



# Caring for the Complex Client: Personality Pathology, Dementia, and Behaviour

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## Complex Client: Intersection of personality pathology, dementia and behavior

### Objectives:

- Review behaviors, thoughts and emotions we experience when providing care to complex clients
- Discuss syndromes that intersect to cause some older persons to exhibit challenging and complex behaviors
- Offer Framework for sorting out these intersecting syndromes
- Build providers' skills in offering services to complex older clients

## Complex Client: Intersection of personality pathology, dementia and behavior

Vignette: Ms. B:

- 79 year old MWF, mother of 3 sons, seen in geriatric psychiatry outpatient clinic
- Psych history:
  - Recurrent depression onset in 30's
  - Middle Age: 3 Inpt stays, some requiring ECT
  - Older Adult (Past 10 yrs): "Chronic depression", frequent re-hospitalizations, only modest benefit from antidepressant or outpatient ECT
  - Neuro-cognitive: No focal signs, MMSE=26/30
- Medical history / medications: Non-contributory



# Complex Client: Intersection of personality pathology, dementia and behavior

Vignette: Ms. B:

- Behavior: Notable for 8 yr hx of presenting as depressed, helpless, described as “attention-seeking”, “frustration-intolerant”, “rejection-sensitive”.
- Behavioral observations: In clinic wait room, observed moaning at regular intervals, speaking in child-like tone.
- Therapy sessions: Expresses view of self as helpless, requests assistance with simple tasks; vague suspicions that others lie and are rejecting her.
- Interpersonal relationship with husband has become stormy; angry and fearful of being left alone when her husband expressed a need to spend time away from her during the day.
- Husband views Ms. B’s experiences and behaviors as longstanding.
- Provisional Diagnosis: Major depression, recurrent; Personality Disorder NOS (with mixed borderline and dependent features).



## Signs You Are Dealing with a “Complex Client”

You notice behaviors in the client such as:

- Demanding/ Dependent/ Attention-seeking / Help-rejecting Behaviors
- Excessively Critical/ Rejection-sensitive/ Argumentative Behaviors
- Openly Manipulative/ Exploitative Behaviors
- Controlling / Inflexible Behaviors
- Non-adherent to care or a recommended plan
- Excess use of services





## Signs You Are Dealing with a “Complex Client”

You notice thoughts/ feelings in yourself such as:

- Unpleasant feelings you have when around the individual (e.g. angry, hateful, frightened, helpless, guilty)
- Unpleasant thoughts you may have (e.g. “wish this client could be transferred soon to someone else”)
- Unpleasant behaviors you show (e.g. arguing or yelling; avoidance or delay in care; individual “brings out the worst in me”)



## What Causes Some Older Clients to Exhibit Challenging and Complex Behaviors?

Categories of Complex Clients:

- Category 1: Personality Pathology /Disorder (PD)
- Category 2: Personality Change due to a Medical Condition
- Category 3: Behavioral and Psychiatric Symptoms due to Dementia (BPSD)



# Potential trajectories of the course of problems of personality and cognition across the lifecycle



Complex  
Client  
Behaviors

# The “Complex Older Client” with Personality Pathology /Disorder (PD)

Category 1: Clients with “Personality Disorder” (PD/ DSM5)

- Show characteristics or behaviors that are extremely different from cultural norms/ expectations, in regard to how they experience themselves and others;
- Long-standing difficulties in interpersonal relationships, managing mood and impulses, “sorting themselves out”- disturbed self-image
- Difficulties are life-long, not due to current medical illness, another psychiatric illness, dementia, or environment



# The “Complex Older Client” with Personality Pathology /Disorder (PD)

Category 1: Clients with “Personality Disorder” (PD/ DSM5)

- Prevalence: 8 – 10% of community dwelling Older Adults
- Added diagnostic challenges in later life:
  - Onset in early adulthood?
  - Distinguish personality disorder (PD) from:
    - (1) **Neurocognitive disorder** or other psychiatric illness (e.g. depression)
    - (2) Medical condition or medication
    - (3) Environmental or context specific behaviors
    - (4) **A difficult provider-client relationship**
    - (5) Culturally expected roles or related behaviors
- Assessment: Requires multiple sources of information (self and informant-reports, other providers, medical history, etc.)

# DSM Categorical Model of Personality Disorder (PD)

- DSM-IV: 3 Clusters of PDs:
  - “Odd-eccentric”
    - Paranoid
    - Schizoid
    - Schizotypal
  - “Dramatic”
    - Histrionic
    - Narcissistic
    - Borderline
    - Antisocial
  - “Anxious”
    - Avoidant
    - Obsessive-Compulsive
    - Dependent

*Note: Clusters have not been shown to have empirical support*





## DSM5 Dimensional Model of Personality Disorders/ Personality Pathology (Alternative Model of PD)

Trait Models of Personality (FFM): conceptualize 4-5 factors:

- Neuroticism
- Extraversion
- Openness
- Agreeableness
- Conscientiousness

DSM5 Trait Model of Personality Pathology: Conceptualized as 4-5 Factors:

- Negative Affectivity: experiences negative emotions frequently and intensely
- Detachment: withdrawal from other people and from social interactions
- Antagonism: engaging in behaviors that put the person at odds with others
- Disinhibition: engaging in behaviors on impulse, without reflecting on potential future consequences
- Psychoticism: Unusual and bizarre experiences

# Personality Disorder/ Pathology: Associated Features

- Demographic Features (mixed-age adults): Higher prevalence of:
  - Marital status: single/unmarried or separated/ divorced
  - Several marriages but few children
  - Downward occupational change
- Clinical Characteristics (mixed-age adults): Higher prevalence of:
  - History of sexual trauma or other adverse childhood experiences
  - Early-onset Axis I disorders (Depression, Anxiety, PTSD)
  - History of suicide attempt
- Clinical Characteristics (older adults): Higher prevalence of:
  - Early onset, recurrent depression
  - Co-morbid anxiety disorder
  - History of suicide attempt



# Treatment of Older Adults with Personality Disorder/ Pathology: Outcomes Research

- Older adults with Depression + PD (compared to those without PD) treated with standard psychotherapeutic and/or pharmacologic approaches for Major Depression experience less favorable outcomes
- DBT and Schema therapy are promising treatments for Major Depression with co-morbid PD in older adults
- Most other treatments for PD have not been tested in older adults



# The “Complex Client” with Personality Change

## Category 2: Personality Change due to Another Medical Condition” (DSM5)

- Persistent personality disturbance that represents a change from the previous characteristic personality pattern
- Evidence that the disturbance is the direct pathophysiological consequence of another medical condition (e.g. CNS neoplasm, head trauma, CVA, infectious or metabolic disorder, etc.)
- Does not occur exclusively during delirium
- Specify types: **Labile; Disinhibited; Aggressive; Apathetic; Paranoid; Other, etc.**



# Brain Dysfunction and Personality Change/ Behavioral and Psychological Symptoms in Dementia (Bangash, 2020)

**TABLE 2** Personality changes caused by brain dysfunction

| Brain region affected                                                                                                                                                  | Personality changes                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| Dorsolateral frontal cortex impairment                                                                                                                                 | Apathy, dulled affect and lack of spontaneity                                          |
| Orbitomedial frontal dysfunction                                                                                                                                       | Behavioural disinhibition, emotional lability and indifference to social decorum       |
| Temporal and parietal lobe dysfunction                                                                                                                                 | Memory problems, hence paranoia toward others due to not recalling information given   |
| Chronic temporal lobe dysfunction                                                                                                                                      | Emotional instability, epileptic phenomena and aggression                              |
| Basal ganglia dysfunction                                                                                                                                              | Impulsivity, obsessive-compulsive disorder, cravings and loss of control in addictions |
| Dysfunction of the thalamus and hypothalamus                                                                                                                           | Disinhibition, apathy, carelessness, emotional lability and violent outbursts          |
| Left-hemisphere dysfunction                                                                                                                                            | Fearfulness and depression                                                             |
| Destruction of myelin and resultant decrease in conduction velocity occurring in multiple sclerosis, AIDS, brain trauma, alcoholism and, to some extent, normal ageing | Irritability, depression and apathy                                                    |
| Dysfunction of pathways connecting the basal ganglia, striatum, thalamus and cortex                                                                                    | Loss of control in addictions                                                          |



## The “Complex Client” with Personality Change

Category 2: Personality Change due to Another Medical Condition”  
(DSM5)

- Structural brain lesions or functional disturbance of brain circuits associated with various persistent behavioral changes
- Assessment: Comprehensive neuro-cognitive evaluation, assessment of temporal relationship between medical /cognitive disorder and personality change
- Treatment: Modified behavioral health approaches based upon primary medical condition



# Complex Client: Intersection of personality pathology, dementia and behavior

Vignette: What happened to Ms. B?

- On closer inquiry:
  - Social history: College-educated, had brief successful work experiences
  - Married 45 yrs, with stable & supportive relationships with spouse and children until the past 10 years
  - Remote medical record: “Frontal lobe blood clot” 10 yrs ago
  - Brain MRI: “focal atrophy of the right frontal region of unclear etiology”
  - Neuropsych Eval: Impaired verbal/ visual memory, executive functioning
- Revision of working diagnoses to “Personality Change due to Another Medical Condition (CVA)” resulted in more realistic treatment goals and modified interventions for Ms. B and her family



## The “Complex Client” with Behavioral and Psychological Symptoms of Dementia (BPSD)

### Category 3: Behavioral and Psychological Symptoms due to Dementia (BPSD)

- BPSD include depression, anxiety, apathy, repetitive questioning, psychosis, agitation, aggression, disinhibition, aberrant motor behavior, sleep problems, etc.
- BPSD likely reflect “an interaction among a variety of factors including cognitive impairment, unmet needs, symptoms of distress, unrecognized pain and discomfort, under- or over-stimulating environments, and caregiver responses” (APA, 2021)
- Prevalence in Dementia/ Major Neurocognitive Disorder: up to 97%



# BPSD: Interactions at Levels of Patient, Caregiver and Environment

(Kales, Gitlin, & Lyketsos, 2015)

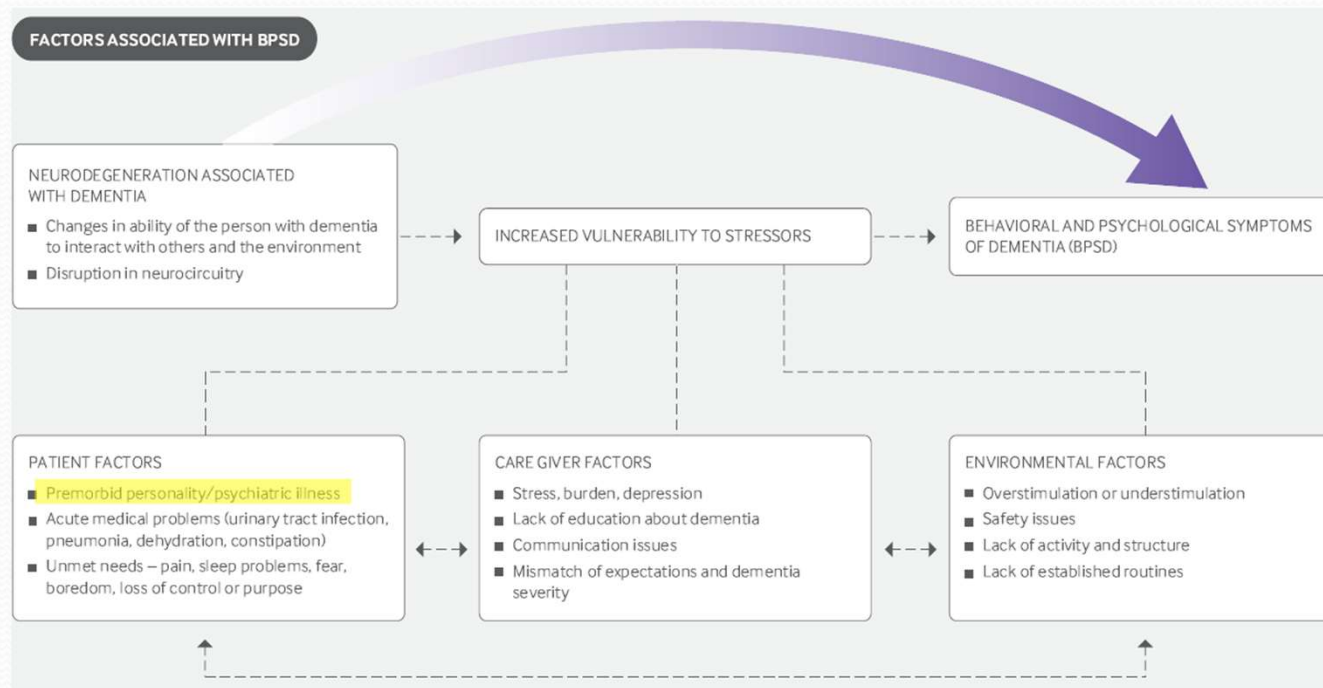


Fig 1 | Conceptual model describing how interactions between the person with dementia, care giver, and environmental factors cause behavioral and psychological symptoms of dementia (BPSD)



## How to Address Challenging and Complex Behaviors?

Sort out which syndrome the client is experiencing:

- Category 1: Personality Pathology /Disorder (PD)
- Category 2: Personality Change due to a Medical Condition
- Category 3: Behavioral and Psychological Symptoms of Dementia (BPSD)

Initial step: ASSESSMENT

1. Screening using DSM-IV-TR/DSM-5 “General Criteria” for Personality Disorder; rule out persisting psychiatric disorder, situational or role-related behavior
2. Evaluate “Personality Change due to a Medical Condition” or “Behavioral and Psychological Symptoms of Dementia (BPSD)” through careful history, neuro-cognitive evaluation, assessment of temporal relationship between medical /cognitive disorder and personality change
3. Address need for safety for individual, others in environment
4. If category 2 or 3, consider responsive behavior approach to plan and intervene





## Skills in Working with a “Complex Client”

When confronted with difficult behaviors.... The “ACT” approach

### A. **ACCEPT** THAT YOU NEED SOME EMOTIONAL DISTANCE

- Before responding, collect oneself physically (e.g. deep breathing) and mentally (think carefully before responding)
- Identify the feelings you are having (e.g. fear, anger, guilt/ shame, helplessness) and **ACCEPT** them as natural and understandable
- Think about whether a response is necessary or not (e.g. not paying attention to abusive comments **IS** an intervention) **AND** avoid responding impulsively (e.g. with an angry outburst)
- Consider sharing your experience with others before responding, in order to problem solve
- Try to turn strong negative feelings into **curiosity**: What human need is underneath this individual’s complex behavior?



# Skills in Working with a “Complex Client”

## B. **COMMUNICATING** PROFESSIONALLY, SHARING CONTROL, FORMING AN ALLIANCE

1. Listen to and then summarize the individual's view of the problem  
(e.g. “I think I understand how you see the situation and how you feel. Let me review what you have told me so I'm sure I have it right.”)
2. Validate the person's experience in order to form an alliance:  
(“Yes, it is true that sometimes we all do not get as prompt a response from a care provider as anyone would want. I can understand why you were annoyed.”)
3. Search for and validate the underlying unmet emotional need: The individual is trying to get a need met but may not know how to do so effectively (e.g. “I know it isn't easy for you to have to rely on other people when you have always been so independent”)





## Skills in Working with a “Complex Client”

### B. **COMMUNICATING** PROFESSIONALLY, SHARING CONTROL, FORMING AN ALLIANCE

4. Communicate limit-setting statements in a firm but matter-of-fact manner with an even tone of voice (e.g. “We don’t tolerate that kind of speech here”; “I’m leaving because I don’t feel comfortable, and will return at another time”)
5. Express your feelings in words rather than actions:  
(e.g. “When you do \_\_\_\_, it makes me/ others feel \_\_\_\_ which is not good for your care”)
6. Limit discussion of issues outside of your professional role (e.g. personal life, feelings about other caregivers, etc.)



## Skills in Working with a “Complex Client”

### C. **TEAM** APPROACH TO NEGOTIATING, LIMIT SETTING, AND PROBLEM SOLVING

1. Mobilize a “behavioral team” of care-providers to address problem behaviors
2. Develop a unified, cohesive approach to address these behaviors; work closely with the team to present a unified approach to the person with difficult behaviors
3. Problem solve with the client on behalf of the team:  
(e.g. “Is the approach you are taking getting you what you really want?”; “Have you considered a different approach?”)





## Skills in Working with a “Complex Client”

### C. **TEAM** APPROACH TO NEGOTIATING, LIMIT SETTING, AND PROBLEM SOLVING

4. Set clear limits, without punishment, mindful of the patient's point of view:  
(e.g. “You are entitled to the best care we can provide. In order for us to do that, you will need to....”)
5. Hang in there “when the going gets tough”: Maintain consistency as well as clear boundaries / limits: Complex clients benefit from consistent care providers, regularly scheduled contact
6. Bees and honey: Look for opportunities to “catch the client doing the right thing”, and provide incentives for this to continue
7. Mutual support by team members: “Call out” other care providers who are doing a great job with a complex client



## Skills in Working with a “Complex Client”

### D. STRATEGIES FOR MANAGING DIFFICULT CLIENTS TO BE CONSIDERED BY THE CARE PROVIDER **SYSTEM**

1. Psychology/ Psychiatry (or if dementia is present, Dementia Specialty Team) consult to evaluate for / document / suggest interventions for complex client behaviors
2. Mobilize the “behavior experts” on the to support and mentor front line care providers
3. Unified, cohesive team approach through regular “Behavior Care Planning Meetings”
4. Consider behavioral contracting as to expectations of the client and provider system
5. Consider a “Behavioral Crisis Command and Control Plan” if concerns for safety are present





## Summary: Managing the “Complex Client”

1. Complex Clients may have personality disorder, personality change due to a medical condition, or a Major Neurocognitive Disorder with Behavioral and Psychological Symptoms of Dementia
2. Interventions will not “cure” but can manage the complex behaviors
3. Skills front line care providers can use: The “ACT” approach
  - Accept that you need some emotional distance
  - Communicate in a manner that is professional, shares control, and forms an alliance
  - Team approach to negotiating, limit setting, and problem solving
4. Managing complex clients requires a system-wide approach

# Thank you!

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## PANEL HIGHLIGHT



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Psychiatry Unit*



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*Therapeutic  
Dementia Worker*



Julie Dennis, OT  
*Dementia  
Speciality Team*



Shelley King, LPN  
*Alzheimer  
Society of PEI*

**Decoding Behaviour Changes:**  
**Building Skills, Confidence and Connection**

# Case Study

## Client Profile:

Mrs. Thompson is an 82-year-old woman living at home with her husband. She was diagnosed with Alzheimer's disease five years ago. Mrs. Thompson is generally pleasant and enjoys sitting by the window watching the birds. She responds best to familiar voices and routines. She has a daughter who visits regularly.

## Current Challenges:

Recently, staff have noticed an increase in what are often referred to as responsive *behaviors*:

**Bathing & personal care:** Mrs. Thompson has been consistently refusing baths. When approached by staff, she seems anxious, waves her hands to push them away, and occasionally yells "No!" loudly. Attempts to persuade her often escalate her distress.

**Displaying Anxious behaviour:** Mrs. Thompson repeatedly asking for spouse, is restless and asks to leave, does not want to engage with me as a care provider, can be teary or express anger/frustration.

**Social Interaction (LTC transition):** Mrs. Thompson has begun seeking touch that is unwelcome, holding hands with other residents, sometimes lingering or seeking physical contact in ways that make other residents uncomfortable. While she is not aggressive, her actions have caused tension with her peers and concern from staff.



# Case Study

## **Impact:**

Staff are struggling to maintain her hygiene without causing distress.

Home care staff feel stressed because the client is in distress, and they are not able to help. She is less able to participate in activities or connection because she is looking for her husband, or seeking to leave.

Her interactions with other residents have created some social challenges in the LTC home.

Her daughter, who visits daily, has expressed concern and guilt, feeling that her mother is suffering.

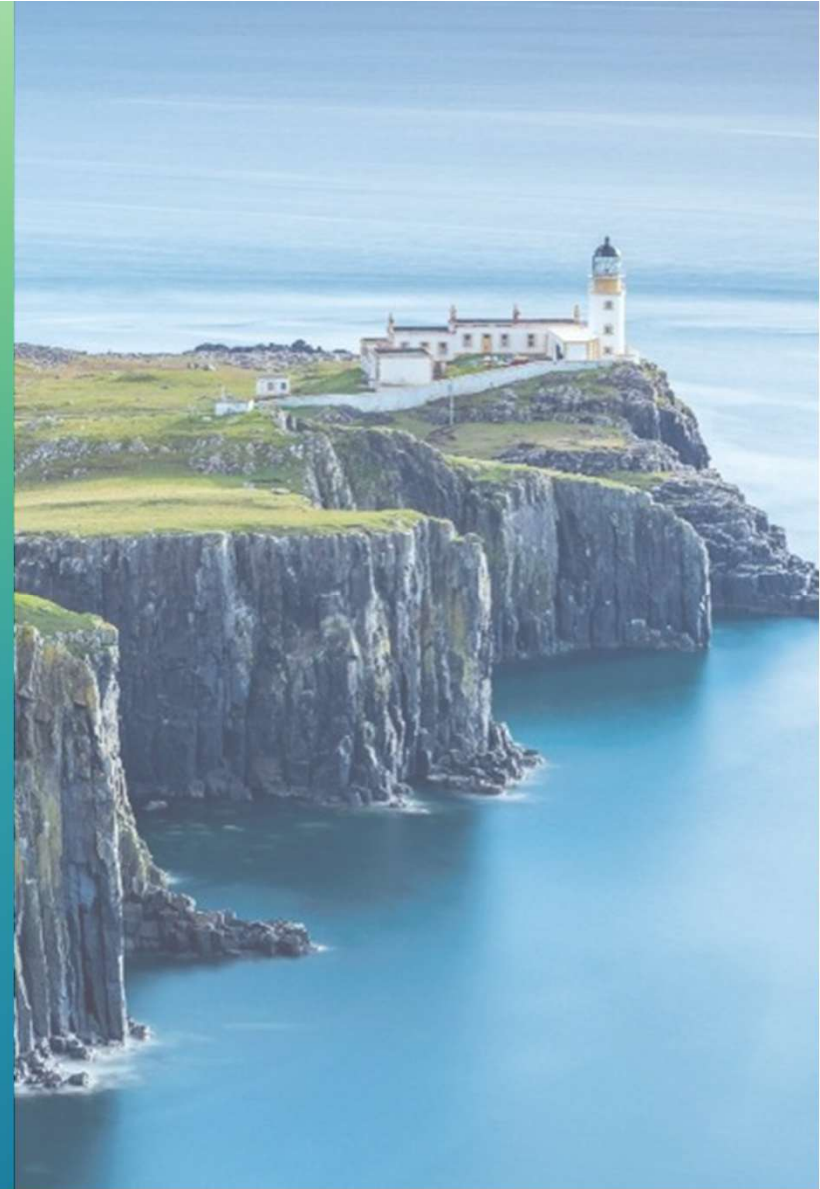


- **Alzheimer Society of PEI**  
Website: [www.alzpei.ca](http://www.alzpei.ca)
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- (902) 628-2257  
1-866-628-2257 (toll-free)
- **Health PEI**
- Provincial Patient Navigator:  
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Email: [patientnavigator@gov.pe.ca](mailto:patientnavigator@gov.pe.ca)
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- **Dementia Specialty Team (DST)**  
(902) 432-2860  
Email: [geriatricinfo@ihis.org](mailto:geriatricinfo@ihis.org)



# Understanding Trauma-Informed Care:

Compassionate Practices  
in Dementia Care



# Goals of this Workshop:



# Goals:

Terms Re-fresh

Rationale Reminder

Application and Implementation

# Key Terms:

Trauma

Trauma Response



# Trauma Responses

AND HOW THEY CAN SHOW UP IN YOUR LIFE WHEN STRESSED

## Fight

- Increased Irritability
- Anger Outburst
- Assertively Critical of Others
- Seeks Power and Control
- Impulsive Decision Making
- Inability to Hear other POVs

## Flight

- Hyperactive, Avoidant
- Always 'busy' or on the go
- Constant Overthinking
- Increased Anxiety, Panic
- Perfectionistic Tendencies
- Overworking or 'Workaholic'

## Freeze

- Feeling Detached, Lifeless
- Feeling Physically Stuck
- Difficulty Making Decisions
- Dissociation or 'Spacing Out'
- Self-Isolation, Avoidance
- Depression, Feeling Low
- Feelings of Shame

## Fawn

- Feeling Overwhelmed
- Lack of Boundaries
- Often Codependent
- Low Self-Esteem
- Lack of Identity
- People-Pleasing Behavior
- Easily Exploited by Others

# Key Terms:

Trauma

Trauma Response

Trigger

# Rationale:

Safety

Trust

Support

Cooperation

Empowerment

Respect



# Application:

- a) Awareness and empathy to the impact of trauma
- b) Recognize symptoms of trauma
- c) Apply/Adapt procedures with trauma in mind
- d) Avoid re-traumatization

# Application Strategies:

Self-Care contributes to empathy, patience, and skills.

Practice Observing Clues or Bids

Communicate to Build Trust

# Resources:

[https://brainxchange.ca/Public/Special-Pages/BSO/Files/My-Personhood-Summary/Trauma-Informed-Care-persons\\_with\\_dementia\\_etc.aspx](https://brainxchange.ca/Public/Special-Pages/BSO/Files/My-Personhood-Summary/Trauma-Informed-Care-persons_with_dementia_etc.aspx)

<https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/>

<https://traumainformedoregon.org/resources/new-to-trauma-informed-care/trauma-informed-care-principles/>



# Depression AND Dementia - a 2 WAY STREET Assessment and Treatment



2025 Alzheimer's Awareness  
Conference – September 16, 2025

Charlottetown, PEI

Robyn Waxman MD FRCPC



# Disclosure/Conflicts

- None to Declare

# My Inspiration





## Which direction is it...

"Basically there are 2 lines of thought on this...The first is that depression is a risk factor for dementia, and the second is that depression is merely a consequence of the disease or a symptom of dementia."

Dr. Saczynski

## Objectives



- To review the diagnoses of dementia and depression
- To examine the relationship between depression and dementia
- To highlight the unique issues with respect to a diagnosis of depression in dementia

## MCQ: Depression in old age:

- A) Is more prevalent in women than men
- B) Prevalence rates rise sharply with age
- C) It is accompanied by a lower suicide risk than younger adults
- D) Is unresponsive to treatment in half of the cases



## CASE#1 - Mrs. B

### Is this a recurrence of Depression or Early Dementia??

- 83 year old widow
- Longstanding history of depression
- Worsening mood and increased anxiety over past year
- Subjectively feels memory is worsening as well, objectively some deterioration
- Calling 911 due to non-specific anxiety – unable to manage at home – no medical condition found
- MMSE - 27/30

# What is Depression? = Major Depressive Disorder

- Depressed Mood and/or loss of interest/pleasure + 4 or more of the following for 2 weeks:
- Change in sleep, feelings of worthlessness/guilt, decreased energy, decreased concentration/difficulties making decisions, change in appetite/weight, psychomotor retardation/agitation, suicidal ideation
- **Elderly:** more somatic complaints, may not look depressed, anxiety or “bad nerves”, more psychosis, loss of interest replaces depressed mood

# Depression - Who is at Risk?

- history of depression
  - Female
  - medical co-morbidities
  - chronic pain
  - family history
  - poor social supports or isolation
  - substance use
  - Dementia
  - recent loss
- 
- 2-4 % with major depression and up to 15% with significant depressive symptoms, increases to up to 35 % in LTCH or hospitalized patients





# Medical disorders associated with depression

- Occult malignancy
- Infectious process (HIV, Syphilis)
- Thyroid Dysfunction
- Cushing's syndrome
- Addison's disease
- Diabetes Mellitus
- Neurologic conditions such as Parkinson's or Huntington's
- CHF
- Cerebrovascular/Cardiovascular



# Medications associated with depression

- Medications with a **probable** association:
  - Anabolic steroids
  - Interferons
  - Isotretinoin
  - Systemic corticosteroids
  - Substances of abuse: alcohol, amphetamines, barbiturates, benzodiazepines, cocaine, hallucinogens, narcotics
  - Oral contraceptives
  - Certain anticonvulsant drugs (vigabatrin, clobazam, phenobarbital)
- **Possible** - antihypertensives



# WHO IS AT RISK OF SUICIDE?

- Over age 70  
(30/100,000)
- Men
- Psychiatric diagnosis
- Previous attempts
- Physical illness
- Social isolation  
(bereavement)
- Substance use
- Organized Plan
- Persistent Agitation
- Family history of  
suicide
- Access to lethal means
- Psychosis



## Why is it Important to Diagnose Depression?

- Increased use of health services
- 2 X length of time in hospital
- Worsens prognosis of other conditions
- Reductions in quality of life, functionality, relationships

# Depression Rating Scales

- For Elderly – Geriatric Depression Scale (GDS)

Choose the best answer for how you felt over the past week. **YES** or **NO**

1. Are you basically satisfied with your life? **Yes/NO**
  2. Have you dropped many of your activities and interests? **YES/no**
  3. Do you feel that your life is empty? **YES/no**
  4. Do you often get bored? **YES/no**
  5. Are you in good spirits most of the time? **Yes/NO**
  6. Are you afraid that something bad is going to happen to you? **YES/no**
  7. Do you feel happy most of the time? **Yes/NO**
  8. Do you often feel helpless? **YES/no**
  9. Do you prefer to stay at home, rather than going out and doing new things?  
**YES/no**
  10. Do you feel you have more problems with memory than most? **YES/no**
  11. Do you think it is wonderful to be alive now? **Yes/NO**
  12. Do you feel pretty worthless the way you are now? **YES/no**
  13. Do you feel full of energy? **Yes/NO**
  14. Do you feel that your situation is hopeless? **YES/no**
  15. Do you think that most people are better off than you are? **YES/no**
- Score 1 point for each bolded answer. Cut-off: normal (0-5), above 5 suggests depression, > 10 = probable depression**

## Case #2 - Mrs. J

Do we still Treat this as a  
'Depression' now that she has an  
established Dementia???

- 86 year old widow
- Long standing history of depression
- Lives in a LTCH
- Several year history of progressive cognitive decline
- MMSE 15/30 – fully dependent for IADLS, some assistance with ADLs
- Says “I am depressed. I want to die”
- Refuses to eat, losing weight, hearing voices telling her to die

# Dementia

## WHAT IS DEMENTIA? = Major Neurocognitive Disorder

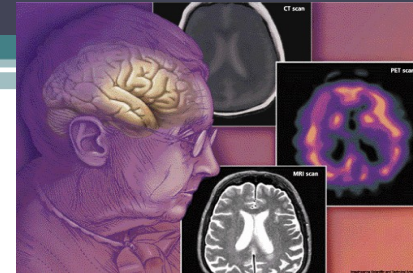
- Evidence of significant **cognitive decline** from a previous level of performance **in one or more areas** of cognitive domains based on :
  1. Concern of the individual, a knowledgeable informant or the clinician re: a significant decline in cognitive function; and
  2. substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or another quantified clinical assessment.
- Impairment in social/occupational functioning and is a decline from previous functioning AND Not due to Delirium and rule out reversible causes

## WHAT ARE ASSOCIATED FEATURES?

- BPSD – Behavioural and Psychological Symptoms of Dementia: Apathy, aggression, depression, self harm, psychotic symptoms



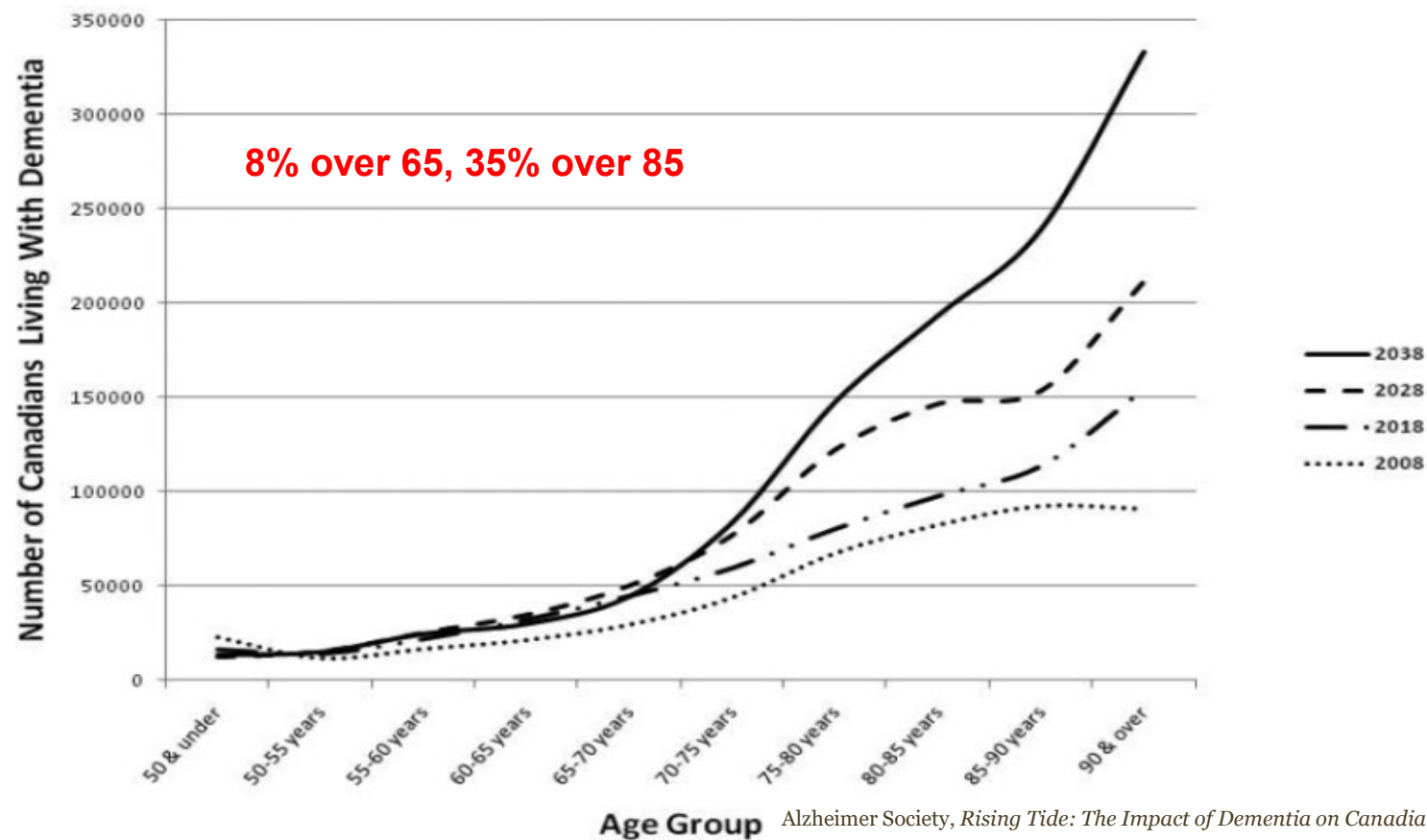
# Cognitive Domains



- **Complex attention:** patient has increased difficulty in environments with multiple stimuli (TV, radio, conversation). Has difficulty holding new information in mind (recalling phone numbers, or addresses just given or reporting what was just said).
- **Executive function:** patient is not able to perform complex projects. Needs to rely on others to plan instrumental activities of daily living.
- **Learning and memory:** patient repeats self in conversation, often within the same conversation. Cannot keep track of short list of items when shopping or of plans for the day. Requires frequent reminders.
- **Language:** patient has significant difficulties with expressive or receptive language. Often uses general terms such as “that thing” and “you know what I mean”. With severe impairment may not even recall names of closer friends and family.
- **Perceptual – Motor:** Has significant difficulties with previously familiar activities (using tools, driving motor vehicle) , navigating in familiar environments
- **Social cognition:** patient may change changes in behavior ( shows insensitivity to social standards). Makes decisions without regard to safety. Usually little insight.

## Current and Future Dementia Prevalence in Canada, Males and Females, All Age Groups: 2008 - 2038

Prevalence of Dementia in Canada by Age Group 2008 to 2038



## MCQ: Which is NOT a risk factor for Dementia?

- A) High Educational Achievement
- B) Diabetes
- C) Head Injury
- D) High Cholesterol
- E) Down's Syndrome

# RISK FACTORS

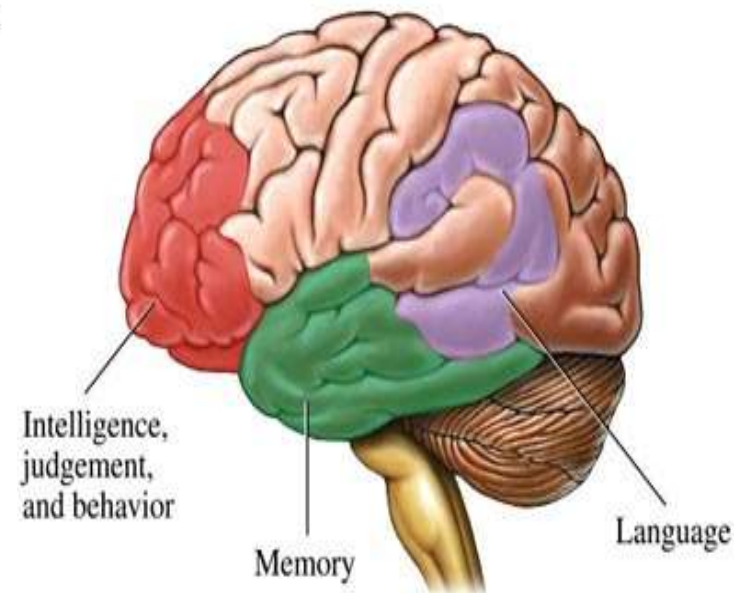
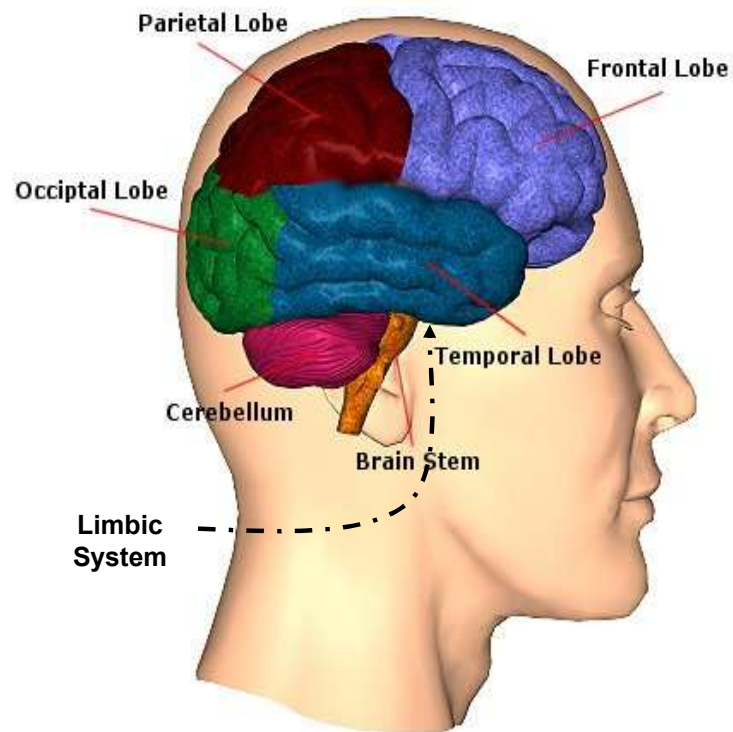
|                      | Population prevalence | Relative risk (95% CI) | PAR (confidence range) | Number of cases attributable (thousands; confidence range) |
|----------------------|-----------------------|------------------------|------------------------|------------------------------------------------------------|
| <b>Worldwide</b>     |                       |                        |                        |                                                            |
| Diabetes mellitus    | 6.4%                  | 1.39 (1.17–1.66)       | 2.4% (1.1–4.1)         | 826 (365–1374)                                             |
| Midlife hypertension | 8.9%                  | 1.61 (1.16–2.24)       | 5.1% (1.4–9.9)         | 1746 (476–3369)                                            |
| Midlife obesity      | 3.4%                  | 1.60 (1.34–1.92)       | 2.0% (1.1–3.0)         | 678 (387–1028)                                             |
| Depression           | 13.2%                 | 1.90 (1.55–2.33)       | 10.6% (6.8–14.9)       | 3600 (2295–5063)                                           |
| Physical inactivity  | 17.7%                 | 1.82 (1.19–2.78)       | 12.7% (3.3–24.0)       | 4297 (1103–8122)                                           |
| Smoking              | 27.4%                 | 1.59 (1.15–2.20)       | 13.9% (3.9–24.7)       | 4718 (1338–8388)                                           |
| Low education        | 40.0%                 | 1.59 (1.35–1.86)       | 19.1% (12.3–25.6)      | 6473 (4163–8677)                                           |
| Combined (maximum)   | --                    | --                     | 50.7%                  | 17 187 028*                                                |
| <b>USA</b>           |                       |                        |                        |                                                            |
| Diabetes mellitus    | 8.7%                  | 1.39 (1.17–1.66)       | 3.3% (1.5–5.4)         | 174 (77–288)                                               |
| Midlife hypertension | 14.3%                 | 1.61 (1.16–2.24)       | 8.0% (2.2–15.1)        | 425 (119–798)                                              |
| Midlife obesity      | 13.1%                 | 1.60 (1.34–1.92)       | 7.3% (4.3–10.8)        | 386 (226–570)                                              |
| Depression           | 19.2%                 | 1.90 (1.55–2.33)       | 14.7% (9.6–20.3)       | 781 (506–1078)                                             |
| Physical inactivity  | 32.5%                 | 1.82 (1.19–2.78)       | 21.0% (5.8–36.6)       | 1115 (308–1942)                                            |
| Smoking              | 20.6%                 | 1.59 (1.15–2.20)       | 10.8% (3.0–19.8)       | 574 (159–1050)                                             |
| Low education        | 13.3%                 | 1.59 (1.35–1.86)       | 7.3% (4.4–10.3)        | 386 (236–544)                                              |
| Combined (maximum)   | --                    | --                     | 54.1%                  | 2 866 951*                                                 |

PAR=population attributable risk. \*Absolute number.

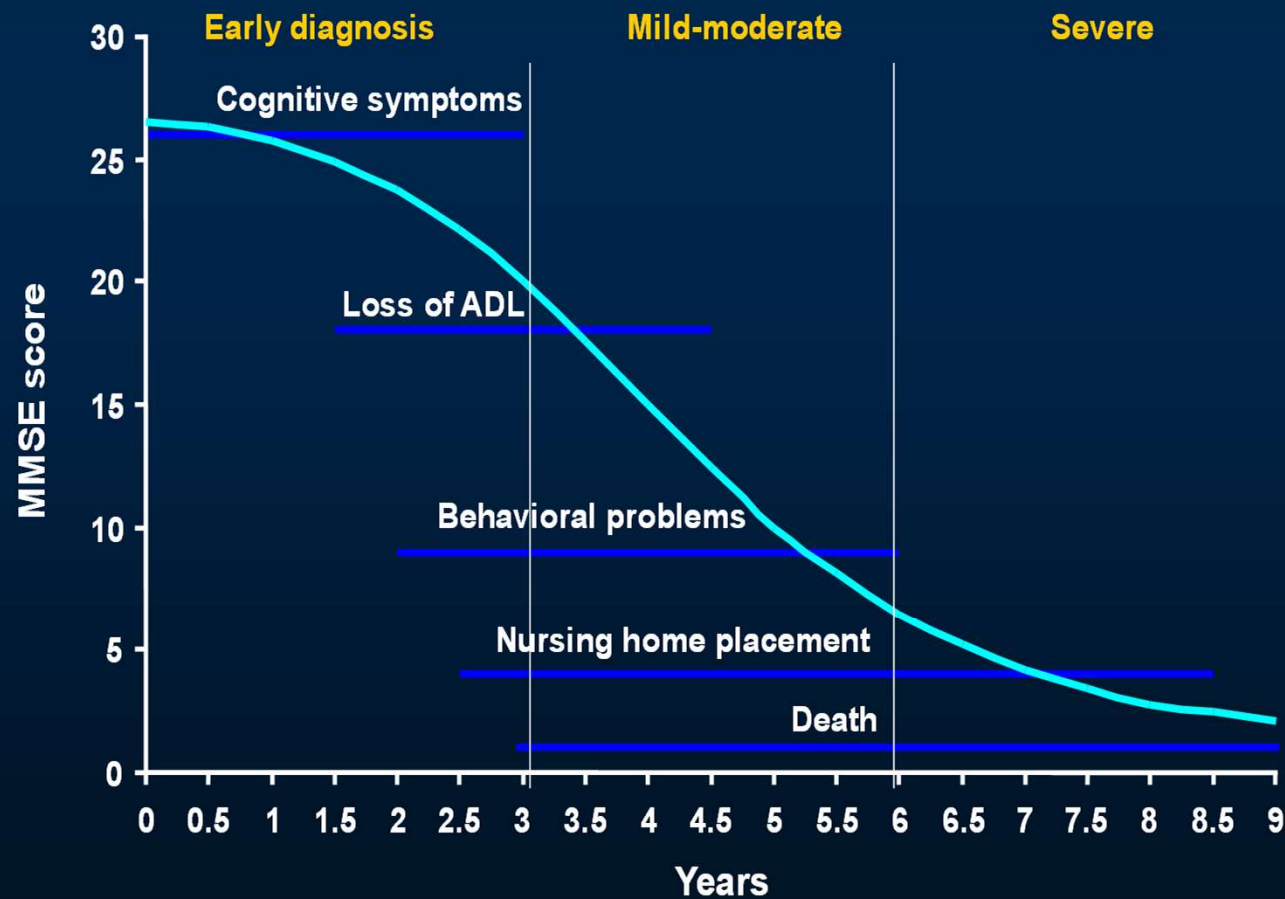
**Table: Alzheimer's disease cases attributable to potentially modifiable risk factors worldwide and in the USA**



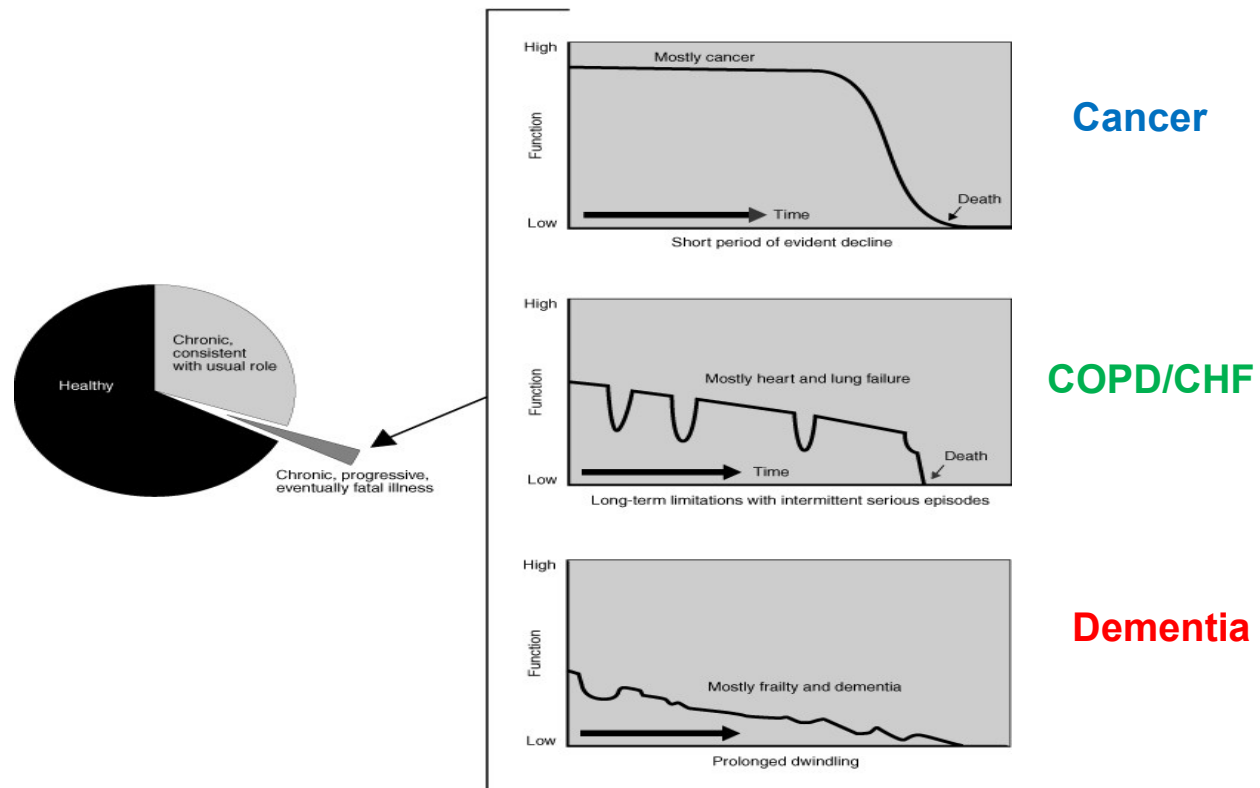
# Types of Dementia



# The Progression of Alzheimer's Disease



# Course of Illness



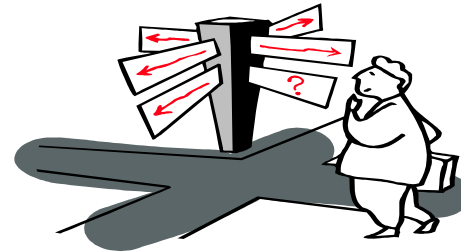


Dementia and Depression in late life - are they the same thing???

- NO!
- But there are lots of connections...



# Which Direction?



Depression



Dementia

Dementia



Depression

Depression + Y

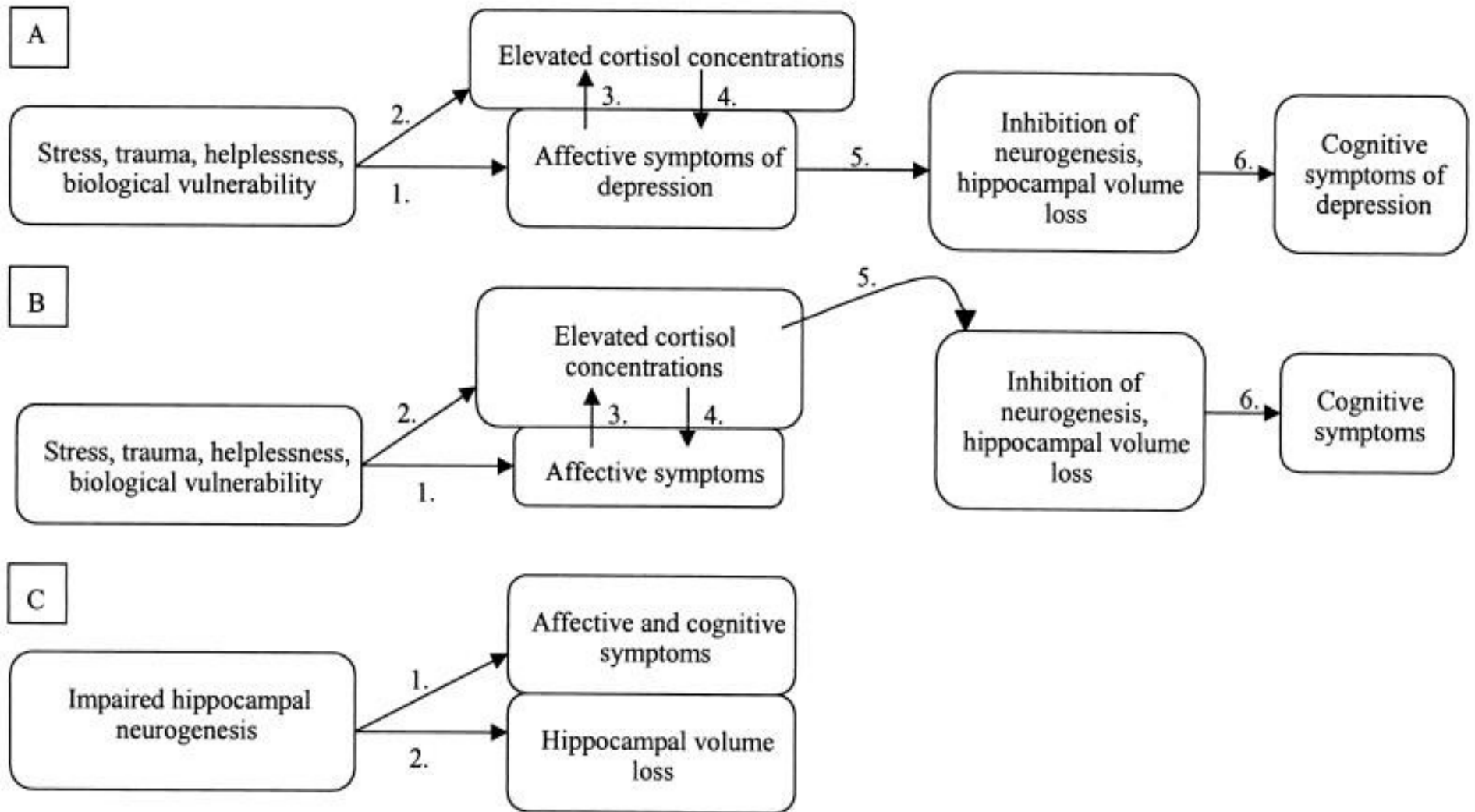


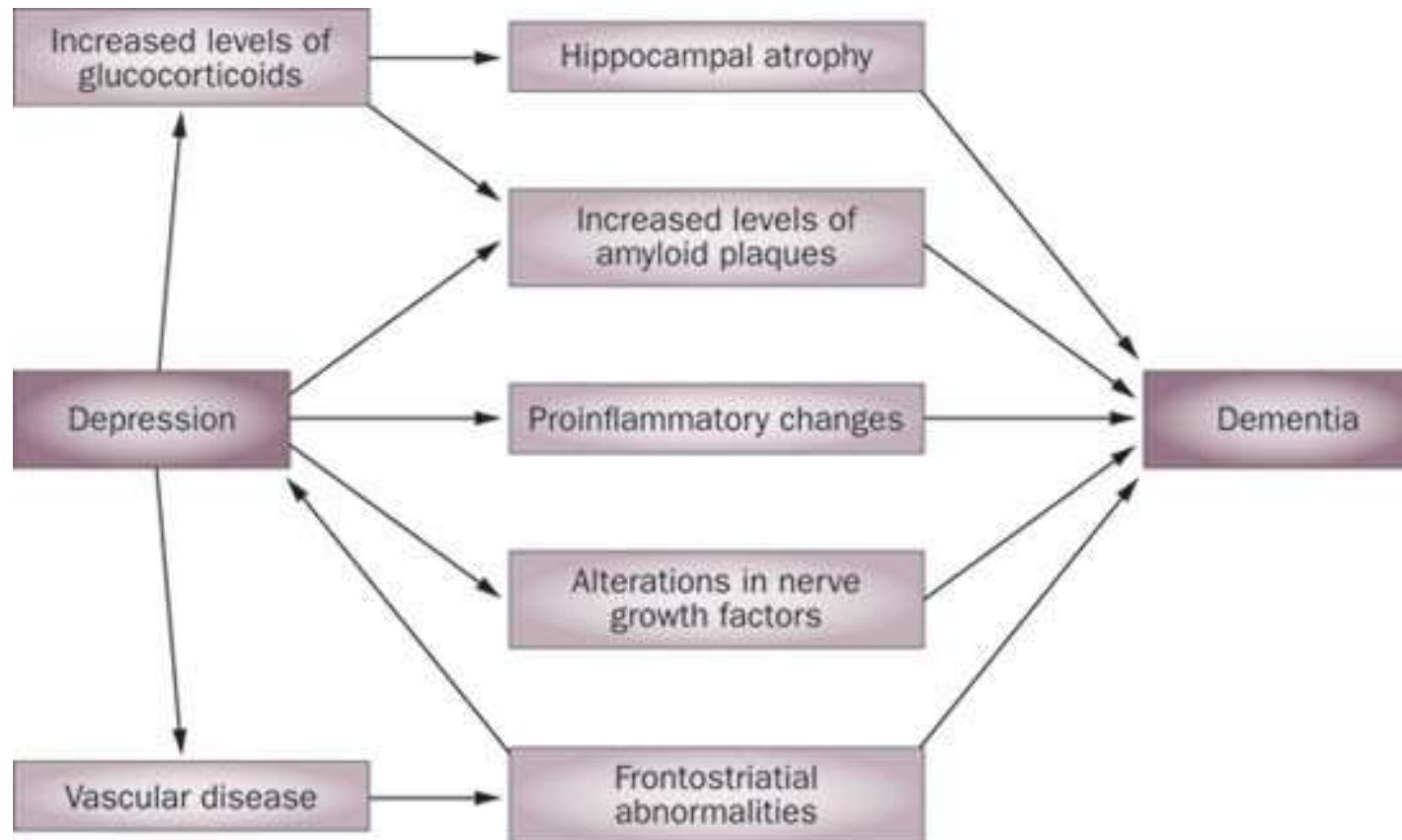
Dementia

Depression



Dementia





**Depression and risk of developing dementia**

Amy L. Byers & Kristine Yaffe *Nature Reviews Neurology* volume 7, pages 323–331 (2011)

## What are the connections?

- Neurological/Structural
- Biochemical
- Psychosocial





## Research that Supports a Connection...

- 3410 participants 7 years later – 658 developed dementia (19.3%)
- Baseline - 9.4% of participants had presence of significant depressive symptoms, and 21.2% reported a history of depression.
- The adjusted hazard ratio for dementia associated with baseline depressive symptoms was 1.71
- Those with **late-life** depression were at increased dementia risk but **early-life** depression had no association with dementia risk
- **Conclusion:** This study confirmed that late-life depression is associated with increased risk of dementia and may be an early manifestation of dementia rather than increasing risk for dementia.

# Association of Early-, Middle-, and Late-Life Depression With Incident Dementia in a Danish Cohort - July 2023 in JAMA Neurology

Holly Elser, MD, PhD<sup>1,2</sup> et al

## **Findings:**

Population cohort study of more than 1.4 million adult Danish citizens followed up from 1977 to 2018

The risk of dementia more than doubled for both men and women with diagnosed depression and was **higher for men** than women

The risk of dementia persisted whether depression was diagnosed in early, middle, or late life.

*JAMA Neurol.* 2023;80(9):949-958. doi:10.1001/jamaneurol.2023.2309

# The Connection between Depression and Dementia

## ❖ NEUROLOGICAL/STRUCTURAL

- **Brain Imaging:**

An increase in the number and/or severity of signal hyperintensities in the white matter in depression - periventricular, basal ganglia, and pons (Rabins *et al*, 1991; O'Brien *et al*, 1996).

- Fronto-striatal pattern – frontal lobe to basal ganglia
- Reduced volumes of the hippocampus in both Alzheimer's Disease and recurrent major depressive disorder



**Healthy brain**



**Hippocampal Atrophy**



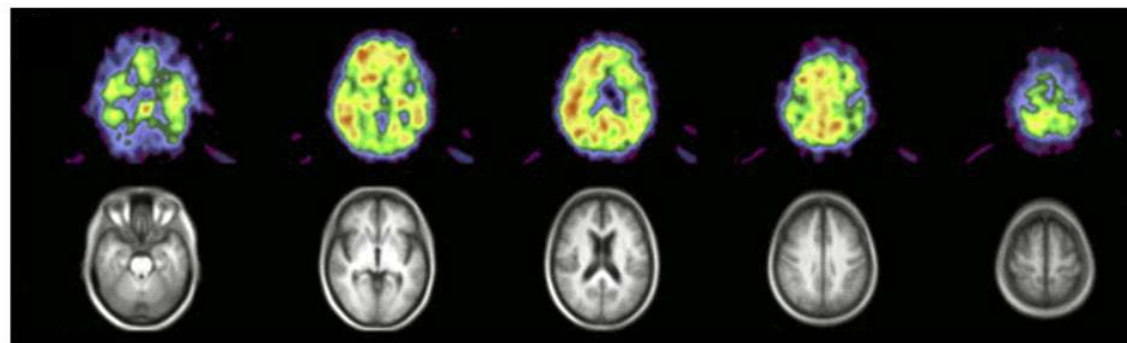
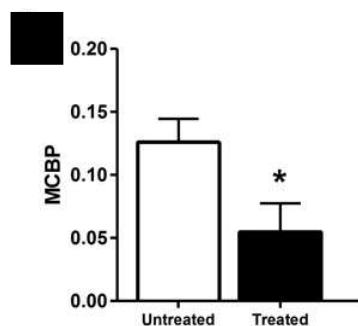
# The Connection between Depression and Dementia

## ❖ **BIOCHEMICAL**

- Inflammation – depression activates pro-inflammatory mediators  
– cerebral small vessel disease with reduction in blood flow  
(Antidepressants can reduce these markers)
- Amyloid Beta – 42 – part of plaques found in Alzheimer's Disease  
– lower levels in the CSF in patients with depression may indicate higher levels in the brain

# Antidepressant use associated with lower amyloid- $\beta$ in humans

- Retrospective analysis of PET scans
- Older adults with antidepressant treatment in the past 5 years showed less amyloid- $\beta$  accumulation
- Longer treatment time correlated with lower amyloid- $\beta$  burden



Cirrito et al, *PNAS*, 2011.

# The Connection between Depression and Dementia

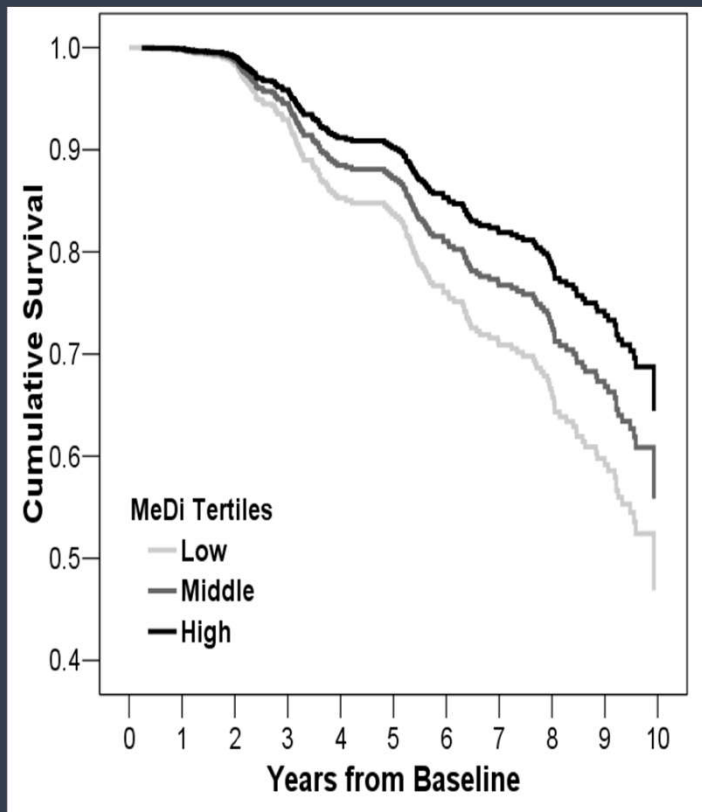
## ❖ **PSYCHOSOCIAL**

- Lifestyle factors: Diet, Exercise, Smoking, social interaction, sleep habits
- Loss of independence and awareness of cognitive changes



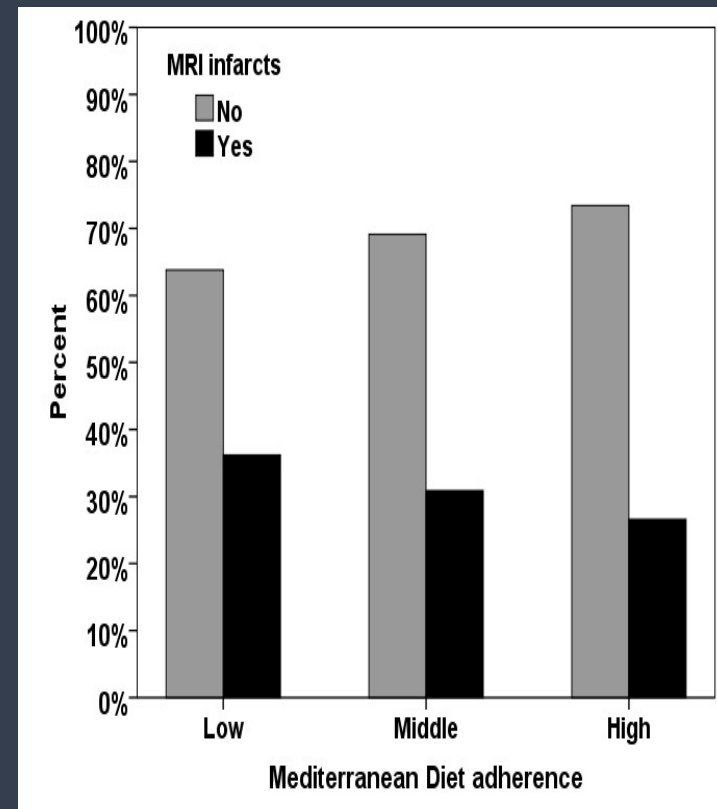
# Mediterranean Diet May be Protective

**Risk of AD decreases with increased Mediterranean diet**



Scarmeas et al, *Ann Neurology*, 2006.

**MRI infarcts decrease with increased diet adherence**



Scarmeas N, *AAN Presentation*, 2010.



# Pseudodementia - What is this?

- Term coined by Leslie Kiloh – clinical phenomenon of patients with cognitive symptoms that improved with treatment
- Is this still a useful term?
- Cognitive deficits sometimes persist even with treatment of depression...
- Is this just a marker of dementia to come?

# Depression-Impact on Dementia

- Major Depression afflicts 20-25 % of patients and occurs at all severities of dementia
- More functional impairment, agitation, caregiver burden vs. dementia without depression
- 1/3 with depression do not improve with antidepressant therapy

## Back to Mrs. B and Mrs. J

- **Mrs. B** – MILD - interface of depression and dementia;  
Start of dementing process presented with  
worsening of depressive and anxiety symptoms  
– memory issues were more in keeping with  
dementia process
- **Mrs. J** – MODERATE - had an established dementia - developed  
a depressive episode once admitted to LTC – aggression and  
psychotic symptoms

## Depression Vs. Dementia

|                                  | Depression                                                                                   | Dementia                                                                               |
|----------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <b>Affect/mood/<br/>demeanor</b> | Pervasive sadness,<br>negativity, lack of interest,<br>tearful                               | Blunting, flat, not tearful                                                            |
| <b>Memory</b>                    | Poor concentration and poor<br>effort on testing                                             | Progressive impairment of<br>short-term memory –<br>repetitive, misplacing objects     |
| <b>Function</b>                  | Functional ability diminished<br>by lack of motivation, lack of<br>energy, negative thinking | Instrumental activities of daily<br>living decline, then activities<br>of daily living |
| <b>Organization</b>              | Impaired decision making                                                                     | Impaired executive function<br>(e.g. organization,<br>prioritization)                  |



## Depression Vs. Dementia

|                                            | Depression                                                     | Dementia                                                       |
|--------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|
| <b>Thinking/reasoning/ability to learn</b> | Slow thinking and reasoning, Ability to learn is retained      | Impairment                                                     |
| <b>Safety issues</b>                       | Possible suicide and poor nutrition                            | Safety concerns because of impaired judgment                   |
| <b>Somatic complaints/pain</b>             | Possible multiple or exaggerated somatic complaints<br>Fatigue | May be underreported – portrayed as behavioural symptoms       |
| <b>Depression screening tool</b>           | Geriatric Depression Scale                                     | Cognitive Testing – MMSE and clock<br>Cornell (R/O depression) |

## Mr. C

- 10 year history of dementia
- MMSE – ZERO
- Fully dependent for ADLs
- Admitted to hospital for management of aggression in context of dementia of the alzheimer's type
- Appears depressed, in distress, suspicious of others

# Depression in Dementia

- Prevalence : 17–35% have depression in severe dementia (Lazarus et al., 1987; Rovner et al., 1989; Lebert et al., 1996).
- Depression is more frequent among hospitalized patients, and seems to appear independently of the severity of dementia (Lebert et al., 1996; Marin et al., 1997).
- Teri et al. (1999) reported that depression was found to be related to anxiety in 54% of cases.
- Depression, even when severe, often has an atypical presentation and must be considered as a possibility whenever patient's behaviour changes subacutely.
- The mode of presentation may be an inversion of the day/ night cycle, aggressiveness or agitation.

## Depression in Severe Dementia

- ★National Institute for Mental Health - Modified DSM-IV diagnosis - 3 or more symptoms (vs. 5 or more), Less pervasiveness of symptoms, presence of irritability and social withdrawal or isolation (validity of NIMH criteria yet to be established)
- ★Psychosocial - 1 trial used exercise for patients and education for caregivers about behaviour modifying techniques ➡ improved modestly ratings of disability, depression and physical functioning - up to 2 years

# Screening Tool: Cornell Scale for Depression in Dementia (CSDD)

Scoring System: a = unable to evaluate  
0 = absent  
1 = mild or intermittent  
2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview.  
No score should be given if symptoms result from physical disability or illness.

## A. Mood-Related Signs

|                                                         |   |   |   |   |
|---------------------------------------------------------|---|---|---|---|
| 1. Anxiety<br>anxious expression, ruminations, worrying | a | 0 | 1 | 2 |
| 2. Sadness<br>sad expression, sad voice, tearfulness    | a | 0 | 1 | 2 |
| 3. Lack of reactivity to pleasant events                | a | 0 | 1 | 2 |
| 4. Irritability<br>easily annoyed, short-tempered       | a | 0 | 1 | 2 |

Behavioural Disturbance, Physical Signs,  
Cyclic Functions, Ideational Disturbance



#### **Box 4: Management of depression in patients with severe Alzheimer disease**

- Selective serotonin reuptake inhibitors can be used to treat severe depression (grade B recommendation, level 3 evidence)
- If behavioural disturbances fail to improve after appropriate nonpharmacologic and pharmacologic interventions, the patient should be referred to a specialty service (grade B recommendation, level 3 evidence)

**MODIFIED: SPECIAL POPULATIONS: DEMENTIA**

**UNCHANGED:** Patients who have mild depressive symptoms or symptoms of short duration should be treated with psychosocial supportive interventions first. [D]

**MODIFIED:** There is limited evidence to recommend antidepressant therapy for mild or moderate depression associated with dementia at this time. Behavioural interventions may be utilized as a first-line intervention and antidepressant medication could be offered if symptoms are severe and persistent, understanding that efficacy is not well established and that side effects could occur. [D]

A number of meta-analyses and systematic reviews have investigated the efficacy of antidepressants for depression associated with dementia. The initial Cochrane review in 2002 was negative (Bains et al., 2002). This was followed by a positive meta-analysis of 5 studies, which showed a NNT of 5 to achieve remission (Thompson et al., 2007). Subsequently, 4 more meta-analyses, including another Cochrane review in 2018, were negative (Nelson et al., 2011, Sepehry et al., 2012, Orgeta et al., 2017, Dudas et al., 2018). We would still suggest that antidepressant medication could be offered if symptoms are severe and persistent.

# How to Approach Depression

- Safety First!!
- Screen for suicidal thoughts:  
“Do you feel like life is not worth living” and  
“Do you have a plan of how you would end your life?”
- If imminent safety concerns, hospitalize,  
THEN

**BioPsychosocial Approach!**



BioPsychoSocial Approach

For **understanding** of Depression

**AND**

For **Treatment** of Depression

# BioPsychoSocial - Understanding

- **BIOLOGY:** family history, medical conditions, medications, past history, developmental (temperament), dementia (type)
- **PSYCHOLOGICAL:** early attachments to caregivers, self esteem, relationship history, ability to trust others, emotional regulation
- **SOCIAL:** losses in life, transitions, marital status, financial status, social supports



# BioPsychoSocial Treatment

- **BIOLOGICAL** – medical work up (Cbc, lytes, renal, liver, TSH, calcium, magnesium, vitamin B12, ferritin) + Pharmacotherapy (SSRIs, SNRIs, TCAs) + Brain stimulation techniques (ECT, rTMS)
- **PSYCHOLOGICAL** – Therapeutic Alliance, psychotherapy (CBT, IPT, supportive)
- **SOCIAL** – community supports? Living situation, family, resources, senior centers

## Antidepressants - Are they effective in Dementia?

Sertraline or mirtazapine for depression in dementia  
(HTA-SADD): a randomised, multicentre, double-blind,  
placebo-controlled trial

Not shown to be effective....

**BUT**

Used Cornell depression scale – a Screening tool,  
NOT diagnostic

Low threshold for inclusion – antidepressants may  
not work as well for milder forms of depression

# Electroconvulsive therapy (ECT)

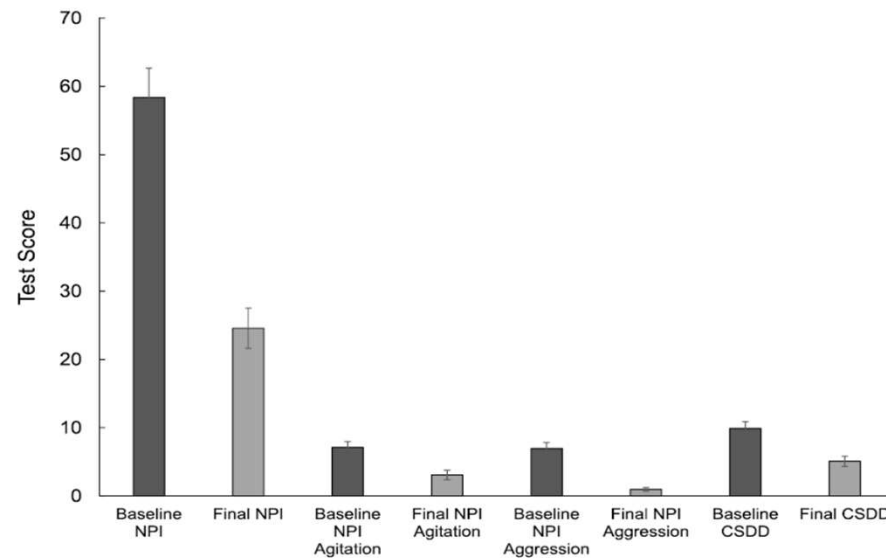
- The most effective treatment in psychiatry
- Well tolerated, SAFE in the elderly
- 80% remission for depression
- Cognition can Improve after ECT
- Ontario Shores Study



# Electroconvulsive Therapy for Neuropsychiatric Symptoms due to Major Neurocognitive Disorder

## *A Prospective, Observational Study*

*Peter Chan, MD, FRCPC, DISAM,\*† Robyn E. Waxman, MD, FRCPC,‡§ Simon Woo, MD, FRCPC,\*||  
 Claire Docherty, MB, BCh, BAO, FRCPC,\* Kaveh Rayani, PhD,¶ Ilan Fischler, MD, FRCPC,‡#  
 Omar Ghaffar, MSc, MD, FRCPC,‡\*\* and Sarah Elmi, MD, FRCPC,‡§*



**FIGURE 1.** Comparison of baseline and posttreatment scores. The average score for each test administered is shown at baseline and after treatment. Standard error of the mean bars is displayed to allow for comparison between groups. The average score obtained for each baseline condition was significantly greater than the final score  $P < 0.05$ .



#### CASE REPORT

## Efficacy and safety of maintenance electroconvulsive therapy for sustaining resolution of severe aggression in a major neurocognitive disorder

Melanie Isabella Selvadurai,<sup>1,2</sup> Robyn Waxman,<sup>2</sup> Omar Ghaffar,<sup>2</sup> Ilan Fischler<sup>2</sup>

### Learning points

- ▶ Alternating between acute and maintenance electroconvulsive therapy (M-ECT) dependent on patient symptomatology may be a good therapeutic option for treatment-resistant behavioural and psychological symptoms of dementia (BPSD) to sustain improvements in the long term.
- ▶ Tapering ECT frequency slowly over several weeks to months can prevent relapse of BPSD.
- ▶ Bilateral ECT can be well tolerated for a patient with a progressive major neurocognitive disorder.
- ▶ Symptom burden should be measured in the long term to ensure effectiveness of M-ECT.



## Take Home Points!

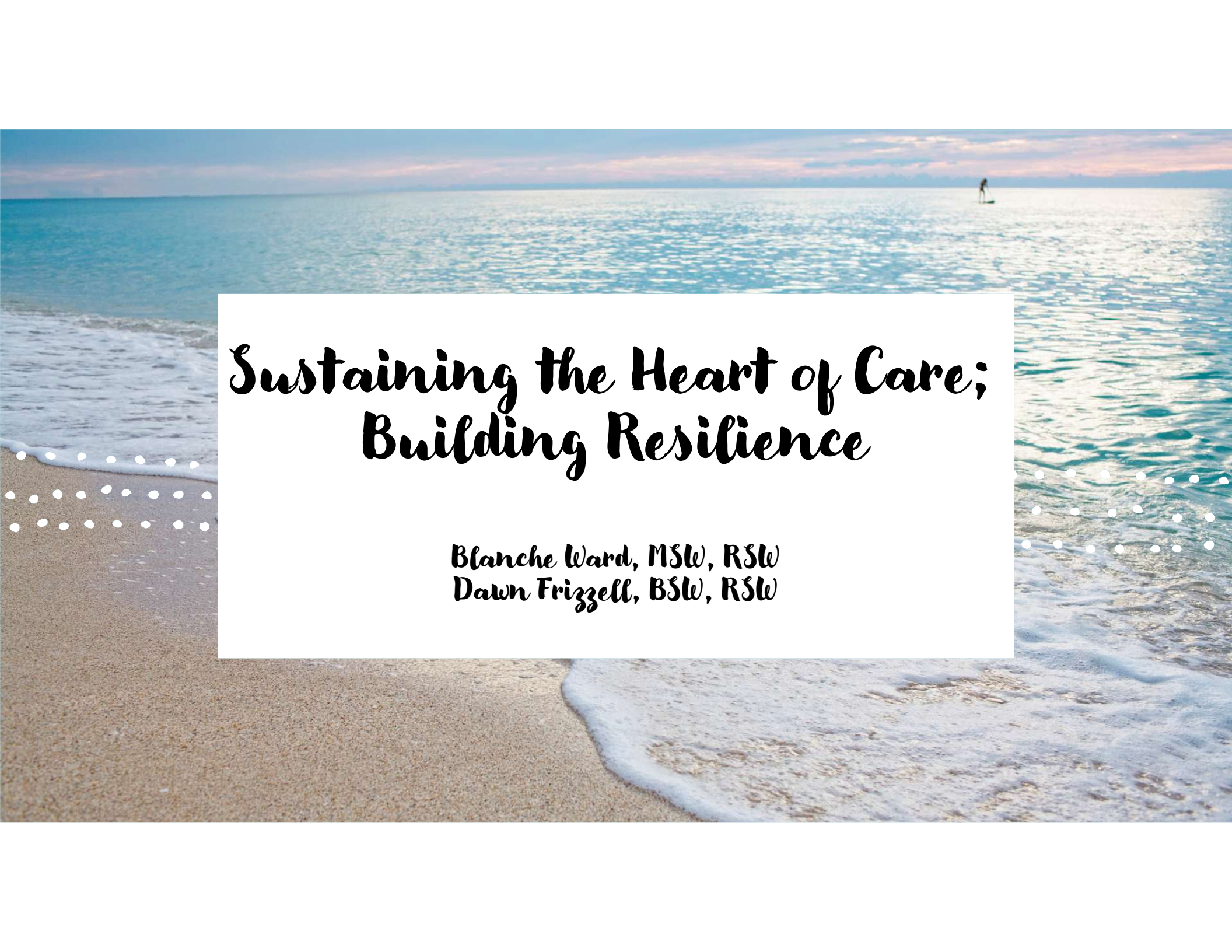


- Depression and Dementia in Late life are Distinct Clinical Syndromes with common risk factors
- Depression is common IN Dementia
- Depression at any time in life is a risk factor for development of Dementia – treating depression aggressively can modify this risk

# Thank you!

- Questions?





# *Sustaining the Heart of Care; Building Resilience*

*Blanche Ward, MSW, RSW  
Dawn Frizzell, BSW, RSW*

# Agenda

- Ways to reduce stress and anxiety while caring for patients
- Burnout and Compassion Fatigue
- Dealing with Ambiguous Loss
- Building Resiliency; what is it?
- Staying well while caring for others



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*What are some of your unique challenges working with Alzheimer's patients and their families?*





*What are some of  
the wins/rewards in  
working with this  
population?*



*What's the first word that comes to mind upon hearing stress, burnout and compassion fatigue?*

# Caregiver Stress - Signs

- Becoming easily irritated or angry
- Feeling overwhelmed or constantly worrying
- Experience periods of high blood pressure
- Grinding your teeth at night
- Having difficulty sleeping
- Being forgetful
- Heart palpitations/rhythms
- Trouble concentration
- Frequent headaches, body pains
- Others?

# Signs to watch for burnout

- Being late for work
- Procrastination
- Having trouble relaxing
- Decreased sexual desire
- Having less energy, feeling tired all the time
- Neglecting responsibilities
- Withdrawing socially from friends and family
- Thinking cynically
- Feeling increasingly resentful
- Drinking, smoking or eating more
- Feeling apathy
- Others?



# Compassion fatigue

- Feeling hopelessness and meaninglessness
- Having chronic stomach or bowel problems
- Feeling overwhelmed, exhausted or drained
- Chronic headaches
- Desiring to “drop out” of society
- Avoiding and not wanting to be around friends, work, even family
- Thinking of suicide as a means of escape
- Feeling nothing or feeling everything







## *Zones of stress; checking in*

### GREEN ZONE

- Feeling-your absolute best, well rested, organized, on top of the world. Enthusiastic and excited to go to work.
- Thinking – Life is good, work is good.
- Reflection – Are you in the green? If not can you remember being there? What does green look like to you? Do you have ways to care for yourself that keeps you in the green zone?



## Zones of stress; checking in

### YELLOW ZONE

- Feeling-not coping as well. Things aren't as smooth. More tired or irritable. Feeling overworked, overwhelmed by workplace demands. Feeling bored. Ignoring more challenging tasks/problems.
- Thinking – I used to love my work but I'm starting to dislike it now. I don't feel the same joy or rewards. Sometimes I hate it and then feel bad about myself.
- Reflection – What does yellow feel like? What contributed to bringing you here? Do you have physical symptoms? Chronic pain? Headaches? Irritability? Might eat more junk food, exercise less, poorer sleep. What are your health behaviors in yellow? What might push you back toward green?





## Zones of stress; checking in

### RED ZONE

- Feeling-unable to cope. Sleep difficulty. Possibly unable to get out of bed and go to work. Frequently teary at the drop of a hat. Quick to anger. Thinking about stress leave but even that seems too much work. Think about quitting. Wondering about depression. Hopelessness.
- Thinking –I knew I was tired but one day I woke up and couldn't get out of bed. Couldn't care for myself or my family. Completely immobilized. Numb. Off on stress leave, then start to process the pain.
- Reflection – Have you been or are you in the red zone now? What does it feel like? If you are in the red zone, it is essential to get some professional help. Speak to your physician, a counsellor, EAP. What can you do to nourish yourself today? What strategies can you learn and develop?

# Reflective exercise

Wellness starts with INTENTION

How are you feeling today? Really? Physically and mentally?

What's taking up most of your headspace right now?

What was your last full, nutritious meal? Water intake?

How is your sleep?

Any physical exercise?





## *Reflective exercise*

What did you do today that made you feel good?

What's something you can do today that would be good for you?

What's something you are looking forward to?

What are you grateful for right now? (3 things)



# Connections

It's so easy to fall out of social circles, activities and habits!

It's easy to repress your emotional and physical needs  
(especially as caregiver types!)

You might feel helpless, anxious, stressed, depressed and angry  
all at once!

Caregiver types often don't have outlets, so its easy to become  
isolated from family and friends

## Taking care of yourself.....

There are no easy answers!

It is important for you to discover  
your own path while caring for  
others.

Develop a personal plan for coping

Build **RESILIENCY**



# Resiliency; What is that??

An active process of enduring, adapting, growing and coping successfully. It is struggling *well* with what life sends our way.

The capacity to adapt and cope with difficulty

To bounce back or recover from stress

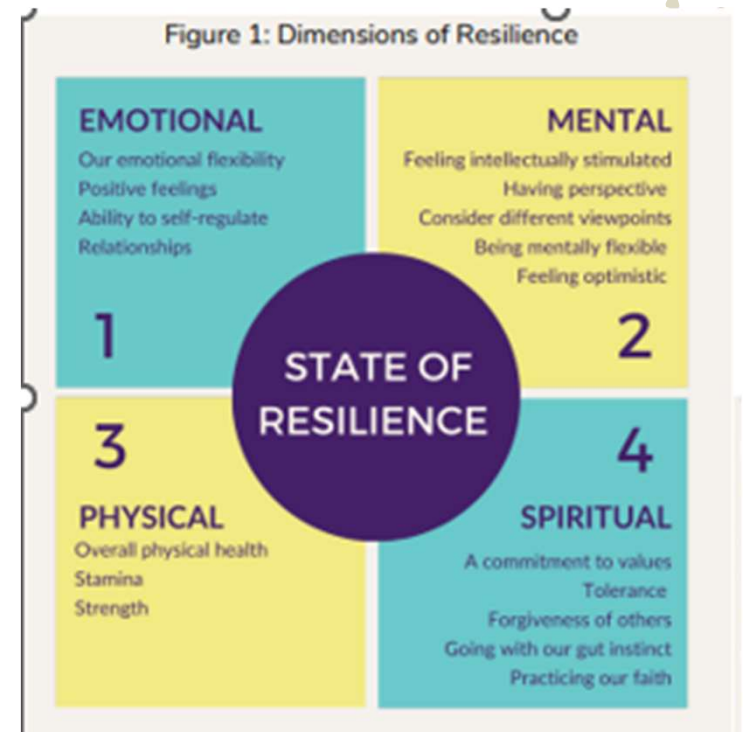
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# Resiliency.....

There is no one size fits all resiliency plan, however a common thread to building resiliency can be found through fulfilling activities that support your physical, emotional, mental or spiritual health!

Committing to at least one of these areas, research has shown that it greatly contributes to personal well being and your ability to cope with stress!



# How to build resiliency

## Prioritize Self Care

Caregivers (professional and non professional) often prioritize the needs of others over their own leading to physical exhaustion and emotional depletion. Self care is not a LUXURY. It's a NECESSITY. It helps you recharge, reduce stress and maintain emotional and physical health, all which are critical for long term resilience.

# How to build resiliency

## Prioritize Self Care

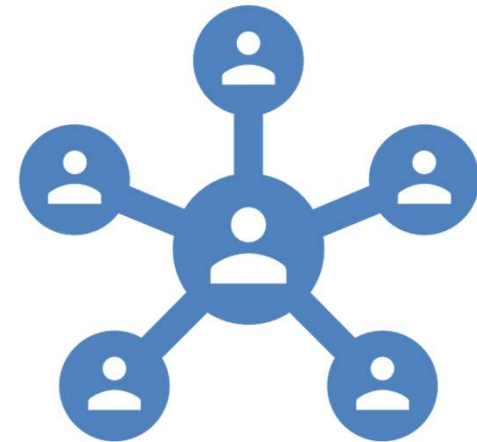
- Take regular breaks; schedule time to relax, read a book, go for a walk, mindfulness
- Sleep and nutrition; poor sleep and nutrition exacerbate stress and reduce coping
- Engage in activities that bring JOY – make time for hobbies or activities that make you HAPPY ie painting, gardening, socializing. These moments boost your well being and help you manage stress.



# How to build resiliency

## Develop a Support Network

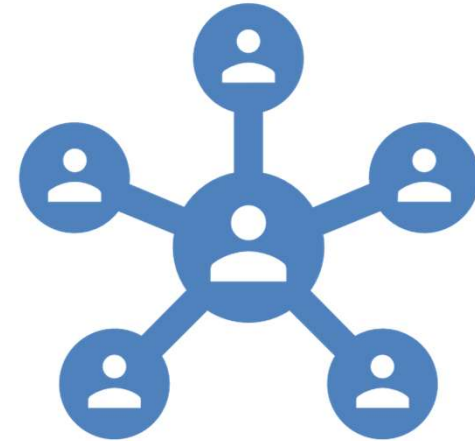
Building a strong support network can help you share emotional burdens, gain perspective and find comfort when things are tough. Meaningful connection with others who “get you”, feeling heard, validated and understood is a powerful tool for emotional resilience.



# How to build resiliency

## Develop a Support Network

- Reach out to family and friends, talk about your experiences, having someone to listen can make a big difference.
- Find a co-worker, manager etc you can trust to share feelings, challenges and coping strategies. A work buddy to check on each other can be helpful. Hearing from others in similar situations helps reduce feelings of being alone in your struggles.
- Seek professional support that specializes in caregiving stress. They can offer guidance on managing emotions and help you build resilience.



# How to build resiliency

## **Learn and Practice mindfulness and stress relief techniques**

Mindfulness involves focusing on the present moment without judgement, which is very helpful in managing stress, anxiety and negative emotion. Regular mindfulness practice has been shown to improve mental clarity and emotional stability which are essential components of resilience

# How to build resiliency

## **Learn and Practice mindfulness and stress relief techniques**

- Breathing exercises –deep intentional breathing can help reduce stress in the moment and bring you back to present. Practice a few minutes each day and use as a calming tool in stressful times
- Mindfulness meditation – dedicate a time to meditate, where you can focus on your breath, your body sensations or calming words/phrases. Can improve emotional regulation and promote relaxation
- Body scans – involves mentally scanning your body from head to toe, paying attention to areas of tension and gently releasing them. Keeps you connected to your physical and emotional state.

# How to build resiliency

## **Set realistic expectations and boundaries (at work and home!)**

- Without clear boundaries, we can become quickly overwhelmed, leading to stress and emotional burnout. Realistic expectations and boundaries can protect your emotional well being.
- Recognize your limits! Be honest with yourself and know what you can and can't do. Its ok to say NO. Its ok to acknowledge that you can't do it all.
- Communicate your needs – to coworkers, loved ones. Ask for help when you need it, when you're feeling overwhelmed. Say no to extra tasks, make time for you.
- Delegate tasks – don't hesitate to ask others to share/help.



# How to build resiliency

## Focus on positive and gratitude –why does this matter?

Maintaining a positive mindset is crucial for building emotional resilience. This work can be emotionally challenging, focus on the positive aspects of your role-such as the impact you are making in a person's life. This can help reduce stress and promote emotional strength. Practicing gratitude helps caregivers shift their perspective from what is going wrong to what is going well, providing a sense of purpose and fulfillment.

# How to build resiliency

**Focus on positive and gratitude –why does this matter?**

**How?**

- Keep a gratitude journal – each day write down a few things you are grateful for. Shifts perspective
- Celebrate the small wins! – your role is full of small victories!! Take time to celebrate these moments.
- Reframe challenges as opportunities –try to see challenges not as insurmountable obstacles, but opportunities to grow and learn. This helps you approach problems with patience and resilience.
- Know what is in and not in your control. Focus on what is in!

## Ambiguous loss

- Death of a loved one is distressing and is a clear loss with expected and validated feelings of grief and sadness.
- Many times, however, people can feel significant loss when there isn't a death.
- It can be more difficult to recognize and validate these emotions

## Ambiguous loss

- Ambiguous loss is a person's profound sense of loss and sadness not associated with a death of a loved one.
- It can be a loss of emotional connect when a person's physical presence remains.
- Often there isn't closure
- Often there's no recognition of the significance
- You may have intense sorrow, numbness, pain , guilt, anger



## *Ambiguous loss....how to cope*

“everyone walks their own path, cycling through many stages over years or a lifetime. There’s no one path through grief; every loss is unique, and our responses to it vary depending on our culture, upbringing, personality and stage of life”





## Ambiguous loss....examples

- ***Goodbye without leaving ie chronic illness,***  
divorce, incarceration, relocation  
“I miss the person he/she used to be”
- Leaving without goodbye ie addiction, missing person
- Situational goodbye – natural disasters, covid 19

## *Ambiguous loss....how to cope*

*Identify your loss*

Validate your loss.  
Write down all the  
things that will change  
due to loss. Share these  
with a trusted person.

## *Ambiguous loss....how to cope*

*Recognize and validate multiple emotions*

Many people experience multiple emotions simultaneously. You may feel intense sadness, frustration, anger, disappointment all at once. It's important to validate all these emotions.

## Ambiguous loss....how to cope

*Seek meaning through creativity –make meaning out of ambiguous loss through art, singing, dancing, poetry, gardening*

“we listen to the music of our ancestors and our role models, which expresses something deeper about our own grief while showing us how others made their way through it”

## *Ambiguous loss....how to cope*

Explore a new identity for  
grief

Grief is love looking for a  
home. Your grief can take  
on a new meaning with  
time. Finding something to  
love can be a coping skill.  
le pets



## *Ambiguous loss....how to cope*

Become ok with ambivalence

Its natural to feel ambivalent in the wake of grief. What matters is how we handle our complicated emotions. Its human to want to turn away from painful emotions, but numbing shuts down a deep part of ourselves....which can lead to burnout....

## *Ambiguous loss....how to cope*

Pursue Hope

One way to find hope is to acknowledge your grief by setting aside time to intentionally ponder memories or allow emotions. Even 10 minutes to deliberately think about the loss may help relieve your mind from constantly searching for solutions. This allows you more time for you to focus on other tasks.

## *Ambiguous loss....how to cope*

Consider ceremonies.....

We often pay tribute through ceremony when a person dies. Ceremonial activities can provide therapeutic benefit with ambiguous loss as well.....write a letter to the person, plant a tree, donate to a cause, host a remembrance ceremony



## *Seek support.....*

People aren't meant to carry their emotions alone.

Family, friends, support groups, church are good resources to help you work through your feelings

Professional counseling can help you explore emotion and develop healthy coping skills

Feelings of loss are VALID!



## **Final words.....**

***The expectation that we can be immersed in suffering and loss daily and not be touched by it is about as unrealistic as expecting to walk through water without getting wet.***

Knowledge is power.

Self awareness is key.

You can build resiliency.

If you're stuck, don't be afraid to reach out for professional support and grief counseling.

**QUESTIONS???? THANK YOU!!!**



Thank you for  
joining us  
*See you next year!*



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