MESSAGES ABOUT COGNITIVE ABILITIES

Suggestions of Assumptions to Make about a Person who Needs Help

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TO KEEP IN MIND

Cognitive abilities include a person's ability to **think**, **understand** what they see or hear, **figure out** how to do things, **remember**, **imagine**, and many **other cognitive functions**. Cognitive abilities allow us to **communicate**, **understand** and **respond** to our surroundings, **create**, and **perform tasks**.

This handout lists 13 **basic** general **messages** as recommended assumptions about a person and their cognitive abilities (their cognitive strengths and their cognitive needs). This list is not exhaustive and is not in order of priority. It simply addresses various **issues that might arise**. The information applies to **all persons** regardless of their setting, their health (with or without a brain disorder), or the situation (whether or not it is a crisis). It includes assumptions about a person who needs much assistance as well as a person who needs minimal assistance. So, some of these assumptions can apply to a student doing homework, an architect learning new skills, a neighbor you are conversing with, a store employee, a person diagnosed with a disorder, or a person who finds movement, speaking, and understanding extremely difficult.

These assumptions are for someone who is trying to understand and help a person feel more comfortable, competent, and safe.

More assumptions, suggestions, information, and details about cognitive abilities and interventions (including support strategies) can be found in **other CAIS Handouts** by S Weaverdyck (43 total) including: "**#1 Messages about Cognitive Intervention**", "**#5 Recognizing Cognitive Abilities**", "**#8 The Brain and Cognitive Abilities**", and in the *Cognitive Abilities and Intervention Strategies (**CAIS**) **Questions to Ask*** and ***CAIS Intervention Strategies*** by S Weaverdyck. The CAIS provides detailed intervention strategies that address **specific cognitive abilities**, the **environment**, **tasks** and daily routines, and your **communication** with this person. These interventions can be **individualized** to a particular person and situation. These are all found on the Michigan website called Improving MI Practices at **https://www.improvingmipractices.org**

ASSUMPTIONS AND SUGGESTIONS

1. **Individual:** This person is a **unique individual**. All information and suggestions should be accepted and applied only as it fits this person, at this time, in this situation, with this person's **unique set of strong** and **weak cognitive abilities** (cognitive strengths and needs). If this person is living with a disorder, then the type and severity of disorder also needs to be addressed. There are many confounding factors that are specific to this person and time, even moment to moment, that affect their thinking, emotions, physical comfort, needs, and desires. This person and those who know them best are in the key positions to observe, consider, and make decisions. The individual needs and desires of those around this person also need to be considered, since the situation is likely stressful and can significantly affect their lives.
2. **Brain Disorders: All psychiatric and neurological** disorders (such as Severe Mental Illness, Traumatic Brain Injury, and Dementia) are **brain disorders** and **involve altered cognitive abilities** as a result of altered function of specific parts of the brain. **Specific cognitive abilities** play a major

role in this person's behavior, emotions, verbal statements, ability to communicate and perform tasks, and general quality of life. Recognizing the role of each cognitive ability can increase understanding of this person and the possible impetus for behavior and ways of thinking. It can reduce the urge to think of this person as stubborn, "mean", ornery, lazy, or manipulative. It can also be a reminder that this person likely has reduced control over their behavior due to their cognitive needs and brain changes.

3. **Cognitive Abilities:** Adding **interventions** that **directly address cognitive abilities** (that is, this person's cognitive strengths and needs) to a repertoire of interventions currently used can expand the pool of intervention options. Interventions that rely on cognitive strengths and support or compensate for cognitive needs can be highly **effective** and **efficient**, since they **address** one of the major **causes** of difficulties with communication and tasks, and of distress and distressing situations. They can reduce a trial and error method of intervention. Some cognitive abilities will improve, some decline, and some will stay the same. It is important to support and nurture all cognitive abilities, including those that are improving even temporarily (for example, art skills in Frontotemporal dementia).

4. **Behavior:** Very often a person with changes in their cognitive abilities views the behavior of someone else as difficult or distressing. By taking a good look at the specific cognitive abilities underlying your interactions with this person, you can **avoid unintentionally engaging in behavior** that is overwhelming, fatiguing, or **distressing to this person**. (For example, you might remind yourself to speak more slowly or calmly, move less quickly or suddenly, and try to understand more completely this person's ability to process information and initiate responses.)

5. **Coping Strategies**: The human brain changes over a person's lifetime due to growth, maturation, experiences, and a variety of minor or sometimes major disorders. This means a person's cognitive abilities also change over time and sometimes day to day. **Behavior** often reflects a person's strategies for **coping** with life experiences, frustrations, and altered cognitive abilities. Behavior can be a window into a person's needs, desires, and capabilities (strengths and needs). It is important to discern how this person's behavior might be a part of their effort to address their needs or desires (that is, how it is a coping strategy for them). For example, this person may listen to loud music to help them concentrate, talk aloud to themselves through a task, try to leave the building when they need a bathroom, shout at someone to stop them from talking so much, or strike someone for changing something this person uses as an "anchor" or reference point (such as moving an object from one spot to another spot). It is important to a**void depriving** a person of their **coping strategy** (that is, their behavior) without addressing the source or cause of the need to use a coping strategy. When the trigger or **cause** of the **behavior** is removed or **addressed**, the behavior often becomes unnecessary and is therefore reduced or prevented. Sometimes interventions can replace or improve coping strategies, as well.

6. **Trust this Person's Efforts**: We all have cognitive needs. No brain is perfect. We all have, since birth, created cognitive interventions for ourselves to adapt to or **compensate** for the particular cognitive abilities that are difficult for us. Most of this process is **not conscious**. Trust this person and their efforts to compensate for or cope with their own cognitive needs, and try to build on their efforts. Avoid asking them directly about their cognitive abilities and cognitive interventions since they likely do not have the insight or know how they process information or adapt. When and if you do begin to discuss this with them, gently share your observations of their coping strategies and how they seem to help this person, to increase their awareness of and increase the effectiveness of their own cognitive interventions.

7. **Goals**: An important goal of intervention is to help a **person discover** their **own abilities and desires**, including their own ability to perform various cognitive functions, and to discern and implement the **interventions** that would be most helpful. Address this person's own self-concept and life goals. Consider the relative importance to this person of their emotional versus physical health.

(For example, this person may prefer to fatigue themselves physically if it helps them emotionally, or wash themselves less frequently if the feel of water on their skin is highly distressing.) The content and process of considering goals will need to be adapted to this person's cognitive abilities to help them participate in a way that is comfortable and satisfying.

8. **Conditions – Four Factors**: Focus on the conditions surrounding a person and the situation. When trying to understand and intervene, systematically study and address the **Four Factors: Person**, **Environment**, **Interactions** with this person, and the **Task** or daily routines. In general, **try modifying the conditions**, rather than modifying this person or behavior.

9. **Distress**: Address a **person's feelings** rather than primarily their behavior. That is, in general, **address the distress**, rather than focusing on behavior. Discern **who is distressed** and conscientiously inform or include that person, regardless of who they are, in the intervention. Check to see how successful the intervention was in resolving their distress. Modify the intervention as necessary.

10. **Types of Dementia**: There are many disorders that cause dementia, resulting in various types of dementia. Each type of dementia varies in course and challenges. Alzheimer's disease is the most common cause of dementia. Effectiveness of various interventions vary with the different types of dementia. (Please see CAIS Handouts #20 and #37 about Dementia with Lewy Bodies, #21 and #38 about Frontotemporal Dementia, and #19 about Alzheimer's Disease.)

11. **Diagnosis:** Neurological disorders frequently look like psychiatric disorders. When diagnosing a disorder, carefully **avoid a misdiagnosis**. Avoid misdiagnosing neurological disorders (e.g. some non-Alzheimer's dementias) as psychiatric, or psychiatric disorders as neurological. They can look very similar. It is also important to avoid misdiagnosing **delirium** as dementia or another irreversible brain disorder. The consequences of misdiagnosis can be profound. Do not assume **changes** in **behavior** or **cognitive abilities** are due to this person's disorder (e.g. mental illness, dementia) or to a new major disorder. **Consider factors** such as effects of medication, pain, medical/physical disorders, allergies, sensory changes, aging, emotional and environmental changes, and changes in this person's family and support system.

12. **Common Triggers:** Some of the common triggers of distress and of changes in behavior or cognitive abilities **that can be immediately addressed** are: medications, pain with or without movement; hypersensitivity to touch, sound, smell, and other senses; temperature fluctuations in the air, water, and inside this person's body (this person's brain or body may have difficulty controlling the body's temperature); an unmet need or desire; feeling overwhelmed; confusing cues; too little information; sensory changes, not knowing what to do next; feeling alone; stress; fatigue; physical infections and illness. (Please see **CAIS Handout #8** for more information.)

13. **Optimism and Caring**: **You can improve a situation** no matter how severe or acute it is. Conscientious **discernment of causes** and implementation of **small interventions** are key. Focus more on this **person** than on their behavior, their disorder, or the tasks of assisting them. (Please see the ***CAIS Questions to Ask*** and ***CAIS Intervention Strategies*** for options of specific, concrete, and practical intervention strategies.)