

Lesson 2.

A. Behavior Management – What Priority Does It Have?

Once behavior is under control, cognition often begins to improve, and the participant can begin to make sense of his world again.

Team Work and Consistency – It's Essential

There is no 'one recipe that fits all' in managing behavior. The approach must be individualized to fit the person. And it's critical that everyone who comes in contact with the individual (therapist or caretaker) CONSISTENTLY adheres to 'what we are doing now' in response to an aberrant behavior. This takes teamwork and excellent communication between staff and caretakers.



With STRUCTURED responses to aberrant behavior – used in the context of SKILLS GROUPS and other program activities – we can decrease ongoing disruptive behavior which makes functional living difficult or impossible for both the geriatric patient and his or her caretakers. The location may be within the nursing facility, geriatric day care, or the home environment. We can also prevent many behavioral CRISES from occurring. To do so, we must learn to ‘head problems off at the pass.’

**A quick
perspective
on behavior
management**

In this program design, we assign individuals to 'Tracks'. [More about that later in this lesson.] Especially with 'Track I' [lower functioning] participants, the treatment approach must oftentimes FIRST attain a measure of control over any disruptive and maladaptive behavior, in order to impact the other areas of difficulty.

Once behavior is under control, cognition begins to improve, and the individual begins to make sense of his world again. From that point we can attend directly to the acute cognitive or psychiatric problems which underlie everything else.

Behaviors which are frequently addressed with this Level I participants include physical aggression (hitting, biting, kicking, throwing things), extreme verbal hostility or abuse of others, escape behavior, self-injurious behavior, overt sexually inappropriate actions, disruptive outbursts, repetitive motor rituals, constant pacing, hoarding of potentially dangerous items, prolonged refusal of oral foods and liquids, etc.

We want to be clear that these behaviors oftentimes require more than one person on hand to bring under control - particularly in the context of a group setting: One person to take the individual aside to work briefly with him or her, and one to carry on with the group. And it requires a team approach. We must be consistent in how we approach these behaviors each time they recur.

**NOTE:
Occasionally, some 1-on-1 interventions must occur for a period of time BEFORE the individual can be incorporated into a Cognitive Skills Group on a regular basis.**

For most, ‘taking the person aside’ is enough – during group activities. See ‘Pause-And-Address’ a few slides over.

Re Medication Management: Since this program – like most treatment formats in this day and age – must be seen as reasonably 'short-term', *behavioral intervention* must be rapidly implemented when necessary. *Along with well-structured interventions, getting control of behavior may necessitate responsible medication management* by a primary care physician or consulting program psychiatrist.



But where is **BEHAVIOR** on this 'Skill Targets' list?

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**
6. **Activities of Daily Living [essential self-care routines]**
7. **Social Interaction [using a gross motor interactive medium]**

Remember these items from the previous lesson? These are the seven (7) 'Skill Targets' which are addressed in small SKILLS GROUPS. BUT where is 'behavior' on this list?

BEHAVIOR is certainly an issue for many of our clients, *but we don't list BEHAVIOR as a separate Skills Group here. Why? Because behavioral issues may occur and are addressed in *any* group, *at any time*. We'll talk about specific, creative behavioral interventions for use in multiple situations, in upcoming slides.*

Q: But does it really make sense to focus on an individual's behavior FIRST – when it seems that his impaired cognition is playing a significant role?

A: Yes, it makes sense, although it does seem odd when first suggested. After all, we know that both behavior and affect are WORSENERD BY cognitive dysfunction and confusion (disorientation to environment, poor sensory-motor integration, memory problems, not thinking things through, etc.) . . .

. . . and we know that 'clearing' of confused cognitive processes frequently brings about a remarkable IMPROVEMENT in an individual's disruptive behavior and his mood or affect.

And so it would SEEM that we need to attend to the cognitive and affective issues first.

However . . .

- **HOWEVER, sometimes the individual's overt behavior is so 'out of control' that we cannot 'get to' the cognitive functions, in order to bring about much improvement. In fact, UNCONTROLLED, DISRUPTIVE BEHAVIOR PATTERNS have a direct, inhibiting effect upon the geriatric client's ability to respond to the treatment process. *Sometimes, the individual is so disruptive, angry, and agitated that he cannot attend to anything else. In such cases, we must 'make a dent' in the aberrant disruptive behaviors BEFORE we can expect to get much else accomplished.***

You might anticipate that 25% of program participants will fall into this category.

Behavioral interventions – they occur in the CONTEXT of the regular day-to-day work.

Certainly, not every participant in a geriatric therapeutic program requires intensive behavioral intervention, but many do - and when required, the interventions are *integrated into_his day-to-day program activity schedule.*

In other words, there is NO SCHEDULED GROUP IN WHICH THE SUBJECT IS 'BEHAVIOR MANAGEMENT'. We simply place our emphasis upon tending to the behavioral problems when they arise, WITHIN the Skills Groups. **NOTE: Given their need for behavioral intervention, such individuals are almost always placed first in Track I. In Track I, we are prepared for the occasional need to do a little 1:1 when things get out of hand in a Skills Group or elsewhere.**

It's "Whenever and wherever . . ."

We must address the client's specific behavioral patterns **WHENEVER AND WHEREVER the behavior occurs - whether it occurs during a sensory-motor integration group or during lunch, or during the van ride from the retirement center to the mental health clinic.**

Working with collateral behavior issues is an 'adaptive' clinical process. There is no 'cookbook'.

Q: So what are we really talking about here? HOW do we gain control of major problematic behaviors?

A: There are multiple approaches – of both the 'commonplace' and the 'creative individualized' variety – to gain control of aberrant behaviors. We'll review some of these shortly, and will also provide some case examples of the more creative approaches. But essentially, this is what we are doing: Through coordinated planning, we RE-STRUCTURE the ENVIRONMENT and our APPROACH to the geriatric individual, in order to gain control of his aberrant behaviors . . .

. . . rather than expecting the individual to determine a better course of action, based upon cognitive awareness of potential consequences.

Key Concept: We Re-structure the Environment And Our Approach

. . . rather than expecting the individual to determine a better course of action, based upon cognitive awareness of potential consequences.

This is one of the unique principles that separates behavioral treatment of geriatric persons with cognitive disorders, from treatment of other clients with mental illness.

In terms of 'timing' of our responses: When disruptive or aggressive behavior occurs in a Skills Group or elsewhere, we . . .

***'Take the person aside'* - This focused behavioral intervention may occur on a brief 1:1 ad hoc basis to RESOLVE or PREVENT a crisis, i.e., by 'taking the person aside' and carrying out the PRE-PLANNED intervention.**

OR

***'Intervene Immediately'* - Intervene with the PRE-PLANNED intervention, and do it 'right there' – in the context of a Skills Group or elsewhere (during lunch, preparing to leave for the day, etc.) - either WHEN the target behavior appears, or to PREVENT the behavior from erupting when we see 'the signs'.**



Please note that we work to PREVENT as well as to RESOLVE.

The point here is that we prefer to NOT wait until something happens – and then react. So we build into our plan some approaches to ANTICIPATE and PREVENT predictable behavior from happening to the extent that we can.

- **And we can't rely upon the individual to do that for himself, initially – *although* with time most individuals can develop the skill of 'getting control' before they 'lose it'. We post large signs around the room that say "GET control . . . before you LOSE it!" – and it becomes a slogan of sorts.**

The goal is to 'short-circuit' or reduce the negative behaviors and promote more acceptable alternative behaviors.

This approach is far preferable to simply medicating (as in sedating) problematic geriatric patients – which is too often seen as the "only alternative".

The Basic, Commonly Utilized Behavioral Techniques

Although the *cognitive techniques* are quite different for the geriatric population, the **BEHAVIORAL TECHNIQUES** are similar to those we use with any individual – adult or child – who has agitation or anger management problems . . . but with less reliance on *cognition*.

- **Teaching stress relief routines ('stop-breathe-breathe-again' or 'ask for the music headphones' or 'ask to move to a quieter area for a few moments').**
- **Pre-crisis intervention by the staff who see it coming.**

We'll get into specific activities for the Cognitive Skills Groups in the next lesson.

- **Obtaining and giving on-the-spot individual feedback when behaviors occur – which improves the individual's ability to recognize and 'head off' his own oncoming symptoms of agitation or anger. (Give positive feedback and praise, too, when things are going in the right direction!)**

Developing and reinforcing alternative behaviors ("Do THIS when you feel like you're going to do THAT!") – *and select alternatives which are incompatible with the focal behavior.*

- **Developing effective coping mechanisms (e.g., closing eyes and visualizing flowers when feeling overwhelmed, slow deep breathing, asking for a quick 'one-on-one', asking for p.r.n. medications if allowed)¹⁷**

- **Environmental adjustment, defined as restructuring an individual's environment in an attempt to eliminate the maladaptive behaviors. Applicable to the program site and to the living situation.**
- **Determine the underlying precursors or causes of the behaviors (stressors), and help the individual to recognize and make alternative responses to the stressors.**

***NOTE:* This takes careful OBSERVATION by staff. The trigger of a behavior may be somewhat obscure, and often can't be verbalized by the geriatric patient – particularly if they have verbal apraxia [inability to say what they want to say].**

- **When the patient doesn't see trouble brewing, but YOU DO, personally redirect the individual toward more appropriate, adaptive behaviors. As they say, better to close the windows before the storm starts.**

- **Instruct staff to avoid responses which seem to aggravate or precipitate maladaptive responses by the individual.**

Example: To the extent possible, avoid invading the 'physical space' of a person who is becoming aggressive or threatening. **Work from a respectful distance.**

- **Use 'Area Time Out' [i.e., brief removal of the individual from the immediate treatment area] for highly disruptive behaviors such as screaming, cursing, yelling, spitting, scratching, etc.. But utilize 'Area Time Out' for short intervals ONLY.**

Implement 'Area Time Out' with the assistance of an 'egg timer' in order to a) set a limit on the time-out period, lest it lose its effectiveness, and b) to demarcate the point at which praise and a return to the group are merited for successful completion.

Q: OK, you may say – “but what’s so different in the techniques used here, to manage disruptive or otherwise problematic behavior? Sounds like what we do with most people with behavior problems.”

A: Yes, there are definitely some similarities. But generally speaking, the TARGET BEHAVIORS are different with persons of advanced age, compared to what we normally encounter with non-geriatric outpatient clients. And our physical and verbal RESPONSES must be tempered, because of the physical frailty and cognitive ‘blank spots’ of our clients.

- **Remember these behaviors from previous slides? Repetitive motor rituals, constant pacing, escape behavior, hoarding of object on one's person, prolonged refusal of oral foods and liquids, unprovoked physical aggression (hitting, biting, kicking, throwing things), extreme verbal hostility or abuse of others (*often aggravated by verbal apraxia*), self-injurious behavior, overt sexually inappropriate actions, disruptive outbursts which don't respond to normal interventions, etc.**

And so the behavioral management issues are a bit different – and we must tailor our approach to a person of advanced age.

**Remember Hattie? Let's take a
closer look at her – including what
we do to help her.**

'Hattie', age 74

(name and some details changed for confidentiality purposes).

- **Psychiatric DSM V Diagnoses: 1. Primary Dx - Personality Change Due to Another Medical Condition (CVA), Aggressive Type (310.1) 2. Secondary Dx - Obsessive Compulsive Disorder (300.3)**
- **Physical diagnoses: low potassium, chronic gastritis, congestive heart failure, post left hip fracture and post Cerebral Vascular Accident (CVA – or stroke)**
- **Psychiatric Medications: none**
- **Physical Medications: Lasix 40 mg QD, ASA 80 mg QD, Lanoxin 0.25 mg QD, Zantac 150 mg BID, Ferrous Sulfate 5cc TID, KCL 20 mcg. QD, Oscal D 250 mg BID**

Review of Hattie's Functionality Issues

'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 hospitalization. These behaviors include physical aggression and combativeness, anxiety and psychomotor agitation, obsessive/compulsive hoarding of objects which present a serious safety issue, as well as compulsive wheelchair pacing and escape behavior. Her skin is breaking down due to angry, very 'physical' refusal of basic toileting and bathing care. She is electively non-verbal (which may be her way of dealing with some verbal apraxia), and eats poorly.

Specific Behaviors and Triggers of Same . . .

- **She becomes anxious and enraged, biting and screaming obscenities, whenever staff attempt to remove hoarded items from her possession. or to redirect her actions. She takes and hoards objects that belong to staff and other residents and visitors, implements from the dining room and the nurses station – *all of which disappear under her skirt, into her blouse, or into her mouth.***

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. This is a contributing factor in her 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 creating havoc.

**Looking
Closely at
Contributing
Issues**

HINT: Does Hattie perhaps 'need a job'?

. . . more contributing issues . . .

Track I-B, cont.

Hattie's anxiety has an overlay of depression. Her affect is often flat, and she stares at others with an expressionless gaze. She is **electively non-verbal** most of the time, other than for verbal obscenities.

**With all of this, how then do we treat her - effectively?
We shall discuss this in Part B of this lesson.**

Because of some verbal ataxia, staff have trouble in determining what Hattie wants or needs - which increases Hattie's frustration with day-to-day routines, and prompts aggressive episodes.

Lesson 2 continued . . .

B. ‘Levels of Functioning and Treatment Tracks’

**‘Treatment Tracks’ Assign Clients According To
The Level of Intensity
and the Approach They Need – and
Management of Behavior Is a Key Element!**

Treatment Track Assignment

For practical and therapeutic reasons, we assign each individual to a **Treatment Track**. Each 'Cognitive Skills Group' has two different formats – one format for those individuals assigned to *Track I*, and another format for those assigned to *Track II*. (More specific criteria for track assignment continues with coming slides, along with clinical examples).

These two tracks may be further subdivided into *A* and *B* levels of functioning, depending upon the specific functional characteristics of the individuals. [Remember that "Hattie" is assigned to Track I-B – the lowest functioning because of her seriously problematic behavior.]

'Treatment Tracks' Assign Clients According To The Level of Intensity and the Approach They Need!

- **TRACK I** is for clients with the most severe functional impairments, which may also include **BEHAVIORAL** symptomatology. [Track I clients oftentimes have a relatively **LOWER** level of verbal communication skill than do Track II clients].
- **TRACK II** is for clients who may have serious psychiatric and/or cognitive difficulties but do **NOT** have severe behavioral issues requiring **1-to-1** intervention. [Track II clients oftentimes also have a relatively **HIGHER** level of verbal communication skill than do Track I clients].

The interventions are designed and scaled to the functional level of the client and to his or her assigned 'track' – so that, for example, if we are engaged in a Communication Skills Group with Track I clients, the *intervention and the content* will be LESS complex than the intervention and content used with a Track II Communication Skills Group.

Treatment Tracks . . .

A unique daily program schedule, matched to the individual's functionality.

Each track has a unique daily *program schedule*, with therapeutic activities and approaches which are specifically designed with the LEVEL of participants' functioning in mind. Although the treatment groups may bear the same 'descriptive labels' (e.g., "Communication Group" or "Memory Group") the actual treatment activities, materials, and therapeutic approaches vary significantly, depending upon whether it is a Track I group or a Track II group.

**An example of an individual who would be appropriate for each therapeutic level is presented in following slides. The client types are presented in order, from the perspective of "lowest functioning" [Track I-B] to "highest functioning" [Track II-A].
NOTE: The first example we provide will contain the most detail, for demonstration purposes.**

TRACK I-B - This is the Group Level for those who are impaired in multiple areas of cognitive functioning due to physiological or psychiatric issues - who are *also the most challenging in terms of the management of their overt behavior.*

Track I-B

Recall Hattie, our “wheel chair Houdini” slight-of-hand expert from a few slides back.

KEY: Although Hattie appears unable to maintain attention to any task, she watches the actions of people intently. Although she never initiates interaction with others and never participates in planned activities, she is keenly alert to details of the environment, and never misses an opportunity to escape or hoard. We keep this in mind, to design a plan.

The Therapeutic Approach for Hattie – Our Track I-B Client

Some behavior targets must be addressed FIRST before we can move on to improving cognitive issues:

Behavior must be controlled and channeled before staff can impact Hattie's cognitive impairment with appropriate therapies. She must be encouraged to *sublimate* her compulsive behavior patterns with actions that are safe and non-disruptive, and which leave time for other meaningful activity.

Cognitive Goals: Her predominantly non-verbal behavior patterns, which are punctuated with outbursts of vulgarity and loud verbal hostility, need to be enhanced if possible so that meaningful communication with staff can occur about her wants and needs. She also needs to adopt a basic tolerance for self-care activity (toileting and bathing) and needs to improve her constructive on-task capability.

For the first four weeks of the program, staff cannot allow her out of arm's reach because she grabs and snatches at anything that catches her attention. Nor can they leave any door unlocked for even a few moments; Hattie enters – quickly removing scissors, pens, staplers, papers, paper clips, etc., stuffing them under her dress and into body orifices. She also hoards – on her person and in bodily orifices – all manner of therapeutic supplies, and physically attacks other patients – grabbing for their clothing, hair combs, etc. Explosive behavior results from staff attempts to remove dangerous objects from her person.

Required 1:1 Intensive Interventions: During the first two weeks in the 6-hour per day (5 days per week) program, Hattie required a total of 80 units of intensive 1:1 staff intervention of 10-15 minutes each – a total of 16.6 hours over 2 weeks – for disruptive, combative, and high-risk behaviors. And when 1:1 intervention was not being conducted, her activities were not productive.

During her second two weeks in the program, she required 72 units of brief 1:1 intervention of averaging 9 minutes each – a total of 10.8 hours over 2 weeks. Total for this first month: 27.4 hours of intensive 1:1.

During the second month (4 weeks), disruptive and risk behavior required only 27 units of 1:1 intervention averaging 8 minutes each – or a total of 3.6 hours – a remarkable reduction of 87% in her need for such therapeutic intensity. This improvement in behavioral functioning was brought about, in part, by a BEHAVIOR MANAGEMENT PLAN, which . . .

. . . which . . .

- **taught Hattie *alternative behaviors* to her dangerous hoarding and "escape" patterns [and thus halted the explosive behavior which resulted from attempts to redirect her], and**
- **provided a high level of *structure* which nevertheless offered "safe space" to exercise her motor agitation without explosiveness, and**
- **utilized her *cognitive strength* of alertness to environmental details, to give new purpose to her activities.**

Remember that although Hattie appears unable to maintain attention to any task, she watches the actions of people intently. Although she never initiated interaction with others and never participated in planned activities, she is keenly alert to details of the environment, and never misses an opportunity to escape or hoard. We keep this in mind, to design a plan.

Can Hattie's attention to details and 'alertness to opportunity' be turned into something POSITIVE?

Track I-B, cont.

**Can Hattie's
attention to details
and 'alertness to
opportunity' be
turned into
something
POSITIVE?**

Yes, they can. We needed natural antidotes [incompatible behaviors] to her aimless and erratic wandering and her compulsion to steal and hoard dangerous objects – something that made good use of her talents (eagle-eyed attention to details and 'alertness to opportunity') .

And so we gave Hattie a JOB.

Through the behavioral management plan, she becomes the officially designated "checker", who briefly enters staff offices 2 or 3 times per day under staff supervision, straightens desks [e.g., aligning staplers and placing pens in holders], and closes closets and drawers. In addition, she is allowed to choose one safe item each morning which she will "take care of" for the duration of the day, which she secures under the folds of her lap blanket and returns to staff before leaving. Through this approach, staff consistently reinforce "non-hoarding". Because she has been given something meaningful to do which utilizes her strengths, her aimless motor agitation and escape behavior is significantly reduced to the level that little 1:1 intensive intervention is needed. Interaction is much more relaxed and positive.

Also as part of the behavior management plan: Verbal communication and appropriate, non-aggressive behaviors toward other patients are brought about when she becomes the designated "helper" for other participants – to observe whether they are "comfortable", and to report this to staff. Social service staff at her nursing home report that her improved behavior "carries over" to the nursing facility, in terms of control of her most disruptive behaviors.

Now, on to Improving Hattie's Cognition:

With these *behavioral* changes, Hattie becomes more *cognitively* functional. She begins to utilize and rebuild skills that have long since fallen into disuse. She works in very small groups of two or three, and her program emphasizes utilization of basic cognition. With these improvements, she is more connected and responsive to her caretakers, peers, and environment.

Cognitive Work, cont.

Let's look at how we approach Hattie's **COGNITION issues in Track Level I-B , once we have attended to the most disruptive and high-risk behaviors.**

Therapeutic activities emphasize . . .

- 1. basic orientation to person, situation and time, with staff prompting simple oral or signaled feedback from Hattie to ensure 'connection' and understanding;**
- 2. sensori-motor movements which are purposeful and constructive, and which reinforce Hattie's new on-task behavior – using brightly colored form boards, puzzles, and other objects which are too large to easily conceal [e.g., large disks for stringing, "bead mazes" attached to metal wire guides], and freeform design with watercolors and freeform shapes (temporary mosaics);**

- 3. non-verbal and verbal communication with Hattie – accepting hand signals when she so desires, but rewarding verbal communication with praise and sometimes an extra item to 'take care of for the day';**
- 4. recall and utilization of basic practical information, which is woven into simple verbal dialogue with Hattie during small group Level I exercises and on an ad hoc basis; and**
- 5. practical memory functions using shell games and other "where-is-it" games which utilize her alertness to the environment and to details which capture her attention.**

You can see details of how these functional activities are typically carried out, in Lesson 3.

Once Hattie has become more functional and begins to respond to praise and positive physical interaction with staff (instead of the daily struggle of the first few weeks), staff are able to reinforce Hattie's attention to activities of daily living (continence, basic toileting tolerance, personal hygiene), which become part of her 'job' – including "reminding" staff that it's time for her "cleanup". Special treats (rewards – such as listening to a favorite set of music on the headphones) are dispensed for compliance with these major, less-fun activities.

Track I-A

Example of an Appropriate Client

Track I-A participants have some islands of fairly functional cognition but often have major behavior management problems and major psychiatric symptomatology which will clearly lead to hospitalization if not treated and stabilized.

'Leona' - age 70

Leona was a bookkeeper until six or seven years ago, when worsening circulatory problems apparently caused changes in her mental efficiency - with indicators of "spotty" cognition (mild impairment). She is assigned to Track I-A, because she requires extensive 1:1 intervention for control of aggressive and severely disruptive behavior. There is also a need to stimulate her mildly impaired cognitive functioning.

Psychiatric Diagnoses:

Track I-A . . .

1) Primary Dx - Persistent Depressive Disorder/Late Onset/severe (300.4) DSM V

Secondary Dx – Mild Neurocognitive Disorder Due to Multiple Etiologies, With Behavioral Disturbance (331.83) DSM V

- **physical diagnoses: diabetes mellitus, seizure disorder, congestive heart failure, atrial fib**
- **psychiatric medications: Prozac 10 mg qam**
- **physical medications: Dilantin, Lasix, KCL, Surfak, Bantec, Isodil, Cardizen, Lanoxin**

'Leona' is verbally and physically abusive of all who enter her "space", and she alienates others so that she has little constructive interaction with the environment. When not engaged in some disruptive action, she seems "split off" from her environment, and is becoming more disoriented to her surroundings.

Track I-A . . .

'Leona' had a history of periodic depression preceding the onset of her cognitive confusion, but the depression has worsened steadily since the onset of organic disease. Affect is chronically depressed and hostile. Leona is essentially non-verbal except to verbally attack others. She is frequently explosive and combative in the nursing facility where she lives, particularly when she is unusually depressed, or is incontinent and needs to be "changed", or does not get what she wants [despite not having asked for it directly], or is prevented from withdrawing from contact with staff and other residents.

Assessment indicates that Leona still has significant "islands" of cognitive intactness. However, alienation from her environment seems to increase her confusion about person, place, and time, and prevents participation in activities which stimulate mental processes. Her cognition is therefore deteriorating faster than it might otherwise. 47

The Therapeutic Emphasis with 'Leona'

Track I-A . . .

Behavior:

Behavior must be at least marginally controlled in order to deal with the primary psychiatric illness. In other words, improvement in depression will ultimately move into the therapeutic forefront, but *not until* behavioral cooperation can be achieved.

The immediate goal is therefore control and remediation of Leona's severely disruptive, explosive outbursts and combativeness. Secondary behavioral goals include direct communication of wants, needs, and depressive feelings without resort to hostile behavior, and more appropriate social interaction (i.e., a decrease in loud verbal obscenities, no alienation of others).

Track I-A . . .

Behavioral Approach:

During her first month in the program, Leona requires 54 units [of fifteen minutes each] of intensive 1:1 intervention for such dysfunctional behavior. During her second month in the program, she had a 61% decrease in the need for such 1:1 - requiring only 21 units. Her third month in the program, 1:1 intervention was rarely required.

"Area Time Out" is used as an effective management approach, i.e., removing Leona from the immediate treatment area to space with less stimulation when she first begins to escalate - where she is better able to bring her outburst or combativeness under control. In the company of one to two staff members, Leona is helped to process the source of her immediate disturbance. She is taught to recognize the internal

Track I-A . . .

cues ("feelings") which precede outbursts, and to withdraw briefly from the situation so that she can regain control without becoming assaultive. Over several weeks, Leona is able to initiate withdrawal from the immediate treatment area prior to an explosive reaction, at an increasing frequency.

Leona is also taught through modeling and consistent verbal reinforcement, to express wants and needs directly. She is then less prone to agitation, because she expresses wants and needs directly to staff (either verbally or non-verbally).

Mental status/affect:

The primary goal of treatment, once behavior is stabilized, is to alleviate severe depression. The approach was as followed:

Prozac proves effective in facilitating some demonstrable relief from the historical indicators of her major depression (e.g., a tendency to be virtually non-verbal except for verbal attacks, withdrawal from the environment, refusal to eat), although her overt affect continues to be moderately depressed.

Her increased verbal and cognitive competence also reduces her depressive reaction to the day to day frustrations of living in a nursing facility - and the opportunity for verbal expression of grief over loss of her competent lifestyle helps her to come to terms with the changes. Staff help her to remember, with humor and pride, the various milestones of her competent career, and to understand that time cannot rob her of those events in her life.⁵¹

Cognition:

Track I-A . . .

The goal in this target area is to strengthen or "recharge" cognitive functions which have fallen into disuse with depression and early-stage dementia.

Approach: Therapeutic activities which emphasize

- 1) orientation to person (others), situation and time, through continually connecting her to her environment [verbally and non-verbally, using all her available senses to integrate her awareness]; and**
- 2) exercise and rebuilding of essential cognitive skills (motor planning and organization, on-task behavior, non-verbal concept formation, and communication); and**
- 3) activities of daily living (improved toileting and continence, personal hygiene).**

Cognitively, Leona responds quite favorably to the structure and ongoing cognitive therapies. Her use of organizational skills and the ability to make simple decisions improve measurably, as do her on-task behavior and her ability to communicate effectively. As she begins to feel more confident and "tuned in" to her environment, her behavioral outbursts become rare.

Track I-A . . .

The details of how to conduct these interventions through Cognitive Skills Groups are covered in the next lesson (Study Guide 3).

Track II-B

Example of an Appropriate Client

This is an example of an individual who is appropriate for Track II-B, i.e., those who have *fairly good verbal skills*, better overall *cognition* than Track I, and *significant psychiatric dysfunction without major behavioral disturbance*. These individuals need additional structure and a slower pace of activity because they become episodically agitated, mentally confused, delusional, or hallucinatory.

'Eric', age 76

- **309.28 Adjustment Disorder with mixed anxiety and depressed mood [DSM V]**

Track II-B . . .

2) Secondary Dx - Unspecified mental disorder due to another medical condition [in this case, due to Closed Head Injury] (294.9) DSM V

3) Additional Dx - Anorexia nervosa (307.1) DSM V

- **physical diagnoses: post closed head injury and post hip fracture and low body weight associated with eating disorder**
- **psychiatric medications: Prozac 10 mg qam (admitting meds, taken for 18 months prior to admission). D/C'd by program psychiatrist two weeks into program with a change to new medication (Paxil) to better address his anxiety as well as depression.**
- **physical medications: none, although he has G-tube for nutritional maintenance.**

Track II-B . . .

'Eric' has become progressively dysfunctional and depressed since an accident resulted in closed head injury two years ago. He has twice made significant suicidal gestures, although he is hampered in these attempts because he is wheelchair bound. Many aspects of cognitive functioning - memory functions, response to stimuli, eye-hand coordination, on-task behavior, etc. - have deteriorated to some extent over the past two years, although he retains a good "basic intelligence" which surprises those who happen to encounter it. He is appropriate for Track II-B rather than Track II-A because, despite these indicators of intact cognition, he has special problems which require extra "management" on a daily basis.

Track II-B . . .

One complicating factor is that Eric has become expressively aphasic over the past 18 months, which is the "trigger" for frequent panic attacks, culminating in rage and occasional assaultiveness. Eric becomes highly agitated and anxious when he cannot express himself verbally, or when people ask him questions - which leads to physical combativeness, screaming, and increased depression and withdrawal. He has also stopped eating, and has a G-tube for all but water intake.

Track II-B . . .

Eric now lives in a nursing facility because his wife cannot care for him at home. His wife is insistent that everything be done for him, and she visits the nursing home daily - tending to multiple details that the staff feel he could do for himself. As a result of his increasing cognitive disuse over the past two years, and his wife's over-protection of him, Eric has become almost incapable of making a decision, and he becomes distraught if asked to make a decision as simple as whether he is ready for bed.

The Therapeutic Emphasis with 'Eric' . . .

Track II-B . . .

***Mental status/affect:* Goal is to alleviate both severe depression and reactive anxiety which produces agitation and episodes of explosive behavior. Eric is evaluated by the psychiatrist regarding his depression, anxiety, expressive aphasia, and psychomotor agitation. It is felt that the aphasia may be, at least in part, a side effect of the Prozac, and thus the psychiatrist D\C's the drug on a trial basis. Within two weeks, the aphasia and the agitation are somewhat improved, and work begins on rehabilitation of oral expression. However, the anxiety and depression continued.**

- **Therefore, the psychiatrist gives a trial of an anti-anxiety / anti-depressant psychoactive drug (Paxil), which has the primary effect of making Eric more "available" to the treatment process - in terms of cooperation, motivation, attention span, and energy.**

Eric works with a therapist in individual therapy twice weekly, to work on verbal and alternative expression of his frustration and rage which accompany panic attacks. He has done much "grief work" in this context - using snapshots and a "family diary" provided by his daughter to revisit old memories - both good and sad. With the subsequent gains Eric makes in his emotional stability and verbal facility, he ultimately gains improved control over his rages and periods of extreme agitation and depression. He begins to "wean" from the program at eight weeks, and is ready for discharge after 13 weeks.

Behavior:

Eric is taught to withdraw from the immediate situation very early in the onset of an "anxiety attack", and to let staff know

with hand signals that he is frustrated and on the verge of "blowing up". Staff always respect this withdrawal, and Eric makes the decision about when he is ready to rejoin the group. He is also taught to respond to hand signals from staff - which are less stimulating than oral communication when he is upset - in terms of cues that will help him regain control.

Cognition:

Goal is rehabilitation of cognitive functions which have fallen into disuse since closed head injury occurred and the depressive process began.

Approach: Therapeutic activities emphasize . . .

- 1) connection to situation and time, primarily through prompting alertness to surroundings and timeframes;** 61

Track II-B . . .

- 2) the use and enhancement of multiple cognitive skills - including eye-hand coordination, organization of "work" behaviors, on-task behavior, spatial relationships, sensory integration, planning, and verbal concept formation (which he begins to integrate carefully into well chosen words such as "similar", "absolutely!" and "complete and total!").**
- 3) the expression of wants and needs [initially through non-verbal mechanisms], and decision making.**
- 4) It is discovered that sensory integration and organization of spatial relationships [through form boards, puzzles, and free-form designs] are the cognitive functions which seem to "pull everything together" for Eric - in terms of attention span, concentration, planning, decision making and sense of accomplishment.**

***Eric's activities of daily living* are addressed by the OTR in terms of building strength and mobility, which improves Eric's confidence and reduces his anxiety and depression.**

***Expressive aphasia* is addressed by the speech therapist for a period of four weeks and then is addressed by program staff as a routine part of each interaction. Verbal expression by Eric is never forced – hand signals are acceptable. The staff also use manual cues to indicate "take your time" and "try another word" – which reduces Eric's anxiety and the panic attacks which are often triggered by his aphasia. As the panic episodes decline, there is significant improvement in verbalization. Rages and assaultiveness, often associated with the panic attacks, are reduced by 75%.**

An interesting concomitant is that, when he begins to speak and make decisions, he also begins to eat again - selecting one or two items from his tray each day, and drinking Shake-Ups each morning. The G-tube remains in place, however, as oral nutrition is incomplete. Could it be that his refusal to eat was his way of maintaining control, since his ability to make decisions and to verbalize his preferences were temporarily disabled?

Track II-B . . .

Track II-A Example of an Appropriate Client

This is an example of an individual who is appropriate for Track II-A, i.e., those who have essential cognitive intactness despite *episodic confusion and disorientation* which is likely caused by their depression and anxiety or other diagnoses, and who have *fairly intact oral communication and verbal conceptualization skills*, and who do NOT have major behavior management problems. However, such individuals DO have other *major psychiatric problems* such as severe depression, delusional disorder, anxiety disorder, organic personality disorder, suicidal ideation, etc., which threaten hospitalization and have not responded to other less intensive outpatient treatments. If these issues can be stabilized, we can work on remaining cognitive and functional issues.

'James', age 67

Track II-A . . .

Psychiatric diagnoses:

- 1) Primary Dx - Delusional Disorder (297.1) DSM V**
- 2) Secondary Dx - Unspecified Depressive Disorder (311) DSM V**
- 3) Additional Dx - Mild vascular neurocognitive disorder (331.83) DSM V**
 - physical diagnoses: congestive heart failure, post hip fracture**
 - psychiatric medications: Haldol 0.5 mg po BID, initially, increased to 1.0 mg BID**
 - physical medications: Lasix, KCL, Lanoxin**

Track II-A . . .

James has become progressively confused about daily routines during the past eighteen months, following circulatory complications and frequent TIA's. He has had increasing problems with short-term memory and attention span, and he cannot complete "anything" he starts, including personal hygiene. The family reports that he is having increasing difficulty in disorientation to his surroundings, and has become manually clumsy, which produces panic. He is experiencing severe anxiety, marked depression, and an exacerbation in his long-term delusional thinking in connection with these problems. He is withdrawing from social contact. Appetite is severely depressed, and he is losing weight at a rapid rate.

James has had delusions and hallucinations for some time, which have been fairly well controlled with anti-psychotic medication; however the auditory hallucinations and delusions, which involve religious figures and messages, have become increasingly severe and disturbing to James.

He is basically pleasant, but is becoming quite socially isolated - partly out of embarrassment about memory failures and disorientation, and partly due to depressive episodes that are increasing in frequency and severity, and partly due to preoccupation with his hallucinatory "visitors". He requires frequent redirection and response to questions that stem from disorientation to time and place, and he senses that this is disturbing to caretakers. He is assigned to the Track II-A treatment program because he retains good oral communication skills and presents no particular behavior management problems.

Track II-A . . .

The Therapeutic Emphasis with James . . .

Mental status:

The primary goal is to alleviate, to the extent practicable, delusional and hallucinatory processes.

Approach: James is evaluated by the psychiatrist regarding his increasing hallucinations, from the perspective of any needed changes in his medication regimen (Haldol 0.5 mg BID). Haldol is increased to 1.0 mg BID, which reduces the hallucinatory activity but does not halt it. It is felt that the increased sedation we might expect from a further increase in Haldol would offset any gains we might make in eliminating the hallucinations - particularly since James is no longer upset or disturbed by the voices, but only distracted and preoccupied.

Although James continues to hallucinate auditorially, the structure of the program enables him to "tune out" or ignore the hallucinations, and thus he is better able to maintain attention to his immediate environment.

Cognition:

The goal is stabilization of available cognitive functions, which have tended to deteriorate more than they might otherwise with withdrawal from the environment and general disuse.

Approach: Therapeutic activities emphasize . . .

- 1) connection to environment, peers, situation and timeframes;**
- 2) use and rehabilitation of multiple cognitive skills - including organization of "work" behaviors, on-task behavior, visual and verbal concept formation;**

- 3) social interaction, and expression of wants, needs, and ideas;**
- 4) activities of daily living – toileting, personal hygiene;**
- 5) sensory-motor coordination.**

Track II-A . . .

Within the context of the structured therapeutic program, James begins to actively use mental functions which are vital to prevent or slow progressive cognitive decline. He also achieves an optimal internal management of his delusional and hallucinatory process, in that he is now "too busy" to attend closely to the voices. James becomes much more outgoing and self confident, which seems commensurate with his increased sense of competence and mastery in cognitive areas.

Track II-A . . .

At the point of discharge, nine weeks following admission, James has recouped or improved many of the cognitive and functional skills which had begun to atrophy through disuse, and his psychotic process is stabilized. The family has been very involved in the content of the treatment program and has learned how to mentally stimulate and orient James within the home environment.



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