



Fighting a New Battle to Improve Quality of Care: A Bathing Care Standard for Caregivers of Elderly Male Military Veterans with Delayed-Onset Post Traumatic Stress Disorder



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Abstract

For other aging military veterans who have post-traumatic stress disorder, activities of daily living, particularly bathing, can be an improbable, exasperating, and stressful task. To counter maladaptive behaviors such as kicking, biting, hitting, scratching, throwing objects, spitting, and cursing of the elderly male veterans during bathing, Patient-centered care (PCC) techniques initiated from nursing research known as Bathing Without a Battle can be used. This body of research for persons with dementia can be translated to elderly male military veterans with delayed-onset posttraumatic stress disorder (DOPTSD). By changing the bathing routine and environment and developing trusting relationships with caregivers, these veterans may be better able to adapt to bathing so that it will no longer be a battle.

Keywords: Aggressive behaviors; Bathing; Delayed-on set post traumatic stress disorder; Dementia; Veterans

Introduction

Several years after a war, many aging veterans can find themselves fighting a new battle as they strive to cope with delayed-on set posttraumatic stress disorder (DOPTSD). For these and other aging military veterans who have this delayed form of posttraumatic stress disorder (PTSD), activities of daily living-particularly bathing-can be exasperating, and stressful tasks. The bathing process for elderly male military veterans with DOPTSD is often a challenging experience for both veterans and their caregivers. Specifically, agitated and aggressive behaviors manifest more often during bathing than at any other time [1,2] assert that bathing can be pleasant and without harm to older adults in the home, the hospital, and LTC facilities. Maladaptive behaviors threaten the safety and well-being of veterans and their caregivers.

Persons who have DOPTSD can become confused and misinterpret the actions and verbiage of caregivers. Those with DOPTSD who have experienced combat, torture, and/or sexual assault can respond with fear, anxiety, and/or aggression. Nilsson [3] define aggressive behaviors as a response to touch or invasion of personal space [1]. Bridges [4] define aggressive behavior as a way to "fight back" in an attempt to prevent harm

from occurring during bathing (p. 192). Behaviors such as kicking, biting, hitting, scratching, throwing objects, spitting, and cursing interfere with the provision of care [1].

The insecurities, anxieties, and fears of veterans with DOPTSD may surface in the form of verbal or physical abuse toward their caregivers. These disruptive behaviors have long been a concern among healthcare workers, and they have often gone unchecked or, even worse, have become an accepted part of the healthcare and nursing systems [5]. By not addressing maladaptive behaviors, caregivers can experience stress, frustration, and fear, and their ability to perform competently in their jobs can be affected.

Nursing homes/LTC facilities in the United States indicate that the aggression of patients toward their caregivers has led to a substantial problem with work-related injuries [6]. In one study, Khatutsky et al. [6], concluded that work-related injuries are extremely prevalent among certified nursing assistants (CNAs) who are employed in nursing homes/LTC facilities in the United States and that many report multiple injuries. These injuries vary from scratches and human bites to black eyes and open wounds resulting from lifting, bathing, and handling residents;

from resident aggression; and from incidents involving facility equipment [6]. Most nursing staff, including CNAs, receive little or no training regarding the handling of patients' aggressive behaviors. Most of the training that they do receive is tasking oriented [7]. Without attention to caring, aggressive behaviors associated with bathing can escalate to verbal and physical abuse of caregivers by patients. This has import when providing care for patients with DOPTSD as well.

A number of approaches have been employed among persons with dementia and related conditions to treat maladaptive behaviors that occur during bathing. One of the most prominent approaches is the Bathing Without a Battle (BWOB) learning tool for LTC caregivers and families who have been affected by Alzheimer's disease and related dementias [8]. In addition to serving as a tool for the general population of those who have some form of dementia, principles of BWOB can be applied in the care of veterans with DOPTSD. Safety among caregivers is important in order to have a positive effect on job satisfaction and the quality of care provided to elderly male military veterans.

Although BWOB has been used in the care of elderly persons with dementias [8], approaches specific to elderly veterans with DOPTSD have not been developed. Fighting a New Battle (FANB) care standard was developed to employ patient centered (PCC) bathing techniques adapted from BWOB. The purpose of FANB, is to use nursing research to implement a best practice bathing care standard specifically designed for a vulnerable population of elderly male veterans who live in LTC facilities and residential settings. FANB is a quality improvement measure that was designed to achieve the goal for elderly military veterans with DOPTSD that bathing can be accomplished "without a battle" and can be modeled into a more humane, gentle experience for patients and for their caregivers. The FANB care standard was also developed to introduce evidence-based standards to caregivers of veterans who have DOPTSD. It focuses on the development of communication behaviors in caregivers who demonstrate their abilities to adopt patients' values and to provide care that promotes qualities of a secure relationship (interdependence), such as love, respect, compassion, and nurturing. Employing creative techniques from FANB, such as the use of music, big band music in particular and additional assistance can assist in creating a compassionate therapeutic bathing experience that facilitates feelings of safety, comfort, and dignity in clients.

Background

Based on over 10 years of research and clinical experience, BWOB was started in the early 1990's to improve bathing for individuals with dementia. In their Bathing With out a Battle manual, Barrick [8] shared techniques to provide practical approaches that staff could utilize to individualize and to humanize the bathing experience. The manual presented an individualized, problem-solving guide to bathing and personal care for individuals with dementia. It changed current bathing

practices that often provoked rather than alleviated unnecessary distress and discomfort for persons with dementia.

In LTC facilities, the bathing method and schedule are usually based on the facility's routine and not on the residents' preferences [2]. Other contributing factors include confusion, anxiety from being naked in front of strangers, being in noisy or unfamiliar places, discomfort from cold shower rooms, and harsh water sprays. The BWOB principles held that bathing was not a task to be performed, but rather a human interaction [2]. This perspective convey that research using BWOB principles and techniques supported a change in philosophy and practice, whereby bathing was not a task to be performed, but rather a human interaction.....persons should think about bathing others as they would think about bathing themselves. This interaction forces caregivers to interact with and relate directly to the persons they are bathing. Persons should think about bathing others as they would think about bathing themselves.

The care standard FANB was created to better ensure that veterans have a therapeutic bathing experience through a "person-centered philosophy" that constitutes safe, effective methods of reducing agitation, aggression, and discomfort during bathing. Patient-centered care (PCC) is a person-centered philosophy in which patients are treated as unique individuals. The Institute of Medicine (IOM) (2001) defined PCC as "care that is respectful and responsive to individual patient preferences, needs, and values" and ensures that patient values guide all clinical decisions (p. 49). Development of the FANB drew from the evidence from the BWOB movement and focused on person-centered bathing in which the patient's point of view was considered when making decisions that affected his or her care. The potential outcomes of PCC are as follows:

- A. Satisfaction with care.
- B. Involvement with care.
- C. Improved health.
- D. Feeling of well-being.
- E. Creation of a therapeutic culture [9].

Implementing PCC can result in better care and better quality of life for veterans with DOPTSD in a wide array of care settings.

Further evidence from BWOB conclude that by shifting the focus to getting to know the resident, communicating clearly (by reassuring or apologizing for any discomfort caused, for example), and thinking creatively, behavioral symptoms lessened [2].

There was also a marked reduction in all behavioral symptoms (by 32% in the shower group and 38% in the towel-bath group)..... aggression declined by 53% in the shower group, 60% in the towel-bath group, and only 7% in the control group [2].

Delayed- Onset Posttraumatic Stress Disorder

Frueh [10] concluded that according to the DSM-IV, symptoms that are exhibited more than six months after the index trauma meet criteria for DOPTSD. The fifth Edition (DSM-V) is the current edition and has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations. This newer edition pays more attention to the behavioral symptoms that accompany PTSD and proposes four distinct diagnostic described as re-experiencing, avoidance, negative cognitions and mood, and arousal [11]. By suppressing and camouflaging feelings and being reluctant to talk about war experiences, some veterans may initially display symptoms of PTSD well after the war, even 50 years afterward. This phenomenon is known as DOPTSD. For most veterans who are now in the geriatric age group, their memories could still be dismayed, although only occasionally and for brief periods, more than 50 years later. The National Center for PTSD (2012) adds, for a smaller number of WWII veterans, the war trauma memories caused severe problems still in the form of PTSD. About one in 20 WWII veterans have had so much war trauma and so many adjustment difficulties that they now suffer from PTSD [12]. A groundbreaking study conducted in 2007 at the University of London revealed that DOPTSD accounted for almost 40 percent of PTSD in military troops [13].

Dementia and PTSD

PTSD is highly prevalent among elderly male military veterans because of combat, and it may impair cognition. A study showed that older veterans who suffer from PTSD are almost twice as likely to develop Alzheimer's disease and other age-related dementia as veterans who do not have PTSD [14]. Boyles [14] studied more than 180,000 older veterans (males mostly) for seven years, including just over 53,000 who had a diagnosis of PTSD. Yaffe [15] concluded that those who had PTSD were at a nearly twofold higher risk of developing dementia as compared with those who did not have PTSD. In further studies, Sapolsky, Nemeroff, Johnston, Mittal and Acherberg, Rohrbaugh, and Aouthwidk suggested that the severe and prolonged trauma of PTSD may actually place aging veterans at risk of cognitive decline and onset of dementia [16].

PTSD and Aggression in LTC

Only a few studies have addressed PTSD and aggression among veterans in LTC. Carlson [17] indicated that studies by Cook et al. [16] concluded the presence of PTSD in a substantial number of LTC patients. Older adults with PTSD symptoms may also feel threatened by caregivers who speak loudly, give commands, appear angry or impatient with care, or are of unfamiliar ethnicities [17]. It is unclear whether the prevalence and incidence of dementia are due to a common risk factor underlying PTSD and dementia or to PTSD being a risk factor for

dementia. Regardless of the conclusion, veterans who have PTSD should be screened for dementia [18,19].

Conclusion

There is definitely a need for future study in improving the experience of bathing for veterans and their caregiver, so that these veterans may be better able to adapt to bathing so that it will no longer be a battle. The development of and implementation of FANB in LTC facilities and residential settings can increase the knowledge and awareness of caregiver of the importance of employing PCC during bathing. By changing the bathing routine and environment and developing trusting relationships with caregivers, these veterans may be better able to adapt to bathing. In so doing, bathing will no longer be a battle.

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