. What are characteristics of clients who are confused?
3. What are three causes of confusion?
4. What are the three types of responses to confusion?
5. What is the difference between delirium and dementia?
6. What are the four stages of Alzheimer’s disease?
7. What are correct methods of dealing with severe behaviors (catastrophic reaction) resulting from confusion?
8. What are correct approaches for the client who is confused?
9. What are some other nervous system disorders?
10. What are some types of mental illness?

Student Exercise

1. The two general types of confusion are _____ and _____.
2. What is the difference between delirium and dementia?
3. List five possible causes of confusion.
 - a.
 - b.
 - c.
 - d.
 - e.
4. What is the most common form of dementia?
5. List four changes in behaviors and actions that indicate a client is confused.
 - a.
 - b.
 - c.
 - d.

Circle the correct answer.

6. A client who is confused may respond to confusion by becoming____.
 - a. suspicious
 - b. friendly
 - c. curious
 - d. affectionate
7. Disorientation to time, wandering, and combativeness are symptoms of ____.
 - a. Stage I AD
 - b. Stage II AD
 - c. Stage III AD
 - d. Stage IV AD

14. What causes a stroke or a CVA?

15. What is the difference between paraplegia and tetraplegia/quadriplegia?

16. What is hypochondriosis?