BASIC MESSAGES
ABOUT
COGNITIVE IMPAIRMENT

Suggestions of Assumptions to Make
When you Care about or for a Person with Cognitive Impairment

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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 disorder and severity of disorder. There are so 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. The 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 the person also need to be taken into account.

2. **Brain Disorders: All psychiatric and neurological** disorders (such as Severe Mental Illness, Traumatic Brain Injury, and Dementia) are **brain disorders** and **involve altered cognition** as a result of altered function of specific parts of the brain. **Specific cognitive functions** play a significant role in the behaviors, level of functioning, affect, verbal statements, and general quality of life in all the persons seen by mental health and other health care professionals. Recognizing the role of each cognitive function can increase understanding of a person and the possible impetus for behaviors and ways of thinking.

3. **Cognition:** Adding **interventions that directly address cognitive functioning** to a repertoire of interventions currently used can expand the pool of intervention options. Some cognitive functions will improve, some decline, and some will stay the same. Use interventions that rely on, support, or compensate for cognitive functions. Nurture the cognitive functions that are improving (for example, art skills in Frontotemporal dementia).

4. **Behaviors:** Very often a person with altered cognitive functioning views the behavior of a caregiver or health care professional as difficult. By taking a good look at the specific cognitive functions underlying interactions with persons with altered cognition, we can **avoid unintentionally engaging in** some of those **difficult behaviors**.

5. **Coping Strategies**: Behaviors often reflect a person's strategies for coping with life experiences, frustrations, and altered cognitive functioning. A behavior can be a window into a person's needs, desires, and capabilities (strengths and vulnerabilities). It is important to discern how this behavior might be an effort to address this person's needs or desires (that is, how it is a coping strategy). **Avoid depriving a person of their coping strategies** (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 at least some cognitive impairment. No brain is perfect. We all have, since birth, created cognitive interventions for ourselves to **compensate** for the particular cognitive

functions we have difficulty performing. Most of this process is not conscious. Trust this person and their efforts to compensate for or cope with their own cognitive impairment. Try to build on their efforts.

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

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

9. **Distress**: Address a **person's feelings** rather than simply the behavior. That is, in general, **address the distress**, rather than the behavior. Discern **who is distressed** and conscientiously include that person in the intervention.

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.

11. **Diagnosis:** Neurological disorders frequently look like psychiatric disorders. Such a distinction in labels may inhibit some types of assessment and intervention. 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. The consequences of misdiagnosis are very important. Do not assume changes in behavior or cognition are due to the 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 the person's family and support system.

12. **Common Triggers:** Common triggers of distress and of changes in behavior or cognition **that can be immediately addressed** are: pain with or without movement; hypersensitivity to touch, sound, smell, etc; temperature fluctuations in the air, water, and inside the person's body due to the body's reduced ability to control its own temperature; an unmet need or desire; feeling overwhelmed; confusing cues; too little information; sensory changes, not knowing what to do next; feeling alone.

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 the **person** than on the behavior, their disorder, or the tasks of caring.