CLINICAL CASE STUDIES OF CRISIS MANAGEMENT OF OLDER ADULTS DIAGNOSED WITH MENTAL ILLNESS IN LONG-TERM CARE

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When we think of mental health and the concerns associated with it, often we think of the younger population. Those who are 60 and over are often forgotten or ignored, with their mental health devalued. Have you ever heard someone say, "He is just a crabby old man" or "She is just a mean old woman" when examining an older adult who may be presenting symptoms of depression or anxiety? Health care providers for older adults have heard such statements too many times to count. After all, who would think that someone who has lived a long life and been successful in the world would have mental health issues? Nevertheless, according to the World Health Organization (WHO, 2020), an estimated 15% of all individuals over the age of 60 suffer from a mental disorder. And it is projected that by the year 2050, approximately 15.9% of the population worldwide will be over the age of 65 (Gupta et al., 2015).

Mental health disorders among older adults include depression, anxiety, and even psychosis. For caregivers, it is important to understand the differences among these diseases. For the certified nursing assistant (CNA), the registered nurse, or the physical therapist, it can be strenuous and even stressful to care for such individuals in long-term care settings. In this paper we will discuss techniques and activities that may help in caring for these individuals while protecting everyone's safety. As caregivers, we must approach older adults a bit differently than we would 25- to 30-year-olds. As providers, we do not always see the anxiety or fear that a person may be experiencing during a mental health crisis. Crisis management of the older adult looks much different than it does in younger populations. This is especially true when older adults lack a previous history of symptoms. Often the older adult's behavior is diagnosed simply as an isolated episode rather than correctly as a mental health crisis (Aljondi et al., 2019).

This article presents the cases of three individuals whose care was considered challenging yet became rewarding when they received proper treatment. We will also consider how crisis management in their cases led to resolution. The first is Berniece, a woman in her 90s who suffered from undiagnosed depression most of her adult life. Her undiagnosed depression affected her family, but treatment that she received later in life eventually helped her. The second is Fred, a gentleman in his 80s who had never been diagnosed with a mental health condition yet had sudden episodes of rage. The last is Sylvia, a woman in her late 60s who developed paranoia and fear of leaving her room during the day. These cases will suggest recommendations for practice to assist this fragile population and to improve the quality of their daily lives in long-term care settings.

Case Study One: Berniece
Aggressive Behaviors in Older Adults Can Originate with Mental Health Conditions

Berniece was an 89-year-old retired school teacher when she entered long-term care. Her spouse of 60 plus years had recently died after a battle with geriatric leukemia. She had lived independently with him in their home until a few years prior to this time, while his health began to decline. The decision to give up the home in which they had lived for 40 years was difficult for both of them. Their family was able to convince them that caring for the house, going up and down the stairs, and the many responsibilities of homeownership were becoming much too difficult. Berniece was of Polish decent and lead a very secluded life. Caregivers reported that she could get “mean” and “verbally abusive” when she felt that things were not quite right. On many occasions, Berniece would say that she wanted to die and be with her husband. When she was first assessed, she presented as a very stoic woman with a blunted affect; she never smiled. Her providers believed that her affect and what appeared to be anhedonia were related to her

spouse's recent death. She also appeared lonely in her new surroundings without her husband or family. Berniece had one daughter and two grandchildren. They visited Berniece every week even though she sometimes yelled at them or ridiculed them. Clearly they still loved and cared for her despite her sometimes difficult behavior. Staff at the facility reported that they often felt upset in caring for Berniece; she would verbally abuse them or hit them with her walker, and she was generally unpleasant to be around. But staff felt that it was important to continue to work with her, to see how she might be helped and to determine whether anything could be done to resolve her behaviors. So the staff at the center talked with Berniece's family in an attempt to brighten her mood and asked them to bring in pictures and mementos that meant something to her in her earlier days. Soon the family brought in items that her grandchildren had made for her in years past. They also brought in pictures of Berniece and her husband from when they were married and after the birth of their daughter. Shortly after this, things started to get better for her.

Review of Berniece's pictures taken both before and after her daughter's birth showed an obvious difference in her appearance and mood. Providers considered that Berniece's daughter was born in 1940—when healthcare was different, with much less awareness of mental health. The photos taken before 1940 showed her smiling; in them, she appeared to "have a light" in her eyes. Even though the photos were in black and white, she looked like a bright, happy person. Post 1942, however, her affect was blunted, resembling how the staff currently saw her. So the facility staff began to think about what might have caused this change. The family was interviewed, and the staff asked Berniece's daughter many questions about her life when she was growing up. They learned that Berniece had never really shown joy about family accomplishments or being a mother. The facility's psychiatrist then assessed Berniece to determine whether Berniece's behaviors and changes in affect might represent an undiagnosed

depression. It was suspected that undiagnosed depression could have manifested itself after the birth of Berniece's daughter and then progressed, resulting in the person with whom the staff were currently working at the facility.

The psychiatrist completed Berniece's assessment after the family was interviewed. The family was then called in for a team meeting to discuss the diagnosis, along with treatment options. The psychiatrist thought that Berniece had suffered from an untreated postpartum depression that subsequently progressed to a mood disorder, and recommended that Berniece be started on a low dose of an antidepressant medication, to be titrated as needed. This was discussed with the family and Berniece in order to obtain consent. Despite her initial reluctance to taking an antidepressant, Berniece agreed to do so. She was then monitored for any negative effects of the medication or changes in her behavior. The medication was titrated over a 2-week period. At the end of the second week, one of her grandchildren came to visit her for the first time in a few weeks. The granddaughter visited with her for some time, and the staff heard laughter from Berniece's room, something that they had never heard before that day. When the staff checked on Berniece, they found her smiling and laughing as her granddaughter shared stories with her. A family meeting was held approximately a month after the initiation of medication. Berniece's family commented that in all the years that they had known her, they had never seen her smile and laugh as much as they had in the last 2 weeks. Berniece commented that she was not sure exactly what the new pill she was taking might be, but she wanted to keep taking it because it was helping her feel "wonderful." Berniece died at the age of 95, five years after initiation of the antidepressant. When Berniece's family took her belongings home, they told the staff that the last 5 years were their best years with her. They were profoundly grateful

that the staff had considered Berniece's mental health and looked beyond her irritable nature to find a solution.

This case shows how depression can affect the life of the person who suffers from it, as well as the family members who care for them. In the 1940s and 1950s, mental health was often a taboo subject that many families tried to hide (Sorkin et al., 2016). In 2017, depression affected approximately 322 million people globally; in the U.S., those with depression totaled nearly 17.5 million (WHO, 2017). With the world in the middle of a pandemic, these numbers are increasing daily. According to the Centers for Disease Control and Prevention (Czeisler et al., 2020), with the increase of quarantine and social isolation, depression and anxiety are increasing daily and are leading to an increase in death by suicide. When caring for older adults, we must assess their affect and get clear, thorough histories of their lives. But providers and caregivers who try to talk with individuals about mental health must also recognize that many older adults are not comfortable talking about it. It is our job to work around stigma and treat individuals considerately, so that we can achieve the best possible outcomes.

Berniece's case does not resonate as a crisis with imminent risk. However, it was apparent that the quality of her life at the age of 90 was not what it was when she was in her 20s in terms of mood. This is important, because depression is not necessarily a "normal" part of aging. In Berniece's case, her depression had been going on for years. Her positive outcome through the administration of an antidepressant medication shows that her condition could have been corrected many years earlier. As her eldest granddaughter said, "it is sad that we were only able to enjoy the last 5 years with her and only then truly watch her enjoy life." Berniece's case demonstrates how we, as caregivers, need to look at the behaviors of older adults who are seem irritable and restless and find out the why for their behaviors.

Case Study Two: Fred
Mental Health Conditions in Older Adults Can Manifest as a Medical Condition

Fred was an 82-year-old gentleman who lived in a long-term care facility for many years. He had been married for over 50 years, with four children and eight great-grandchildren. Fred had led a very full and rich life in which he traveled to many countries, and he was active in his community until he entered the facility after he suffered an accident that resulted in a hip fracture. After recovery, he was unable to live independently and care for himself. His family realized that he was getting forgetful about taking his medications; they feared that he might accidentally overdose on his cardiac medication because he might forget that he had taken it. He had lived in the facility for approximately 2 years before his mental faculties declined. Family members visited him frequently when he was first at the facility. Staff began to notice a slow decline in his memory, and caregivers were concerned about his memory loss. The family, who had appeared to be regularly active in Fred's treatment and care at first, gradually ceased to visit him. Staff noticed that Fred would wander around the unit; sometimes he could be found in the wrong room. These behaviors became a concern. Fred began to comment that he had to "go downstairs," so that he could take care of household business. He had many such periods, but he also had periods in which he was lucid and appeared to be "on top of the world." Staff reported that he was a "pleasure to be around" and interacted well with others in the facility most of the time. He participated in game nights and activities that the facility provided.

Over the course of about 3 months, staff at the facility noticed a cognitive decline in Fred. On several occasions throughout the day, he would forget where his room was. He forgot to come to dinner and to take his medications. In periods of anger, he lashed out at staff. Previously, Fred had referred to staff by their names—he was familiar with many of them, but

this familiarity soon stopped. One day, as his "favorite" CNA was helping him get his clothes ready, he began to yell at her. He became combative, crying out, "Why are you stealing all of my things? Get out of my house." The staff were alarmed; they had not seen Fred's behavior escalate to such a degree. Fred's family said that he had never had such episodes in his previous or younger years—he was always "as sharp as a tack." Neurological and psychiatric consults were ordered for him, but Fred's agitation and what appeared to be his delusional thoughts made these assessments difficult.

As a result, Fred was initially diagnosed with schizophrenia, because he was having delusional thoughts and he responded with rage to stimuli that were not there. Yet it is odd, indeed generally unheard of, for a person to have a sudden onset of schizophrenia at the age of 82, with no prior psychiatric history. Symptoms of schizophrenia usually manifest in a person's mid to late 20s, with early onset prior to the age of 18 (Chen et al., 2018). Fred's medical history was reviewed with the facility's psychiatrist, and exams were conducted to determine his cognitive function. A Mini-Mental State Exam administered to Fred showed cognitive decline. The medical provider on site also did a thorough physical exam of Fred, which showed that he had a urinary tract infection (UTI). Together, these results answered many questions for Fred's daily caregivers. In the older adult, especially those with dementia or Alzheimer's, a UTI will manifest as behavioral symptoms such as confusion (Rummukainen et al., 2012).

Fred was given antibiotics to help treat the UTI, as well as Aricept, a cholinesterase inhibitor, to treat his cognitive decline. He was also prescribed a low dose of Risperdal, an antipsychotic medication, to help with his episodes of rage and aggression. However, the treatment of conditions such as Alzheimer's disease and other dementias in older adults can be difficult. Medications for the treatment of psychiatric illness in older adults are many times not

the treatment of choice, partly because of the natural decline of kidney and liver function in the older adult. It is therefore important to monitor medications closely for negative outcomes. In Fred's case, the chosen regimen fortunately worked to help control many of his symptoms. After Fred's UTI cleared, the doctor decreased his antipsychotic medication. When older adults suffer from UTIs, this condition will often manifest as periods of confusion and aggression. By the time of his treatment, Fred had multiple concerns, because his outbursts of aggression had begun several months before.

Fred's case was a testament to the staff that it is important to recognize the entire clinical picture in working with older adults. Had physicians and caregivers stayed with the schizophrenia diagnosis, the UTI might not have been discovered, which could have led to more medical concerns. Fred's case gave his caregivers the insight that mental health conditions in older adults can also manifest themselves as medical conditions. Taking care of the entire patient is essential, especially when caring for older adults. Caregivers should not merely consider a patient's present actions, they should also look for the "why" behind new behaviors that emerge.

When we consider the crisis in Fred's case, we can see that he was a man who had led a full life, was loved by his family, and was successful for many years. There was a definite quick decline in his mental faculties and mood. He became angry and extremely forgetful. In Fred's case, it became evident that his behaviors were directly correlated with his UTI. In the elderly, UTIs are one of the most frequently diagnosed bacterial infections (Rowe & Juthani-Mehta, 2014). As caregivers, we must watch for symptoms and mood changes in our elderly population.

Case Study Three: Sylvia
Medical Conditions in Older Adults Can Incorrectly Appear to be Mental Health Conditions

Sylvia was 67 years old when she began to reside at her facility. She was brought there by her family, who felt that she could no longer care for herself. She had experienced a stroke, and her spouse, who was several years older, also had multiple medical concerns and had been living in the facility for a year. During Sylvia's first 3 months in the facility, symptoms of paranoia, along with delusional and obsessive thoughts, began to appear. When family members visited her, they confided to staff that such behavior had manifested itself earlier in Sylvia's life. At times, Sylvia would not recognize her family or even speak to them. Staff probed the family in an attempt to find the cause, but the family did not know why the earlier behavior might have occurred or what had stopped it in the past. Staff noticed that Sylvia was beginning to barricade herself in her room and seemed to be preoccupied with her own thoughts. She also had diabetes, hypertension, and hypothyroidism. Much as in Berniece's case, Sylvia had developed post-partum depression after her second child was born. She had been diagnosed with major depressive disorder earlier in her life, and she had continued to take daily medication for this condition. Patients with severe depression can develop psychosis (Ozdemir et al., 2015), but it did not appear that she had experienced psychosis in her initial crisis. She had been well regulated with her medication until recently, when her paranoia slowly began to increase.

Assessing Sylvia was difficult. She was very distrustful of staff, and she said that she felt everyone was there to cause her harm even though she had lived at the facility for 3 months. Many of the staff attempted to interact with Sylvia to build rapport with her. She began to build trust with one CNA, whom she consistently called "Kathy" despite being told several times by staff that the CNA's name was not Kathy. After several such attempts, this staff member started

answering to the name Kathy when Sylvia called to her, because Sylvia's behavior would worsen when "Kathy" did not respond. During her treatment, it was learned that Kathy was the name of Sylvia's granddaughter, to whom she had been close in the past. Examinations and assessments were scheduled for times when "Kathy" was available to sit with Sylvia, because this was the only way that staff could get her to participate in treatment. Encouragement had to be given by "Kathy" so that staff were allowed to run tests that included blood draws, urinalysis, drug screens, x-rays, and mental status assessment. Sylvia did not show signs of cognitive delays characteristic of Alzheimer's or other dementias; she did very well on the tests. After encouragement from "Kathy," staff were able to draw labs once again. When all assessments were completed, data were compiled and evaluated to determine the best course of treatment. Sylvia's family was involved in the assessment, contributing history so that providers could get a better picture of the time leading up to her treatment.

When all results were compiled and reviewed, the treatment team determined that Sylvia had suffered from depression for many years. But the medications prescribed to treat her depression had not been evaluated for many years either. Her primary care doctor was overseeing her prescriptions without intervention from a psychiatrist before she entered long-term care. The medication for her depression was then changed, because the efficacy of her medication had apparently decreased. Her laboratory results showed that her diabetes was well in control; her HbA1c was within normal limits. This ruled out any diabetic ketoacidosis that could result in confusion. However, her thyroid-stimulating hormone (TSH) was six times the normal level. Despite medication compliance for her hypothyroidism, her medication was apparently not effective. Medication regimens were changed to reduce her TSH to a more therapeutic level,

which would correct myxedema psychosis. Within a week of treatment, Sylvia's paranoia began to improve, and she was able to leave her room and rejoin the facility's activities.

Sylvia's crisis was found to be clearly medical once caregivers looked beyond her behaviors. This was so, even when the medications for her depression were titrated to a therapeutic dose. If her thyroid condition had remained untreated, Sylvia could have developed thyroxic encephalopathy, which results in agitation and confusion. Left untreated, these symptoms would only worsen and possibly lead to long-term psychosis. Unlike Fred, Sylvia presented with a diagnosis of depression. Because she had managed her depression for several years, caregivers at first did not consider it further. As her medical crisis escalated, her symptoms increased. Determining the cause of confusion in the older adult is not always as easy as it was in her case, but it is worth it to investigate such conditions to achieve the best outcomes for patients.

Summary

In all three of the cases presented here, nursing facilities were fortunate to have family involvement that helped determine an individual's baseline and life history. This is not always the case for our older adults, even though it is an important part of their care. With no history, mental health concerns in older adults can be difficult to diagnose. As in the cases of Fred and Sylvia, medical concerns can manifest themselves as mental health issues. Complete assessments of these individuals are imperative. Caregivers should recognize the complete person, not just their current actions. With Fred, if a urinalysis had not been completed, his confusion and psychosis could have continued to increase. In some cases, addressing the medical concern will help to resolve mental health issues.

Caring for older adults is not the same as caring for younger adults in their 20s and 30s. Many factors must be considered and assessed before diagnoses are made. Crisis situations in the older adult can be mood or medically based. When caregivers think of crises, we often think of violent, aggressive behavior with psychiatric implications, but this is not necessarily accurate for older adults. It is important to learn about the entire individual in order to understand the origin of a crisis. An individual, who has never been aggressive, whether verbally or physically, would likely not develop psychosis or schizophrenia "all of a sudden." It is crucial for caregivers to obtain a history from the individual's family whenever possible, in order to determine what the they were like in the years past, not just in the immediate past. This can guide the caregiver to look thoroughly at both the medical and the psychological concerns of the individual. Both areas must be thoroughly explored, because each area can definitely affect the other. But one must always remember that the older adult is an individual and that no two persons will ever be the same.

Advice to the reader: The next time you hear someone say, "Oh he is just a grumpy old man" or "She is just a mean old lady," give this some thought. Were they always this way? Is this a sudden change or has it been gradual? Talk to the family, interview them, look at pictures in the individual's room to learn about their past life. Try to talk with the individual who may know that something is not quite right. Sometimes such small seemingly unimportant things can become the greatest tools to help us learn how to best care for these individuals. Ensuring that we are treating our older individuals with the dignity and respect that they deserve will help determine whether a crisis may be imminent.

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