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This Is An Online Demonstration of Aging Course 4G, Presented By CEU By Net – the Fully Automated, Very Affordable, Non-Traditional Continuing Education Website!

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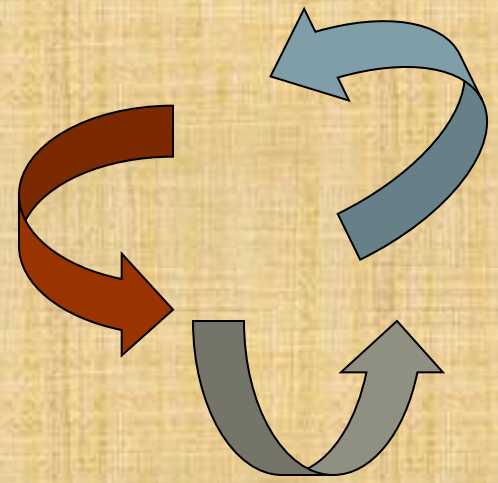
This Course Demo/Preview Contains Excerpted Slides from Aging Course 4G

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

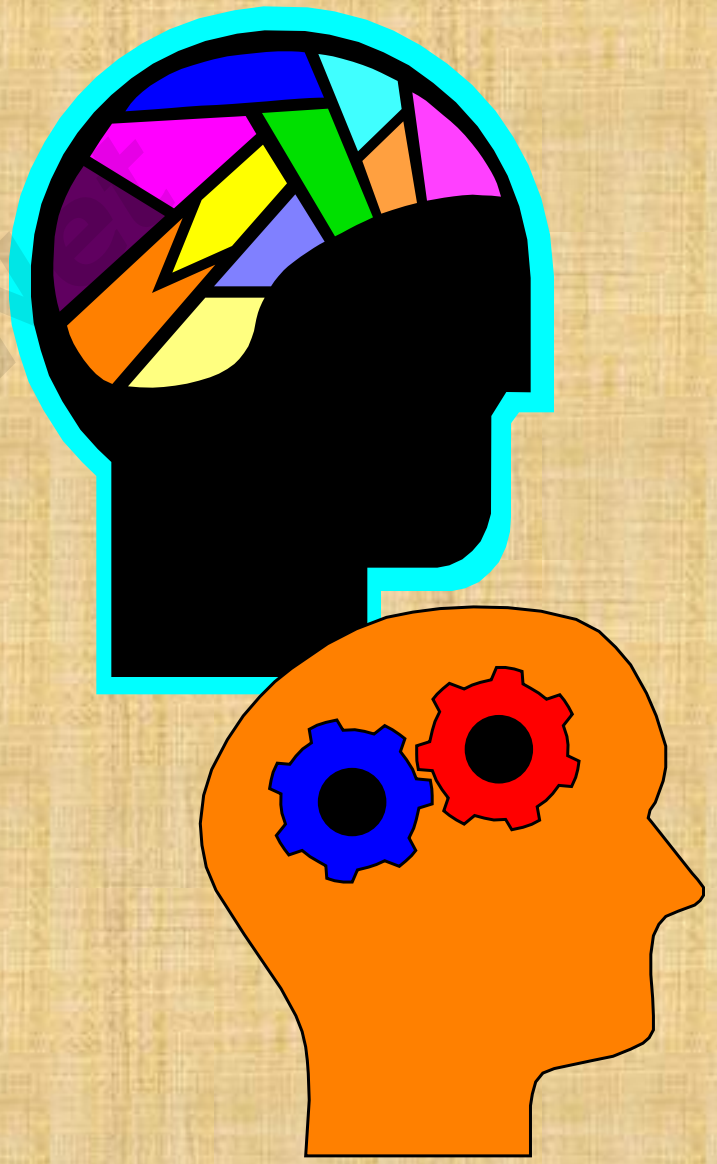
In the elderly, behavioral problems, cognitive confusion, and reduced functionality are oftentimes the SEQUELLAE which follow on the heels of acute medical events (e.g., stroke, major surgery) or situational changes or loss . . .

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



The Changes Are Oftentimes Sequential Events

Cognitive and behavioral *deficits* of geriatric patients take on a 'different face' than those of typical behavioral health consumers. And thus we tailor what we do to their particular characteristics, behaviors, and difficulties.



This course presents

A STRUCTURED SKILLS-BASED TREATMENT APPROACH

to working with COGNITIVE and BEHAVIORAL difficulties of the elderly. The interventions are particularly helpful with cognitive confusion or acute impairment 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.

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. Discussion of the Cognitive/Behavioral (Functional) Deficits of Geriatric Individuals

LESSON 2

A. Behavior Management

B. The Approach: Levels of Functioning and Treatment Tracks

LESSON 3

Specific Techniques for Reconnecting and Reinforcing Cognitive Processes

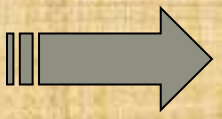
LESSON 4

The Four-Point Approach to Success

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?**

- **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.**



How to deal with these issues? That's what this course is about.

Deficits in cognition and behavior (i.e., *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 functional deficit – or several.

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.

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 stroke or other medical crisis, disruptive environmental changes, etc. – has affected important SKILLS for daily living.

And so we are taking aim at the geriatric individual's specific cognitive deficits . . . seeking to STABILIZE and MINIMIZE problems which are interfering with his ability to function as normally as possible for his age.

There is method and structure to everything we do.

We must oftentimes FIRST attain a measure of control over any disruptive and maladaptive behavior, in order to impact the other areas of difficulty.

And there may be major behavior management issues to attend, as well.

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.

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.

Case Study – An Example of a of a Track I (Lower Functioning) Individual in This Program.

'Hattie' is age 74. She was admitted from her daughter's house 3 months ago. 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 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). Among other things, her communication skills have deteriorated significantly, and her ability to channel her attention into anything meaningful or productive appears to be at a standstill.

Thus, her days are filled with anxious wheelchair pacing . . . attempts to escape from the nursing facility unit, setting off the fire alarms in the facility . . . 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? In this course we describe how we did it – successfully!

We also present three other case studies of individuals at varying levels of dysfunction.

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 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 those of advanced age whose cognitive issues are not complicated by serious behavioral issues.

Reason: 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 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.

And that's what this course is about! To enroll in this course, click here.