AGEING, NEUROPSYCHOLOGY AND THE 'NEW' DEMENTIAS

Definitions, Explanations and Practical Approaches

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To my family,
colleagues and trainees

Contents

Preface

For many years my brain
Worked with a dim and undetermined sense
Of unknown modes of being.

WORDSWORTH

Until the last few years disturbances of brain function as explanations of strange or socially unacceptable behaviour were not considered or investigated.

Neuropsychological concepts were avoided by the majority of care staff as areas that were the province of particular professionals and of no relevance to their work. As more and more articles have appeared which relate specific behaviours to functional deficits, awareness has increased. Unfortunately such awareness is still limited and brain damage remains a subject that is rarely included in training programmes and all too often behavioural disturbances continue to be misunderstood, overlooked and misinterpreted. As a result of this omission in assessment and knowledge, goals can be set which are totally inappropriate, which are destined to fail or actually make matters more difficult for staff, relatives and patients.

Another topic which has suffered from vague discussion in staff training and has been presented in books and articles over the years with a variety of confusing explanations is the concept of dementia. At workshops and seminars, when participants are asked what they think the term means, the majority cite disturbed behaviour, progressive deterioration and possibly cell loss. They rarely have any definite ideas about the causes as often they believe dementia to be a disease in its own right.

In an earlier book, *Neuropsychology and Ageing* (Holden, 1988), some of the neuropsychological concepts and behaviours were discussed. Several of those chapters will be updated and included in this volume. However,

other subjects have now become of equal relevance and chapters will be included to cover recent developments.

Most staff members need to know more about the recent research on conditions with which dementia is associated, with the many mistakes in diagnoses, including jumping to conclusions, overlooking acute confusion and the many normal changes with age that have not been taken into consideration when interpreting responses.

It is hoped that some gaps in knowledge and practice can be filled in – even a little – by the following chapters which are intended to clarify some of the terms, provide explanations and suggestions for simple and realistic assessments and outline some practical approaches to fairly common problems. Although neuropsychology is far from being a new field, there is still so much to learn and research continues to seek further explanations regarding the functions and nature of that remarkable machine called a brain. Many answers can be supplied by applying that rare commodity, common sense, but there is already sufficient available information on unusual behaviour due to brain damage to encourage awareness, to reconsider management practices and interventions in the light of their real value to an individual as well as to question assumptions and incomplete assessments.

Neuropsychology is the study of behaviour directly related to brain function. Although most people accept that psychological factors play a major role in influencing behaviour, the relevance of neuropsychological factors is rarely considered. Certain observed reactions, or lack of reactions, may be the result of brain damage rather than personality, mood, attitudes or affective disorders. To assume that specific behaviours have simple explanations could well obscure the real problems and needs. As previously stated, neuropsychology is not a new science; in fact man was aware of brain function in, at least, the 17th century BC. There is a papyrus dated from about 3000 BC on which accounts of head injury are recorded. Hippocrates, Aristotle, Galen and others from ancient times developed theories about the function and nature of the brain. Gall, amongst others, produced phrenological maps which can still be consulted in libraries. The late 19th century produced some of the classical contributors – Paul Broca and Carl Wernicke – who were followed in recent years by such eminent scientists as Aleksandr Romanovich Luria. Luria was one of the foremost authorities on restoration of function. His approaches are still used in practice and his work has been the inspiration for current researchers.

The role of a neuropsychologist includes:

- assisting in diagnosis;
- providing relevant assessment tools and methods;
- identifying methods to distinguish organic damage from functional states;

- monitoring change;
- identifying precipitants, e.g. effects of light on epilepsy;
- predicting outcome;
- assisting in the isolation and identification of new systems or pathways, syndromes or other aspects of brain-related behaviour;
- developing and assisting in rehabilitation and restoration of function programmes;
- counselling and supporting families;
- research.

This book is intended in particular for those who work with elderly people who have either no knowledge about neuropsychology or who have only a vague grasp of it. It is far from easy to produce something on a subject perceived as difficult that will prove attractive and informative reading for a wide variety of professions. Someone must try, though complete success with such a target is most unlikely; at least if some elderly people benefit, the effort will be worthwhile.

Una Holden-Cosgrove

REFERENCE

Holden, U.P. (ed.) (1988) *Neuropsychology and Ageing*. Croom Helm, London.

Recognizing the problem

We are all capable of misinterpreting human behaviour and language. Everyone is familiar with the problems faced in a doctor's surgery where both patient and physician struggle to get their message across to each other. The patient attempts to explain the pains, aches and feelings in a meaningful manner, and the doctor tries to make sense of all this in order to arrive at a correct diagnosis. Frequently both are frustrated by a perceived lack of understanding on the part of the other. Such a situation occurs every day in most interpersonal contacts. The stress is placed wrongly on a word, a gesture is misunderstood, someone deep in thought apparently ignores an acquaintance, a work situation appears threatening when it is only reflecting anxiety and a husband and wife relationship is put under duress because one or the other partner is tired. These upsets in personal relationships are commonplace and, to a degree, easy to appreciate. However, there are specific behaviours for which there does not appear to be a reasonable explanation and where even professionals are liable to error.

Mankind automatically explains perceptions according to experience, expectations, ability and knowledge. As all of these are essentially finite, errors frequently occur. People rarely stop to think, to examine the facts or to make further enquiry. Everyone is in a rush and too busy to pause. To spend valuable time on searching for alternatives interferes with the progress of work or interests and is regarded as a nuisance or too demanding. No one is genuinely willing to admit to ignorance, so when an unusual situation arises an answer has to be found quickly in order to avoid time wasting speculation.

Odd behaviour is viewed with some discomforture and often a pejorative remark will be used to dismiss the problem. If time to think was given to the situation alternative explanations would soon come to mind and could include:

- The person *is* really odd, a possible eccentric or local 'character'.
- The person could be socially naive or unskilled.
- There is a physical reason – delirium, amnesia, deafness, blindness.
- The problem is physiological – malnutrition, drug related, narcolepsy, etc.

- A psychiatric condition could be present.
- The person could have sustained a closed head injury.
- There could be specific neuropsychological deficits.

There are a whole series of situations where a person's behaviour can be misinterpreted and totally incorrect assumptions can lead to difficulties for all concerned. For instance, cognitive therapy highlights the classical situation by using as an example 'Mrs Jones' who is convinced her neighbour does not like her because she walked straight past her in the street. 'Mrs Jones' can be persuaded to look at many alternative explanations and think again. Her neighbour could have visual difficulties, she could have been deep in thought, thinking about a worrying or very happy experience. Hopefully, one of these suggestions proves correct, so 'Mrs Jones' can become more positive about herself and develop a different view of life. Sometimes the original negative perception proves to be correct and the unfortunate therapist is faced with a different problem!

An eccentric is accepted by society, but the person without social graces is not. It is rare that an individual falls into just one or the other of these categories. Normal people can present in many ways and their reactions may well be explained in a simple manner. Not everyone has perfect hearing or sight, old people in particular have experienced changes in their sensory ability.

At a club meeting Mrs Grant was in the middle of a group of six people discussing the local election. Mr Bell stated that he was absolutely disgusted at the idea that VAT should be placed on heating fuel. Mrs Grant, thinking that he was talking about a visit to a nearby distillery, lent forward and said 'Didn't you know that they closed down recently, so you wouldn't expect the vat to be full'. Everyone laughed at her so much that she refused to return to the club.

Normal changes in the senses can result in embarrassing situations and often the unfortunate individual who mishears or misperceives is so distressed by this that he or she will withdraw from social contact or become isolated in such a way as to suggest that some form of intellectual deterioration has taken place.

Kitwood (1990) has pointed out the importance of a person's background and environment as the most appropriate starting point in understanding a given behaviour. This will be discussed in more detail in Chapter 2, but here it is important to stress that many situations can result in giving false impressions. The older lady whose family insist on talking for her, the spouse whose partner has dominated life so much that he or she has withdrawn from arguments or even opinions or the individual whose life has been so full of tragedy that apathy has taken over, are all capable of providing examples of odd behaviour which can be misinterpreted only too easily.

It is surprising how rarely pejorative statements or erroneous explanations are challenged. The behaviour of those with a head injury and that of old people is invariably labelled, yet there are few who would question that label. Case notes contain word like 'aggressive', 'unmotivated' and 'violent', but the reason for the use of such strong words is not investigated. 'Incontinent' could mean that the person did not know where to find the toilet and could wait no longer. 'Aggression' could reflect a person's anger at being sat beside a patient who constantly swore, spat and interfered. 'Violent' might mean that a peacefully sleeping patient was suddenly awakened and laid hold of without warning by a staff member wanting to dress a wound. The possibility that the 'violent' reaction could be purely defensive has not been considered. When an account of preceeding events has not been recorded pejorative labels can result from false perspectives.

Neuropsychological factors are not understood by the general public. Care staff, too, can be ignorant of them. To some staff the words may be familiar, but the actual meaning or ability to recognize them remains vague. It is unfortunate that so many professionals are unsure of the subject as this vagueness ends in a lack of relevant treatment and understanding which can have tragic consequences for those with head injury and for older people in particular.

Geriatric wards and residential homes provide daily examples of misinterpreted behaviours and overlooked difficulties because staff are unaware of the possible implications. Table 1.1 lists some of the commoner behaviours and the probable conclusions drawn by staff and other observers.

Table 1.1 Examples of common behaviour and hasty assumptions

Observed behaviour	Assumption
Walking into things.	Forgetful. Blind.
Drops things, lacks dexterity.	Clumsy.
Gets into someone else's bed.	Over-sexed.
Complains of an assault.	Trouble maker.
Very slow. No response.	Unco-operative. Losing his/her mind.
Eats very little.	Anorexic. Apathetic.
Will not dress.	Unmotivated. Difficult.
Does not recognize faces or objects.	Blind. Apathetic.
Sings beautifully but will not talk.	Attention seeking. Stubborn.
Speech meaningless, silly words.	Totally deteriorated.
Forgets to pass on a message.	Senile.
Screams, pushes staff away when being dressed or fed.	Aggressive.