THE IMPACT OF SUPERSTITION ON BEHAVIOUR IN DEMENTIA

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ABSTRACT Carr, I. (2007) The impact of superstition on behaviour in dementia. Nursing Times; 103: 46, 34–35. This qualitative study explores the possibility of superstition as a causal factor in some challenging behaviours shown by older people with dementia. The author and a second project worker carried out the study in Guernsey, using funding from a small bursary. Local people, particularly older people, were informally interviewed to identify local superstitions. The study found at least three separate episodes of distressed and disruptive behaviour exhibited by people with dementia that appeared to have a direct causal link to superstitious practices. Helping carers identify, predict, interpret and better manage these behaviours has been worthwhile.

The proposal to explore superstition and folklore in the care of older people with dementia won the 2006–2007 bursary, offered annually by the Insurance Corporation (Guernsey), which aims to support innovation and good practice in Guernsey. This is achieved by encouraging health and social care professionals to bid for a £3,000 award to support small pieces of research, which would otherwise be unlikely to attract mainstream funding.

BACKGROUND

Health professionals working with a person-centred approach to dementia care (Kitwood, 1997) have started to consider superstition as a contributory factor in the lived experiences and personal memories of people with dementia. As a result, this is now seen as a possible influence in their behaviour, particularly in behaviour that challenges the health and social care systems (Moniz-Cook et al, 2001). Local interest in this was first triggered by witnessing what appeared to be manifestations of superstition-fuelled challenging behaviour from patients in the clinical area.

One specific episode was when a patient with dementia spit sugar, thought it was salt and threw copious amounts of it over his left shoulder. This could be seen as a fairly innocent mistake, given the level of his perceptual difficulties and disexecutive function. However, because of the nurse’s misinterpretation and attempts to stop him ‘wasting’ food and making a mess, the situation became fraught and distressing for both parties. This was quickly resolved once the core motivational trigger had been identified and the patient could complete his ritual.

This and other episodes prompted me to look more closely into ritualistic behaviours in Guernsey. Senior staff nurse Patricia De Jersey, who was familiar with these concepts and some of the local traditions, contributed to the project.

SUPERSTITION IN THE CARE CONTEXT

Rogers (1951) first proposed the person-centred approach in relation to counselling and facilitating self-actualisation for his clients by enhancing their own – often untapped – resources. This was later adopted by Kitwood (1997) to create a shared understanding of the complexities of improving quality of life for people with dementia. Each person is responded to as a unique individual and attempts are made to avoid the one-size-fits-all paradigm. This has subsequently become the acknowledged approach of choice for dementia care in the UK, US and most European countries.

Brooker (2004) identified four fundamental elements in a review of person-centred care:

- Valuing people with dementia and those who care for them and promoting their citizenship rights and entitlements, regardless of age or cognitive impairment;
- Treating people as individuals – appreciating that all people with dementia have a unique history and personality, physical and mental health, and social and economic resources, which will affect their response to neurological impairment;
- Looking at the world from the perspective of the person with dementia – recognising that each person’s experience has its own psychological validity, that people with dementia act from this perspective, and that empathy with this perspective has its own therapeutic potential;
- Recognising that all human life, including that of people with dementia, is grounded in relationships, and that people with dementia need enriched social environments that both compensate for their impairment and foster opportunities for personal growth.

An understanding of these combined elements is especially important, given that the person-centred approach argues that better outcomes are achieved when carers are able to understand and focus on the person as an individual with a disability,
rather than on their condition. When trying to understand patients’ attempts to communicate and make their wishes known via behaviour, it is perhaps a small step to connect the value of such an approach and a need to understand individuals’ personal belief systems.

METHOD
We spent much time over the past year getting to know the older people of Guernsey, by using semi-structured interviews and small focus groups in several nursing and residential homes. This qualitative methodology was designed to access well-remembered childhood rituals, such as having a glass ball in the sitting room to ward off witches; folklore, like ‘selling one’s warts’ for managing basic health needs; and avoidance strategies such as not dressing babies in green because it is the ‘fairies’ colour’ and they might appear and claim the baby as their own.

Local ethics committee approval was sought but deemed to be unnecessary, given the nature of the project. However, the project and participants’ potential role in it was explained to each person before the interviews, and their consent was sought in either verbal or written form. Decisions about which format to be used were made by participants themselves, supported by the home manager.

A quiz for local health and social care staff was also used to elicit more up-to-date superstitions and forge links with local professionals in related areas. A literature search was carried out using medical search engines such as CINAHL, MEDLINE, PubMed and the Cochrane Library, as well as generic ones such as Google. These, on the whole, produced little. We also visited the UK to learn from, and share experiences with, other researchers in this field.

We were able to gain a better understanding of some of the care workers’ perceptions of older people with dementia, discuss ways in which behaviour may be interpreted and start a more open dialogue towards jointly resolving some of the problems experienced.

RESULTS
Some of the superstitions discussed were fairly generic and overlapped considerably with many previously identified in the UK but others seemed unique to Guernsey. Superstitions that might be encountered and misinterpreted in the care situation include:

- Beds must not be changed on a Friday;
- The foot of a bed should never be placed directly opposite the door;
- Salt must be thrown over the left shoulder if any is spilled;
- People should never cross on the stairs;
- People should always re-enter a building via the door through which they exited;
- It is unlucky to wear green, cross knives or put shoes on the table.

This suggests that care workers could face challenges with a person insistent that such rituals are adhered to. One example could be a person with dementia refusing to go into residential care because it is a Friday, even if it has been carefully planned with and accepted by them. Or, in the case of a new resident, they may continually sweep shoes off the table when the carer is trying to unpack as putting shoes – especially new ones – on the table brings bad luck.

During the study another example of a patient’s superstitions potentially having an impact on care was recorded. One woman in a care home was reported to be hearing and responding to auditory hallucinations, when she was merely carrying out her usual ritual of saying a special little rhyme on seeing a lone magpie. Without an understanding of the basis of this behaviour, carers might easily have responded to this woman inappropriately and perhaps even given medication to manage her hallucinations.

Given that many people with dementia find it difficult to verbalise their wishes, carers who do not understand the root of these behaviours might easily further frustrate the patient and cause distress for both parties.

FUTURE PROPOSALS
We now plan to put these findings together into a booklet for professional carers, and to disseminate the findings and subsequent recommendations as widely as possible across the island and, possibly, beyond. In addition, we will be providing training and support as required, and assisting others with similar pieces of work in associated disciplines, such as social care for children.

It is unlikely that using these findings will enable care workers to prevent all future episodes of misunderstanding in the local care setting; moreover, it is readily acknowledged that understanding superstition is not a panacea for all episodes of agitated, aggressive or challenging behaviour, as these can have wide and varying aetiologies. However, it is hoped that this initiative will raise awareness about the possible reasons for such behaviour and thereby help carers to consider alternatives to behavioural containment and/or the often unnecessary prescription of sedative medications.

It is envisaged that this area of study will be of particular interest in residential care homes and both continuing care and acute hospital situations – that is, environments where patients are not living in familiar surroundings and with people who know them, and their idiosyncrasies, well.

CONCLUSION
Helping carers to identify, predict, interpret and better manage these behaviours has been a worthwhile project. It provides an additional aspect to our understanding of the complex nature of ‘person-centred’ dementia care.