

'Improving Behavior and Cognitive Functioning In the Elderly Patient, Through A Structured Skills-Based Treatment Approach'

**Aging Course 4G for CE and PDH Credit
An Internet Continuing Education Course**

**Presented By
CEU By Net – Pendragon Associates, LLC**

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What we'll cover in Geriatrics 4G.

The content which we will cover in this 4-Credit Hour Aging Course is organized into 4 lessons. Each topic reflects the GOALS for learning in this course. There will be a short quiz after every lesson.

LESSON 1

- A. Introduction**
- B. Some History of 'Day Treatment' Programs**
- C. Philosophy, Basis, and Scope of This Program**
- D. Overview of the Cognitive/Behavioral (Functional) Deficits of Geriatric Individuals**

LESSON 3

Specific Techniques for Reconnecting and Reinforcing Cognitive Processes

LESSON 2

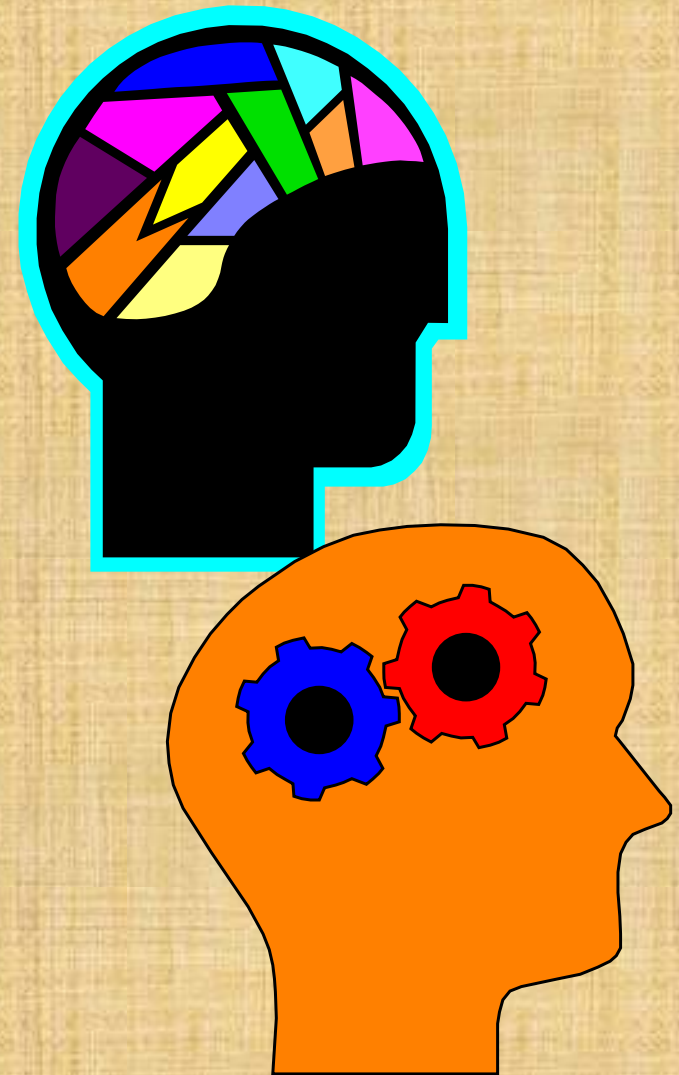
- A. Behavior Management**
- B. Levels of Functioning and Treatment Tracks**

LESSON 4

The Four-Point Approach to Success

Course Overview

Cognitive and behavioral *deficits* of geriatric patients take on a 'different face' than those of typical behavioral health clients. It is therefore important to understand what's going on here (i.e., is it always Alzheimer's?) . . . and then we can tailor our approach to the elderly individual's particular characteristics, behaviors, and difficulties.



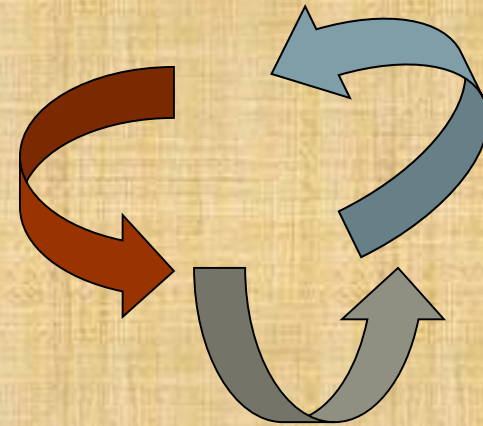
- **IMPORTANT TO UNDERSTAND:** It's **NOT** always a case of **Alzheimer's Disease (AD)**, when an elderly person presents with cognitive confusion and functional impairment.



In fact, the condition *may be short-term and reversible, or at least may be improved with the right interventions* – particularly if the condition is associated with acute physical or situational or emotional issues, abrupt changes in environment or health, traumatic events, or a stroke resulting in non-Alzheimer's cognitive impairment.

In the elderly, acute behavioral problems, cognitive confusion, and reduced functionality are *oftentimes* the SEQUELLAE which follow on the heels of acute medical events (e.g., stroke, major surgery) or situational changes or loss

. . . and these difficulties are *worsened* by – or may even trigger – psychiatric disorders such as depression and anxiety.



Such individuals may present with only one functional deficit – or several. Difficult (even bizarre) behaviors and troubling emotionality may also be present.



The issues and behaviors must be addressed as soon as possible, so that the acutely disorganized individual can make sense of his world – can move forward – can ‘get back in the groove’. Otherwise, a continued downhill course – which may be difficult to reverse – can ensue.

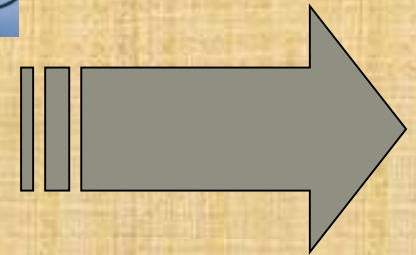


Typically, the mental health professional is called in when caretakers run out of ideas and find that 'common sense' interventions are useless or ineffective to deal with acute or chronic problems of an aging individual.

- **Expressions of frustration such as “We don’t know what to do anymore . . .” are common.**
- **Medications prescribed by the general practice physician may not be working.**
- **The problem may be entirely new and thus frightening for the caretakers – or may have recently exacerbated and thus be especially worrisome. Can the downward trend be stabilized?**

Can the downward trend be stabilized?
Yes, it oftentimes can be stabilized.

**That's what
this course is
about.**



This course presents

A STRUCTURED SKILLS-BASED TREATMENT APPROACH

to working with COGNITIVE and BEHAVIORAL difficulties of a frequently-encountered category of aging individuals . . . those whose cognitive confusion or acute impairment is associated with sudden or traumatic changes or events – things like a stroke, surgery, major shift in living arrangement (e.g., a move to a nursing home, the loss of one’s personal home and possessions), death of a spouse, loss of independence (perhaps due to acute or chronic physical illness), or other external factors.

Part A. Introduction

Lesson 1

As behavioral health professionals, we may be called upon to provide support and therapeutic intervention to elderly individuals who present with agitated or angry behavior. Such behavior is oftentimes accompanied by depressed and anxious emotionality, as well as cognitive impairment or confusion. How best to approach this, therapeutically? That's the focus of this course.

We may find our aging clients residing in nursing facilities or participating in Day Care Centers operated by churches or private individuals – or simply living at home with adult children or other relatives.



THE THERAPEUTIC INTERVENTIONS ARE 'PORTABLE'.

The interventions we describe in this course can be employed in multiple settings, including mental health clinics, professionally operated church day care programs for aging individuals with mental health issues, nursing homes – and at home with family, under professional supervision.





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So, what kind of things have CHANGED here, in terms of the individual's behavior and cognitive functioning? What's DIFFERENT NOW than it was, say, six months ago . . . since the trip to the hospital for surgery, since the stroke, or other medical treatment? Or since the move to the daughter's house or the death of a spouse? Or since the move to a senior living facility or nursing home?

. . . Or, what has deteriorated since we did the previous treatment plan three months ago? If there has been deterioration, a change of approach is indicated.

We may find, for example, that after the individual experienced a change in living situation, health, relationships, or whatever – or *even for no particular reason that we can put our finger on* – there has been a new or worsening **COGNITIVE CONFUSION or impairment. And along with it, there may have been troubling ‘collateral’ changes in **BEHAVIOR** and **EMOTIONALITY** or affect.**

**Why intervene –
with a person who
is clearly in the last
years of their life?
Is there a point?
Yes. Aren't these
problems just a
normal part of
'aging'? No.**

**Yes, there is a
point to
intervention!**

- **The appearance of acute COGNITIVE IMPAIRMENT or confusion presents a major stumbling block to normal day-to-day functioning, AND it impairs adjustment to new situations and health conditions. It also impairs the individual's RESPONSE to caretakers and to basic interventions which may have worked well with the individual in the past.**

**– Cognitive CONFUSION can also bring about an increase in difficult BEHAVIORS such as anger, aggression, failure to attend to activities of daily living, and depressive behaviors – and vice versa.
*How so?***

It's a clinical fact: For some individuals, we may need to impact the most disruptive BEHAVIORAL issues FIRST, before we can stimulate the individual's COGNITIVE SKILLS. Extremely disruptive behavior oftentimes prevents the individual from attending to anything else . . . and he may lose his 'contact' with the world around him.

Once behavior is reasonably stable, and the individual has begun to make sense of his world again, we oftentimes see him or her take a positive leap forward in renewed use of COGNITIVE SKILLS.

HINT: It's best to not get caught up in the 'chicken or egg' question, about which came first – "behavioral problems or cognitive problems?" We simply use our basic clinical judgment about WHAT NEEDS ATTENTION MOST IMMEDIATELY.

- **IMPORTANT:** Cognitive confusion or impairment is **NOT** always associated with the development of Alzheimer's Disease (AD). *It may be short-term and reversible or improvable* – particularly if it is associated with acute physical or situational or emotional issues, abrupt changes in environment or health, traumatic events, or a stroke resulting in **NON-Alzheimer's** cognitive impairment.



- And if the individual is already involved in a psychosocial or other therapeutic program when the cognitive impairment first appears, he or she will likely experience disruption in how well s/he responds to the usual interventions. **A TEMPORARY SWITCH** to a different program approach [such as we present here] may be needed for a period of time.

*How to deal with these issues?
That's what this course teaches.*

In fact, there is much *similarity* in what we SEE when we look at someone with true dementia vs. a person whose cognitive and perceptual impairment is due to a stroke (and thus potentially amenable to rehabilitation). THEREFORE it's crucial that we NOT ASSUME that the individual has Alzheimer's Disease or another form of organic dementia, simply because they have cognitive functional impairment! See the statement below for some statistics.

“Cognitive- perceptual impairment and dementia are common after stroke (up to 60% [of stroke patients] have cognitive impairment and up to 30% develop dementia within the first 12 months), *and there is overlap between these impairments, making it hard to delineate between them.*”

**- Clinical Guidelines for Acute Stroke Management
National Stroke Foundation 2007, Australia**

Bottom line – cognitive confusion and impairment in the elderly are oftentimes the sequellae which accompany stroke or other acute medical or situational crisis or change, and which tend to accompany (and also worsen) psychiatric disorders in the elderly – particularly depression and anxiety.

**There's An
Empirical Basis For
This Approach to
Acute
Or Short-Term
Cognitive
Impairment**

This functional [*non-medical and non-pharmacological*] intervention approach integrates principles which are consistent with extensive research done at UCLA's Brain Institute, and the Sanders-Brown Center on Aging at the University of Kentucky, the and elsewhere, related to the feasibility and value of ADDRESSING AND STABILIZING *non-Alzheimer's* cognitive impairment early in its appearance.



Lesson 1, cont. . . .

Part B. Some Fast History of 'Day Treatment Programs'

**[This will provide some perspective
on how we got here!]**



The 'heyday' of Geriatric Partial Hospitalization (Intensive Day Treatment for elderly individuals in a hospital outpatient setting) ended in the mid-90s when abuse or misuse of the Medicare Part B benefit resulted in an enormous, *unnecessary* expenditure of Federal funds [at least as the Federal Government saw it].

**Historical
Preface**

Indeed, residents of entire floors of nursing homes were bused to the Mental Health Partial Hospitalization Programs (PHPs) of community hospitals on an almost-daily basis for several hours per visit – for which the hospitals billed MEDICARE PART B. Many of the geriatric participants came REGARDLESS OF the presence or absence of any acute or subacute mental condition, and whether or not the individual's cognitive status would likely allow much BENEFIT from the treatment provided.

'CHARGE-BACKS' (Federal recoupment of PHP payments that had been paid to hospitals) ultimately escalated into the millions of dollars, as 'the Feds' clarified what they had intended the use of PHPs to be. We'll note here that it was some time before any final Medicare regulations and interpretive standards for PHP were written, but charge-backs occurred nevertheless – and that put an end to much of the treatment that was being delivered in such a setting.

Historical Preface . . .

But we learned from the experience, that yes, there CAN be GREAT VALUE in this type of treatment for aging individuals who are experiencing early cognitive impairment in combination with behavioral and emotional difficulty.

And so, you may ask, since you can't bill Medicare easily for these services, HOW would a current-day community organization (e.g., a treatment program or day care center) FUND these services?

Our answer is this: From a technical perspective, the treatment approaches described here may be INTEGRATED into the normal daily routine and therapeutic approach of any CURRENTLY OPERATING, PROFESSIONALLY SUPERVISED health care or day care setting (such as a nursing home, a mental health clinic day program, or even an Adult Day Care environment where focal activities are coordinated or overseen by licensed professionals) – *without new funding.*



So How To FUND the Services?

The intervention techniques described here ARE NOT DEPENDENT upon new funding. What is needed to make such a program 'go' is competent licensed professional oversight and effective training of staff in HOW to INTERACT with elderly clients involved in this type of program, and HOW we must STRUCTURE the individuals' activities.

Those staff who provide most of the ongoing interaction are (depending upon type of facility or location) *already in place* – mental health and rehabilitation techs, activity director, nurse aides, personal care attendants or whatever. What we are doing is IMPROVING and TARGETING the current staff-client interaction, with the goal of enhanced behavioral and cognitive functioning.

Any care provider who delivers residential, day treatment, or day care services to geriatric clients with cognitive impairment or mental illness MUST interact with them and MUST provide structured activity for them.

And so we may as well do it 'right', to maximize therapeutic response!

And thus you will find in this course a number of interventions that can be implemented in the context of ANY day care or therapeutic program or residential environment for the aged – including nursing facilities and structured retirement settings – however they may be funded.

Licensed supervision and direction is required, because we are dealing with geriatric individuals who have serious mental health and cognitive disabilities. Psychiatric attention to geriatric medication needs is a given with this population – whether the meds are prescribed by a family physician or a visiting facility physician.



**Bottom line from a FUNDING perspective . . .
it's important to know that the interventions
themselves can be *taught to* and *delivered*
by currently-in-place aide- and tech-level
personnel. This is clearly important in this
day of limited healthcare resources.**

Again, we wish to emphasize that this program is NOT intended as a manual on 'How to Do Medicare Partial Hospital Programs'. Although given hospital facilities may find that some or all of these approaches may be useful in Federally funded programs which they choose to operate, that is not our preface or intent. The regulations for delivery of Federally funded services are oftentimes fluid and open to interpretation, and it would be unwise for any provider to assume that the services described here are 'the ticket' to billing and collecting Medicare Part B or other such tightly regulated funds.

Instead of 'hospital', think Nursing Facility. Or Community Mental Health Center. Or Geriatric Day Care Center.



**Part C. Philosophy, Basis, and
Scope (Focus) of The Program**

There's Method to Everything We Do.

There is 'method' to everything we do in this program format.

- 1. The interventions are highly structured.**
- 2. The interventions STIMULATE and SUPPORT waning or confused COGNITIVE and BEHAVIORAL functions – especially when associated with acute trauma, change of environment, loss and grief, or physical illness.**

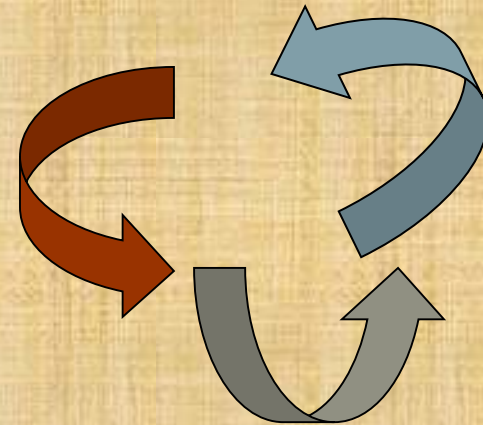
- 3. The interventions are designed to stabilize the BEHAVIORAL AND EMOTIONAL SYMPTOMS oftentimes associated with acute cognitive confusion or impairment in the elderly.**

- 4. Interventions are typically best accomplished in a small 'Skills Group' setting – although individual implementation can be helpful as well even in a home environment, with training of the caretakers.**

The end result is that our actions REINFORCE and SUPPORT the aging individual's AVAILABLE COGNITIVE SKILLS and improve his DAILY FUNCTIONING – cognitive, behavioral, and emotional.

In the elderly, behavioral problems, cognitive confusion, and reduced functionality are oftentimes the SEQUELLAE which follow on the heels of acute medical events (e.g., stroke, major surgery) or situational changes or loss . . .

. . . and these cognitive difficulties are *worsened* by – or may even trigger – psychiatric disorders in the elderly such as depression and anxiety.



Those who work with geriatric patients know that **ANXIETY** and **DEPRESSION** often *mimic* **DEMENTIA** – and that a trial of anti-depressant/anti-anxiety medications may bring about a surprising improvement in cognition. Cognition may not clear completely, but the reduction in depression and anxiety typically improves our ability to work with the acute cognitive and perceptual issues.



Therefore, we oftentimes need the physician and medication management to get things moving,

so that our geriatric patients can benefit from the *non-pharmacological* interventions which we describe here.

NOTE: We are NOT suggesting that these interventions are a medical treatment for halting or reversing Alzheimer's Disease or advanced dementia.

Aside from improving cognition, effective programming can also improve the behaviors which threaten to disrupt the current living situation – and thus can oftentimes PREVENT an UNNECESSARY inpatient admission, or can DELAY the need for nursing facility care. Many interventions can be carried over into the home for use by family caretakers, which is also helpful in this regard.

And as we have said, the therapeutic interventions are 'portable'.

The interventions we use can be employed in multiple settings, including mental health clinics, professionally operated church day care programs for aging individuals with mental health issues, nursing homes – and at home with family, under professional supervision.



OK, so . . . what are we actually doing, in this model of treatment for cognitively and behaviorally impaired aging clients?



In a nutshell, the acute disruption in his or her normal COGNITION – due to crisis or medical or environmental changes – has affected important SKILLS for daily living.

And so these structured interventions – which typically take place in small 'Cognitive Skills Groups' – seek to STIMULATE and reinforce COGNITIVE PROCESSES which have become acutely confused or impaired.

Bottom line, we are taking aim at specific behavioral and cognitive (*functional*) DEFICITS . . . seeking to STABILIZE and MINIMIZE problems which are interfering with the ability of an aging individual to function as normally as possible for his age. And the interventions are geared to the geriatric population.



A summary of this approach to intervention . . .

- 1. Brings about improvement in disruptive FUNCTIONAL and BEHAVIORAL PROBLEMS which affect the safety of non-institutional care.**
- 2. Prevents or shortens the NEED FOR INPATIENT admissions.**

- 3. Focuses upon stabilizing and revitalizing AVAILABLE cognitive skills – thereby improving DAILY FUNCTIONING – cognitive, behavioral, and emotional.**
- 4. Improves AFFECT AND ATTITUDE of the individual (and maybe even that of the caretakers!)**

[In combination with Alzheimer’s treatment medications, it’s possible that these interventions may help to support the delay of disease progression, but we do not have empirical data on that issue.] 38

It's Not a Feel-Good Program

This is not a 'feel good' treatment approach, i.e., it does not seek to keep its geriatric participants comfortable and entertained as a primary goal, as do many 'day care centers'. HOWEVER, as a side benefit, elderly clients typically do feel more comfortable when they are functioning better, and thus most look forward to attendance. Most even describe the activities as 'fun' and a respite from boredom.

Consequently, interest in what they are doing automatically HEIGHTENS the awareness of things around them, and encourages use of skills that have fallen into disuse.

This is a SKILL-BASED approach.

**And their
CARETAKERS
benefit as
well!**

Why? Simply this: What we do here is inherently entertaining to individuals who may be bored and poorly responsive to their normal day-to-day environment . . . and an entertained individual is more content and responsive. Thus, these techniques inherently improve daily management and interaction, and thus remove some of the burden for caretakers.

About Supplemental Therapies

In addition to the therapeutic groups and the Track I or Track II program activities (discussed in later slides), the following services may be provided when appropriate and accessible:

- **Family Therapy**
- **Occupational Therapy or consultation for dysfunctional dietary skills (holding spoons or cups) or other severe functional (physical) deficits.**
- **Individual Therapy from the clinical staff, particularly individuals who are severely depressed or dysfunctionally anxious.**

Lesson 1 cont.

**Part D. Overview of the Cognitive-
Behavioral [Functional] Deficits
Addressed in This Program Design.**

The Cognitive Functions

What is meant by 'Cognition' or 'Cognitive Functions'? In both the academic and the conventional communities, there are various formal and informal schemata and 'lists' which describe 'cognitive functioning' or 'cognition'. For example, Wikipedia (a knowledge base available on the internet which contains both scientific and parascientific information) includes the mental functions listed below – which are commonly included in many schematics which describe 'Cognition'.

**arousal • attention
consciousness • decision making
executive functions • language
learning • memory
motor coordination • sensory perception
planning • problem solving • thought**

But . . . must we use that *same, exact* schematic? No. When it comes to 'lists' of cognitive functions, there are many different groupings, depending upon who's making the list. So the 'listing' of cognitive functions varies somewhat from one resource to another. The nomenclature may be close, but not precisely the same – even though we are talking about the same basic functional skills.

And so what is the 'list' of Cognitive Functions which we will use in this course?

We at *CEU By Net* have chosen to use the set of Cognitive Functions listed on the **next slide, in the work we are describing in this course.**

Our List of Cognitive Functions

- **perception and memory of 'who, what, how, where',**
- **reality orientation,**
- **affective balance,**
- **control of anger,**
- **socially appropriate behaviors and communication,**
- **the ability to perform basic self-care routines,**
- **problem solving and response to stress,**
- **coping with unexpected changes,**
- **willingness to ambulate, toileting, and feeding.**

'Cognitive Confusion' has a major impact on all of these functions.

The **COGNITIVE FUNCTIONS on the previous page are important, and you will see them mentioned throughout this course. This therapeutic approach is designed to effectively address them – including the *disruptive behaviors* which are oftentimes seen as part of *acute cognitive impairment*.**



Deficits in these cognitive and behavioral areas (i.e., the *functional deficits*) must be addressed in order for an acutely disorganized individual to make sense of his world – to move forward – to ‘get back in the groove’. Individuals may present with only one of these functional deficits – or several.

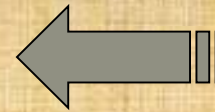


And we address these deficits through seven (7) Cognitive Tasks, or Skill Targets.

7 Cognitive Tasks = 7 Skill Targets = 7 Skills Groups

- 1. Orientation and Response to the Environment – including attention**
- 2. Thinking Things Through – Decisions, Perceptions, Doing (Mental Processing)**
- 3. Memory Functions**
- 4. Communication Skills [including appropriate expression of feelings, wants, and needs]**
- 5. Sensory-Motor Integration – including ambulation**
- 6. Activities of Daily Living [performing essential self-care routines]**
- 7. Social Interaction [using a gross motor interactive medium]**

From our list of Cognitive Functions (3 slides back), we carved out the seven primary ‘Cognitive Tasks’ or ‘Skill Targets’ seen here at the left . . .



which become the focus of ‘Skills Groups’.

These SKILLS GROUPS are the mainstay of the program. How else to describe them? They are essentially ‘targeted skills development groups’ within a geriatric framework.

Q: So, is a lack of **SKILLS in these particular areas – especially when coupled with disruptive behavior – really problematic for a person of advanced age? Don't we expect some decline in functioning in the 7th and 8th decades of life? And aren't such individuals entitled to be a bit 'cranky'?**

A: These functionality issues are indeed a problem – for caretakers as well as the individual. And if not addressed, they can take on a level of severity that is very difficult to manage.

- **Consider the 'ability to perform self care routines'. Cognitive impairment in this area can turn an otherwise agreeable individual into a heavy burden when there is refusal to perform basic self care activities such as toileting, bathing, and eating. Likewise, refusal to ambulate. Likewise uncontrolled anger outbursts or assaultive behavior. Or a tendency to hoard food and objects.**

Let's take a quick look at 'HATTIE' - a person assigned to a lower-functioning Treatment Track. She is assigned to the lowest functioning track (I-B) primarily because of her *behavior*, which is inhibiting our attempts to stimulate her cognitive functioning.

'Hattie' is age 74. Several months ago, she had a mild to moderate stroke with the result being some difficulty in ambulation (balance, coordination). Her **behavior requires extensive 1:1 intervention. On an almost constant basis, she displays severely disruptive and dysfunctional behaviors which threaten to result in hospitalization. These behaviors include physical **aggression and combativeness**, anxiety and **psychomotor agitation**, obsessive/compulsive **hoarding** of objects which presents a serious safety issue, as well as compulsive **wheelchair pacing** and **escape** behavior. Her skin is breaking down due to refusal of basic toileting and bathing care. She is electively non-verbal, and eats poorly.**

- **She becomes anxious and enraged, biting and screaming obscenities, whenever staff attempt to remove hoarded items from her possession, or to redirect her actions, or to assist her with toileting or bathing.**

However, Hattie *also requires assessment of her cognitive functions*, which seem to have worsened steadily over the few months following the CVA (stroke). *Her ability to channel her attention* into anything meaningful or productive appears to be at a standstill, and her days are therefore filled with anxious wheelchair pacing, attempts to escape from the nursing facility unit [where she was admitted from her daughter's house 3 months ago], setting off the fire alarms in the facility, and taking and hoarding objects that belong to staff, other residents, visitors, the dining room, and the nurses station - all of which disappear under her skirt, into her blouse, or into her mouth. How to treat her? We'll soon share details of how we did it.

As we suggested in previous slides, behavioral and cognitive problems like this may be associated with permanent organic (brain) changes - *but oftentimes* they are a **REACTION TO MENTAL CONFUSION and STRESS brought on by an acute illness (e.g., a stroke or surgery), or a disorienting loss, or a new environment or lifestyle (such as a move to a nursing home, retirement center, hospital for medical treatment, or other alternative setting).**

When the problems become acute or severe enough, hospitalization for psychiatric treatment may be necessary. At the very least, disruption of the current living arrangement may result. NOTE: This program seeks to **AVOID or **SHORTEN** transfers to psychiatric facilities – or loss of one’s regular living situation – due to cognitive and behavioral issues.**

Q: But . . . do we really need a 'special' program and a special approach to treatment of elderly individuals who are demonstrating such problems? After all, we already have 'psychosocial programs' – which handle persons with serious psychoses and other major mental health diagnoses. And there's always Cognitive Behavioral Therapy (CBT) to consider, for verbal individuals.

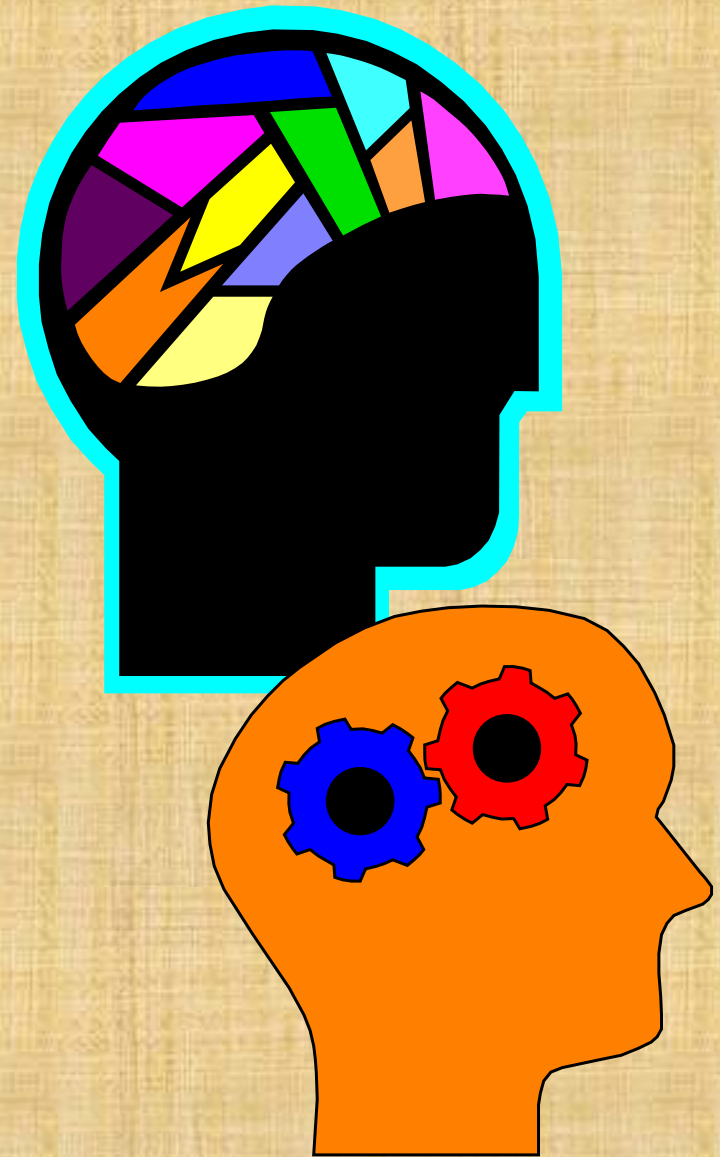
A: Yes, we do need something more specialized, geared to the needs of people like Hattie, and even for those of advanced age whose cognitive issues are NOT complicated by serious behavioral issues.

Why? We know that aged clients oftentimes have trouble responding to either *traditional community-oriented psychosocial programs* (employed with persons with Major Mental Illness) or to *traditional cognitive-behavioral therapies* (typically utilized with persons who are cognitively 'intact' but need a change of perspective and a new approach to problems and issues).



KEY POINT: The approach we use *must adapt* to the limitations of the elderly client. For one thing, we don't have the same expectations for 'community-based independence' that we have for younger clients. And the geriatric client presents vastly different social and situational problems and – oftentimes – **medical complications**⁵⁴

**Bottom line, the
functional deficits of
geriatric patients
oftentimes take on a
'different face' than those
of typical behavioral
health consumers.**



How we STRUCTURE the individual's day, his activities in the Skills Groups, and his social environment – including how we structure our COMMUNICATION and INTERACTION with him or her . . . that's the key to this therapeutic approach. Details are coming up!

But first, in the next lesson we'll say a few things about the role of BEHAVIORAL MANAGEMENT – the first of two topics addressed in the next lesson.

Behavior Management



Congratulations!

You have completed the 1st of 4 lessons in this Aging Course 4G. You may complete the short quiz for this lesson now or later. To reach the quiz link, you may simply close this internet page to return to your My Home Page. Then click the name of the course. You will be on the Study Guides and Quizzes page for Aging Course 4G. Look for the link to Quiz 1. Click it, to take the quiz. You may also return to the quiz links at another time, at your convenience.

So either take the quiz now, or you may resume the course – your choice! To move on to the 2nd lesson of the course, return to [My Home Page](#) and click the name of the course. Then click the link to Study Guide 2.

