Changing Perspectives: Reflections on Managing 'Challenging Behaviours' Towards Haemodialysis with an Older Person in an Acute Neurology Setting

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Abstract:

This reflective piece examines the psychological management of challenging behaviours in an older adult undergoing haemodialysis in an acute neurology setting from the perspective of a Senior Assistant Psychologist. It explores the use of cognitive-behavioural and attachment-informed approaches, highlighting the importance of systemic involvement, MDT communication, and culturally sensitive practice. Key challenges included balancing therapeutic rapport with boundaries and navigating assumptions about age and psychological progress. These reflections aim to highlight the value of psychological input in acute care and call for greater training and integration to support vulnerable patients effectively.

Key words: *challenging behaviours, acute neuropsychology, haemodialysis, behavioural management, culturally sensitive practice, psychological formulation, attachment theory, systemic approaches.*

Introduction

‘Challenging behaviours’ are culturally abnormal actions that, due to their intensity, frequency, or duration, pose risks to safety or restrict access to support (NCCMH, 2015). These can range from non-compliance and sleep disturbances to more severe behaviours like food regurgitation or faeces smearing. They impact both patients and healthcare providers. The COVID-19 pandemic highlighted the urgency of addressing these behaviours and the need for further research to improve outcomes (Newcombe et al., 2021).

Understanding behaviours that challenge over the years has involved recognising their potential value as expressions of physical discomfort, pain, emotional distress, mental health challenges, or conflict within the person’s environment (Emerson & Bromley, 1995). However, these have been traditionally seen through a pathologising lens which tends to overlook alternative explanations in terms of underlying frustration or unmet needs (Jorgensen et al., 2023). For instance, if somebody has an anxious attachment style, they may be sensitive to rejection but are not aware of how this impacts them due to a variety of factors such as cognitive decline. This may cause them to act out if feeling dismissed, meaning they may display one of the behaviours mentioned above as a response to this unmet need. In typical scenarios, medical staff’s response to challenging behaviours might inadvertently reinforce the existing behaviour rather than addressing it positively – for example by avoiding patients potentially prone to shouting when in distress (Emerson & Bromley, 1995; Bailey, 2006). The formulation of the range of psychological factors that may underlie an individual’s challenging behaviour is crucial, especially when non-adherence to life-sustaining treatment is a risk. This approach allows for more effective, compassionate, and person-centred care (Emerson & Bromley, 1995).

Managing challenging behaviours in acute settings can significantly affect patient-staff relationships and treatment outcomes (Bridges et al., 2013). Such behaviours are often seen as socially unacceptable and can provoke strong negative reactions. High exposure to these behaviours, combined with pressured environments and involuntary admissions, can increase staff burnout (Kramarz et al., 2022). Without proper support, nurses may develop coping mechanisms like emotional withdrawal, reduced empathy, and depersonalisation (Mackintosh, 2007).

Research in elderly populations specifically highlights anxiety as a key contributing factor to behaviours that challenge, along with other elements such as physical, cognitive, and environmental factors (Ooi et al., 2018). Non-pharmacological interventions – based on systemic, educational, and multidisciplinary approaches – have demonstrated positive outcomes for the management of anxiety in haemodialysis patients (Gerogianni et al., 2018). Anxiety disorders are also reported to be consistently associated with renal diseases patients and their perception of quality of life, with psychosocial interventions showing positive results in addressing depressive symptoms and anxiety and improving QoL outcomes in these patients and/or their carers when compared to usual care (Pascoe et al., 2009).

Case Presentation

A 79-year-old woman, Angela[1], was hospitalised in northwest England after a fall-related head injury resulting in a right-sided acute subdural haematoma and subarachnoid haemorrhage. She experienced cognitive deficits affecting short term and working memory, problem-solving, and communication. She was unaware of the reason she was in hospital and the severity of her health conditions. She was recently widowed and grieving her daughter-in law. On top of this, she had end stage renal disease (ESRD), which required her to undergo dialysis on a regular basis, with a significant impact on her quality of life.

Angela was referred to Neuropsychology due to behaviours including agitation, aggression, shouting, therapy refusal, and non-compliance with dialysis, which had deteriorated following her prolonged hospital stay. As a bed-bound patient, she relied on staff for transfers, diet changes, and personal care. Angela reported feeling unheard during physical therapy and fearful of dialysis without being able to articulate the cause, often stating she was frightened, not taken seriously, and in constant ‘threat mode’. In response, the care team opted for a psychologically informed approach before considering end-of-life care, with the neuropsychology team assuming a lead role due to ward pressures.

At the time, I was a Senior Assistant Psychologist within that team, under the supervision of a Consultant Clinical Neuropsychologist. Upon seeing her for the first time, I remember wondering whether Angela’s care might have been different if had she been younger, given documented ageist biases in acute healthcare settings (Ben-Harush et al., 2016). Nonetheless, both our team and the wider MDT remained committed to advocating for her care. To address her anxiety, my supervisor and I developed a cognitive behavioural formulation, incorporating grounding techniques, rapport-building strategies, and elements of motivational interviewing such as active listening, empathy, and collaboration. Based on her history and presentation, we hypothesised an anxious attachment style as a contributing factor.

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[1] The name has been changed to preserve anonymity.

To support Angela’s cognitive deficits, visual aids and consistent repetition from staff were implemented to support her short-term memory. Her grief was included in the formulation but not directly addressed since the primary aim of the intervention at this stage was to manage her dialysis-related anxiety. Adopted interventions included grounding techniques such as the 5-4-3-2-1 method, guided breathing, and safe place visualisation. Space was provided to support reminiscences and emotional expression, also facilitated by bonding objects such as photo of her late husband, provided by Angela’s daughter, which also had the potential to meet some her attachment needs. Her daughter’s presence was integral to Angela’s engagement with dialysis, though her own health issues often limited availability.

Challenge 1: Communication Issues

While working with Angela, I noticed several communication gaps among professionals, both in documentation and interactions. Staff inconsistencies during handovers led to varying responses from Angela, with her behaviour worsening when night staff did not recognise or acknowledge her emotional state. Additionally, assumptions about Angela’s psychological progress were made due to the lack of rapid behavioural changes, which affected staff understanding. For instance, Angela’s renal team wrongly believed she might need to halt dialysis due to unclear communication and unchecked assumptions. To address this, I ensured consistent handovers, advocated for Angela's needs, and used my rapport with staff to participate in multidisciplinary team meetings, contributing to a clearer understanding of her progress. This experience was seminal in highlighting the importance of effective communication and the role of psychology within multidisciplinary teams.

In addition, some staff used language that inadvertently triggered negative reactions from Angela during interventions – e.g., "we are going to get you washed and you need to behave yourself". I felt this approach did not offer Angela a sense of control. In response, I raised these observations in supervision, where I developed a plan to replace triggering language with more empowering alternatives. For example, vague assurances such as ‘shortly’ or ‘soon’ were replaced with specific timeframes, helping Angela manage expectations and reduce anxiety. I also reinforced these language changes in daily board rounds and created a visual sign, outlining her preferred approaches, which staff could hang over her bed for quick reference. Despite challenges such as staff turnover and time constraints, these communication adjustments improved Angela's management, building trust and minimizing distress. Consistency in these interventions, alongside my growing rapport with Angela, was vital in helping her feel safe and willing to engage, as trust became fundamental in reducing her 'threat mode' responses over time.

Regarding communication, I also faced an interpersonal challenge in my therapeutic rapport with Angela. As a Black British clinician, I occasionally experienced conflicting emotions when she would refer to Black staff using terms such as ‘coloured people’ or ‘coloured boy’. As I recognised these remarks as being potentially reflective of generational bias and disinhibition, I did not feel it would have been constructive to challenge them directly. Instead, I subtly redirected conversations to prevent further use of such language. For instance, Angela once asked me where a member of staff was from using one of these terms, to which I replied, “I understand you may be curious about this, and I’ve noticed you are quite a sociable person, which is a lovely quality to have…”. Going through this experience, and exploring my feelings about it in supervision, helped me learn the importance of navigating sensitive communication and emotional ambivalence, while maintaining appropriate clinical rapports.

Challenge 2: Different Perspectives Towards Patient Management

My experience with Angela helped me notice the different impact a psychologically minded MDT can have on a patient’s quality of care. Research has highlighted discrepancies in nursing beliefs regarding the care of patients with traumatic brain injuries, emphasising going beyond medical labels in understanding patients (Oyesanya et al., 2016). In Angela’s case, I identified a gap in training needs, particularly in our acute care setting. For instance, there would be MDT discussions characterised using labels to describe Angela – such her as ‘naughty’ or ‘difficult’ – which, although not malicious, were unlikely to be helpful. I felt this to be a barrier to the adoption of psychologically minded approaches, but felt reluctant to address this to avoid hinder my working relationship with the MDT. I therefore raised this in supervision, where my supervisor and I discussed different approaches/ideas based on the literature. Research suggests it may be beneficial for staff to receive training which addresses their attributions, emotions, and behaviours using the cognitive-behavioural approach of rational-emotive behaviour therapy (McGill et al., 2007). We decided I would address this during board rounds by including formulation-based discussions around what Angela may be experiencing, such as her perspective on staff’s approaches, feelings of being threatened potentially triggering aggressive reactions, and the potential impact of her hypothesised anxious attachment on her hospital experiences. This shifted the focus to Angela’s underlying needs being expressed and gave the MDT the opportunity to embrace a wider range of perspectives while also recognising diversity in duties and priorities.

Challenge 3: The Importance of Systemic Work

My interactions with Angela and her daughter were crucial to increase my understanding of the impact of systemic approaches in managing anxiety presentations such as Angela’s. Angela's daughter played an essential role in helping implement consistent psychological strategies, highlighting the importance of familial bonds in interventions. The rationale to include her daughter came from the fact that, at the beginning of intervention, she was the only person Angela trusted when offered to engage with neuropsychology.

However, the involvement of Angela’s daughter did not come without challenges, as she was experiencing her own health issues, high levels of caregiver burnout, and a number of logistical constraints. Recognising this, I signposted Angela’s daughter to relevant sources of support and coping strategies (e.g., mindfulness exercises). We then worked to gradually reduce Angela's dependency on her daughter's presence during dialysis sessions, which helped me acknowledge the trial-and-error nature of some interventions. For example, Angela would not always engage with interventions and found it hard at times to implement mindfulness techniques whilst on the ward. To address this, I set expectations and used a graded exposure approach until Angela was able to attend dialysis without her daughter’s presence. I found that shaping strategies to be more person-centred and adapted to Angela’s interests, wants, needs, and attachment style was considerably more effective than when input was sought only from her daughter in the initial stages.

Challenge 4: Support vs Dependency

Balancing support and managing Angela's levels of dependency also proved challenging at times, since she often saw me more as a friend than a member of the neuropsychology team. This was perhaps due to the age difference between myself (27) and Angela (79) which led to Angela sharing stories from her past, as if I were her granddaughter. On one hand, this facilitated a strong therapeutic alliance with her, also making me feel validated in the support I was providing as a clinician who has lost both my grandparents. However, on the other, it also helped me reflect on the importance of maintaining boundaries as this showed the potential to lead to co-dependency.

With regards to this, my supervisor and I discussed Bowlby’s attachment theory (Hicks & Korbel, 2013) and its value in understanding Angela’s hypothesised attachment style, which made me more confident to plan the intervention in a way to prevent dependency. For instance, I made Angela aware of the expected length of each session as well as the whole intervention – something which may not always happen in inpatient settings. To facilitate coping with anxiety, Angela and I also established clear boundaries, including scheduled visits and my gradual withdrawal during dialysis sessions.

In this regard, ending the sessions required careful management to avoid triggering feelings of abandonment. Consequently, Angela and I co-produced some visual aids and an "All About Me" booklet for her transition to a nursing home. Angela kept these as reminders of our work together and was reportedly adamant that they be displayed on her wall in the nursing home. Despite initial emotional reactions, Angela appreciated the positive closure provided by an ending letter I wrote for her, summarising all the work we had done and what she could take from it moving forward.

Conclusions

In reflecting on integrating psychologically informed approaches within acute neurology care for older adults, I noted key challenges, particularly a communication disconnect with the renal team regarding Angela's psychological progress. Assumptions were made that her behaviour was unchanged, prompting me to question how psychology as a profession is perceived in complex medical scenarios and whether age influenced the team's assumptions and care approach.

Working with Angela required exploring the adoption of different psychological models, psychoeducation, practical strategies, and relational work. While this felt especially challenging in an acute hospital environment, it provided me with a much deeper understanding of how psychological work involves managing progress, therapeutic relationships, and intervention intensity, especially for vulnerable patients.

Ultimately, this experience was pivotal in making me appreciate the application of psychological models in acute care, especially when they may support life-saving treatment, and the need for further implementation. Indeed, while Angela's behaviour improved post-intervention, the long-term effect of my work with her is more uncertain, and further research into sustained psychological input and staff training is warranted to develop more feasible, effective, and impactful interventions.

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