

# **Aging Course 4G**

## **LESSON 4**

**Summary: The Four-  
Point Approach  
to Success In This  
Program**

## Summary Review: The Four Keys To Success. It's a Four-Point Approach.

1. Address severely disruptive *behaviors* first.
2. Shore up seven aspects of *cognitive functioning* . . . including perception, mental processing, communication, sensory-motor integration, ADLs, social interaction, and orientation to reality (response to the environment).
3. Do continuous *assessment* and *documentation* of participants' progress and functional status.
4. Assure that there is *cooperative interaction and planning* within the entire treatment staff and caretakers.

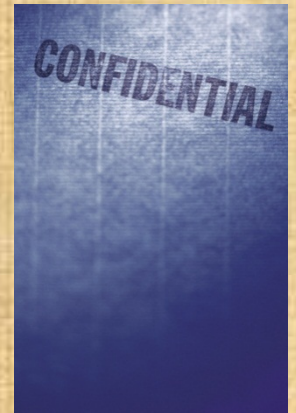
## A Few Words in Review and Summary About The Four-Point Approach – Essential to Success In This Program Design



- The first two points 1 and 2 on the previous page – interventions aimed at *modifying disruptive behavior* and shoring up *cognitive functioning* – form the ‘CORE’ of the program. These are essential to ensuring ‘best outcome’ for the individuals who participate in this type of program. Specifically, through our work to *stabilize disruptive behaviors* in confused and acutely impaired participants, we seek to make them ‘*accessible*’ to treatment. Through our work to stimulate and improve *cognitive functioning*, we help the individual to *make sense of* his or her world again.

- **The third point – the need for continuous *ASSESSMENT and DOCUMENTATION of participants' FUNCTIONAL STATUS and RESPONSE TO TREATMENT* – is now commonplace with programs which have high 'accountability' and 'outcome' expectations – including effective use of funds and other resources (e.g., state and Federal and foundation-funded contracts).**

**Emphasis upon these assessment and documentation activities is also essential for programs operating within a 'managed care' environment – which requires good treatment outcomes and *systematic control of costs and limitation of 'who' gets 'what' treatment.***





- The fourth point – *cooperative interaction and planning* – is essential for INTERNAL CONSISTENCY of program implementation. Everyone – including caretakers – must be on the same track with each program participant.



Many of these approaches and interventions can be (and should be) carried over into the participant's living situation – such as the approach to disruptive behaviors and reinforcement of the most effective communication methods which have been developed with the individual. Frustrated communications lead to more behavioral and affective upheaval than perhaps any other aspect of cognitive impairment.

## 1. ADDRESSING DISRUPTIVE BEHAVIORS

Recall that here – with this area – we are referring to treatment and control of *extremely* DISRUPTIVE BEHAVIORS which absorb a great deal of caretaker time to control and contain. Some of these behaviors may need to be addressed and controlled *before* we can do anything else! Ask almost any nursing home employee or family member about the most difficult challenge they face with mentally impaired geriatric individuals, and they will tell you – AGGRESSIVE AND SOCIALLY INAPPROPRIATE BEHAVIOR!

The Keys To Success . . .

**Here, our MAIN FOCUS was upon development of positive, ALTERNATIVE BEHAVIOR – behaviors which are INCOMPATIBLE with the problem behaviors – which are non-aggressive and socially appropriate.**

- **The control of extremely disruptive behavior is crucial, when dealing with disturbance of COGNITIVE processes and day to day FUNCTIONING. Why? Because the presence of extremely disruptive and aberrant behaviors can prevent us from 'getting to' the cognitive and functional issues, and can prevent the individual from responding to our therapeutic efforts. Until extreme behaviors are stabilized, the individual is NOT ACCESSIBLE to treatment.**



## **2. SHORING UP COGNITIVE PROCESSING ABILITY, Including ORIENTATION TO REALITY**

**Here, we dealt with reinforcement and stabilization of the individual's COGNITIVE PROCESSING ABILITY . . . including his COMMUNICATION ability, his PERCEPTION and MEMORY, his ORIENTATION TO REALITY, and his sensory motor COORDINATION. It does not matter whether such deficits are associated with recent strokes or other physical-medical events, a non-Alzheimer's early cognitive decline, grief, loss, change in living situation, or major mental health disorder. This requires a MULTI-PRONGED APPROACH.**

**The Keys To Success . . .**



## **A MULTI-PRONGED Approach . . .**

### **The Keys To Success . . .**

- A. IT'S ALL ABOUT 'MAKING SENSE OF THE WORLD'. Why do we focus upon the individual's perception of the environment and his orientation to reality? Because until individuals can begin to MAKE BETTER SENSE out of their world from the cognitive perspective, they cannot respond effectively to treatment interventions.**

- **NOTE: We may not be able to return the individual to the status which he enjoyed prior to the occurrence of stroke or psychiatric problems which impair cognition. But there is oftentimes SIGNIFICANT IMPROVEMENT that can be made, in terms of affect, connection to surroundings, ability to effectively communicate, and appropriateness of behavior. And we can very often STABILIZE a downward slide in non-Alzheimer's patients.**

**B. IT'S 'NON-VERBAL', AT FIRST. We know that many geriatric patients – just like adults with a major mental illness – DO NOT RESPOND to the traditional cognitive-based therapies, and must be approached in a way that FIRST taps into their NON-VERBAL ABILITIES.**

**C. AND THEN WE GET TO 'VERBAL'. Overall, of course, we want to strengthen BOTH the verbal and non-verbal cognitive functions through our targeted interventions. Through such work – which is consistent with extensive research done at UCLA's Brain Institute and elsewhere – the individual can make the most of his stabilization program.**

**D. SMALL GROUPS WORK BEST.** This therapeutic approach utilizes a 'small-group' format which is less chaotic and less stimulating than larger groups. It's easier to re-tool functioning with 5 people than 30 people. And we have found that those who 'get it' are able to serve as positive role models for those who are struggling with a skill or concept. We do recognize that some require a specialized group geared to a significantly lower LEVEL of functioning – and so we created 'treatment tracks'.

**IN SUMMARY . . .** The interventions are structured to address the following:

- the array of behavioral symptoms which threaten to result in hospitalization or which may disrupt current residence arrangements (home or facility), and



- the preservation and strengthening of **AVAILABLE COGNITIVE SKILLS** – making the most of what he or she has available, re-connecting and shoring up disarrayed functions, and
- strengthening his or her **ORIENTATION TO REALITY**. Here, we refer to prompting an accurate perception of the environment, as well as stabilization of psychotic symptoms, delusions and major affect disturbances. **REALITY-ORIENTED TALK, PICTURES AND ACTIONS** are utilized by all staff. And we may need to include psychotropic **MEDICATIONS** carefully monitored by a psychiatrist, with periodic assessment of medication side effects.

### 3. COOPERATIVE INTERACTION and PLANNING

**This work goal emphasizes cooperative INTERACTION and PLANNING between licensed professionals, facility staff, or Adult Day Care staff (if applicable) and *family members or other caretakers*, in order to meet the participants' needs effectively and to facilitate 'CARRY OVER' from the program to the living situation. We know that CONSISTENCY in how we relate to psychiatric patients is essential and crucial to outcome.**

**The Keys To Success . . .**

**Obviously, as with any therapeutic program, the amount of time that the individual remains in the formal treatment program is LIMITED.**

**Therefore, we must facilitate 'CARRY OVER' from the program to the normal day-to-day living situation.**

**This requires that the professionals who are responsible for implementation of the treatment program COORDINATE CLOSELY WITH THE CARETAKERS – whether they be family, nursing or retirement facility personnel or church/other day care programs – whoever is a normal part of the individual's usual living situation.**

**The professional staff must therefore TRAIN the caretakers in the details of how to implement interventions and responses to problem behaviors.**

**When designing interventions, we need to keep in mind that what we do will need to be carried forth in a normal living situation – and thus must be PRACTICAL and DOABLE by non-professionals. Our role, as professionals, is to determine WHAT WORKS!**



## 4. CONTINUOUS ASSESSMENT and DOCUMENTATION Of FUNCTIONING and PROGRESS

Here, we emphasize continuous  
**ASSESSMENT and DOCUMENTATION** of  
participants' **PROGRESS and FUNCTIONAL  
STATUS** - including the effects of  
medication management when applicable.  
Also, there must be regular review and  
modification of the **TREATMENT PLAN**.

**RULE OF THUMB:** When things aren't  
working, it's time to re-visit the treatment  
plan and make changes as needed. *To  
continue the status quo in the face of  
inadequate response leads to treatment  
failure.*

The Keys To Success . . .



**So what, exactly, are we ASSESSING AND DOCUMENTING? We are addressing these questions:**

***1. Should treatment continue?*** We assess this question through a 'Care Management' approach [i.e., is continued treatment necessary and reasonable?]. This includes careful 'documentation of progress toward goals' to guide us. As with any mental health treatment, the need for continued treatment in a program such as this is judged by assessing whether the treatment is . . .

- a. **APPROPRIATE AND NECESSARY** to treat the individual's condition, and
- b. whether there is a reasonable **EXPECTATION OF IMPROVEMENT** if we continue the treatment.

## ***2. Is he or she in fact benefitting from the program?***

**Professional staff must formally assess whether the client is BENEFITTING from the treatment - i.e.,**

- Has the treatment been reasonably effective in addressing the cognitive and behavioral problems?**
- Is he or she getting something of significance from the treatment that cannot be provided in other ways or settings?**
- And is improvement likely to continue if the treatment continues?**
- And . . . will he or she REGRESS if we stop treatment in this setting? In other words, is treatment essential to maintain STABILIZATION?**

**To determine the level of 'benefit', we must consider the implications of CONTINUING treatment vs. DISCONTINUING treatment – and here's how to do it.**

**QUESTION TO ASK:** Is there a reasonable expectation that if treatment in this setting is withdrawn, the client's condition would deteriorate? Relapse further, or require hospitalization? If so, the implication is clear: Treatment should continue if possible.

**NOTE:** How to ASSESS whether or not the individual will REGRESS without continued participation: It's often recommended that we attempt to 'WEAN' the client from the program when a 'plateau' has been reached in key functional areas. [A plateau is the point at which it seems that s/he has reached the MAXIMUM level of improvement.] We do this by decreasing the number of hours per week that he attends the program, in a stepwise manner, monitoring response. Work must be done with family and other caretaker staff throughout the treatment process, so that the CARETAKER can support the PROGRESS that the client has made.



## **ALSO, IS RESTORATION POSSIBLE?**

For some individuals, but not all, the additional goal of treatment is **RESTORATION** to the level of functioning which was present prior to the onset of illness. However, this primarily applies to individuals who have developed acute cognitive and psychiatric disorders (including depression) that are amenable to medication management and brief cognitive intervention.

**NOTE:** We must bear in mind that the presence of acute affective disturbance (depression and anxiety) may mimic 'dementia' or other such disorders.

An important **DIFFERENTIAL DIAGNOSIS** issue when dealing with geriatric populations: Major Depression in the elderly is oftentimes mistaken for (and misdiagnosed as) cognitive impairment or early dementia. It is important for a physician who is familiar with geriatric populations to make this differential diagnosis, which is usually accomplished by a trial of anti-depressant medication.



Is there any  
empirical  
validation for use  
of this type of  
cognitive  
stimulation in  
persons with  
'Early Cognitive  
Decline  
(Alzheimer's or  
Dementia)'?

**We have repeatedly made  
the point that we are not  
presenting this material  
as a treatment for  
individuals who are  
experiencing the early  
cognitive decline of  
Alzheimer's or dementia.**

**HOWEVER . . .**

**. . . In the French publication 'Cognitive Stimulation: A New Approach for Alzheimer's Disease Management' – and in subsequent publications – Jocelyne de Rotrou, Inge Cantegreil-Kallen, Annie Gosselin, Emily Wenisch, and Anne-Sophie Rigaud (Department of Geriatrics, Hôpital Broca, Paris, France) DO IN FACT present an EMPIRICALLY VALIDATED case for use of Cognitive Stimulation activities (the essential approach that we have presented here), with persons with Alzheimer's and related cognitive disease.**

**Jocelyne de Rotrou – a French research scientist with a focus upon Alzheimer's – is the author of 44 recognized publications from 2005-2014 on the use of cognitive stimulation and psychosocial interventions with Alzheimer's and related cognitive diseases.**

*Excerpts quoted from multiple publications by de Rotrou and her research colleagues follow on the next few slides:*

*“Preliminary evidence of the exploratory phase of a controlled study from our group on the benefit of Cognitive Stimulation (CS) intervention for thirty first stage AD [Alzheimer’s Disease] patients and their caregivers suggests that CS intervention tends to have positive effects on the patients’ activities of daily living, and demonstrates significant improvement of social activities and reduced stress and burden for the caregiver. Thus, preliminary data show effectiveness on both cognitive functions of the patient, and on well-being of the carer.”*

*“CS focuses on slowing down overall cognitive decline and behavioural disorders by calling on two types of factors . . .”*



(cont.)

- *Cognitive factors: attention, perception, episodic and semantic memory, visuospatial abilities, executive function, verbal fluency. Although CS tackles most areas of cognition, it takes into account the fact that cognition has multiple components. The degree of impairment and level of preserved reserve capacity is highly variable in first stage AD. All of them are not equally impaired whereas memory impairment is considered as a hall-mark."*

(cont.)

- *Psycho-social factors: Self-confidence, self-esteem, motivation, affective state, social involvement. When persons are aware of their memory deficits, they become anxious and depressive and they need understanding and encouragement. Anxiety and depressive mood have negative interferences on the patients' cognition and functional abilities. [Lack of] motivation interferes significantly with the level of cognitive functioning."*

(cont.)

- *Even a subtle enhancement of cognitive function will be perceived by the subject as an affirmation of competence and will, therefore, augment self-esteem and improve affective status. Affective status can be considered as a good indicator of quality of life and [poor affect] interferes significantly with the level of everyday functioning."*
- *Jocelyne de Rotrou, Inge Cantegreil-Kallen, Annie Gosselin, Emily Wenisch, Anne-Sophie Rigaud (Department of Geriatrics, Hôpital Broca, Paris, France)*



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