BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

COGNITIVE DISORDERS

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Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with cognitive disorders. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models and modalities that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for these disorders. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is: effective, efficient, culturally relevant and acceptable to clinicians, program managers, and patients

Definition of disorder

Cognitive Disorders can be broadly categorized as problems with information processing and memory. Although many psychiatric syndromes are associated with changes in cognitive processing, there are some in which this is the primary problem or deficit. For purposes of this guideline, we have followed the DSM-IV system in grouping together Delirium, Dementia, Amnestic Disorders, and other Cognitive Disorders under the "Cognitive Disorders" umbrella. There is a separate guideline for Mental Retardation, Autism, and other Pervasive Developmental Disorders. We have further narrowed our scope to focus on disorders commonly presenting to or treated in our setting. Delirium is important to recognize, but is more appropriately treated in more structured medical settings. We are generally consultants rather than primary providers in these circumstances and treatment of delirium is, therefore, not explored in this treatment guideline. Amnestic disorders, though interesting, do not present in our clinic at a frequency to warrant standardizing treatment in a guideline format. The focus of this document is primarily on treatment of dementias, traumatic brain injury (TBI) and cognitive disorders generally.

Dementia is defined in DSM-IV as the development of multiple cognitive deficits manifested by both

(1) Memory impairment (impaired ability to learn new information or to recall previously learned information)
(2) One (or more) of the following cognitive disturbances:
    a. aphasia (language disturbance)
    b. apraxia (impaired ability to carry out motor activities despite intact motor function)
    c. agnosia (failure to recognize or identify objects despite intact sensory function)
    d. disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)

These deficits must be accompanied by functional impairment and not be better explained by some other potentially reversible process (delirium, depression, etc.).

Traumatic brain injury is probably the most common cause of dementia seen in our practice setting followed by Alzheimer's, and alcohol induced persisting dementia, although the etiology is often multi-factorial or cannot be determined because of an absence of available history and collateral sources of information.

General Goals of treatment

- Optimize mood, adaptive functioning, and health and safety behaviors.
- Lower disruption/disruptive behaviors.
- Lower caregiver burnout.
- Optimize progress toward behavioral and academic milestones
- Encourage problem solving skills.
- Progress in area of presenting problem (i.e. depression, grief, adjustment)

This clinic lacks the resources and expertise to provide intensive rehabilitative services. These services are generally lacking in our community and our state. We can provide targeted interventions such as basic mood regulation skills, activity scheduling, or support groups for caregivers.

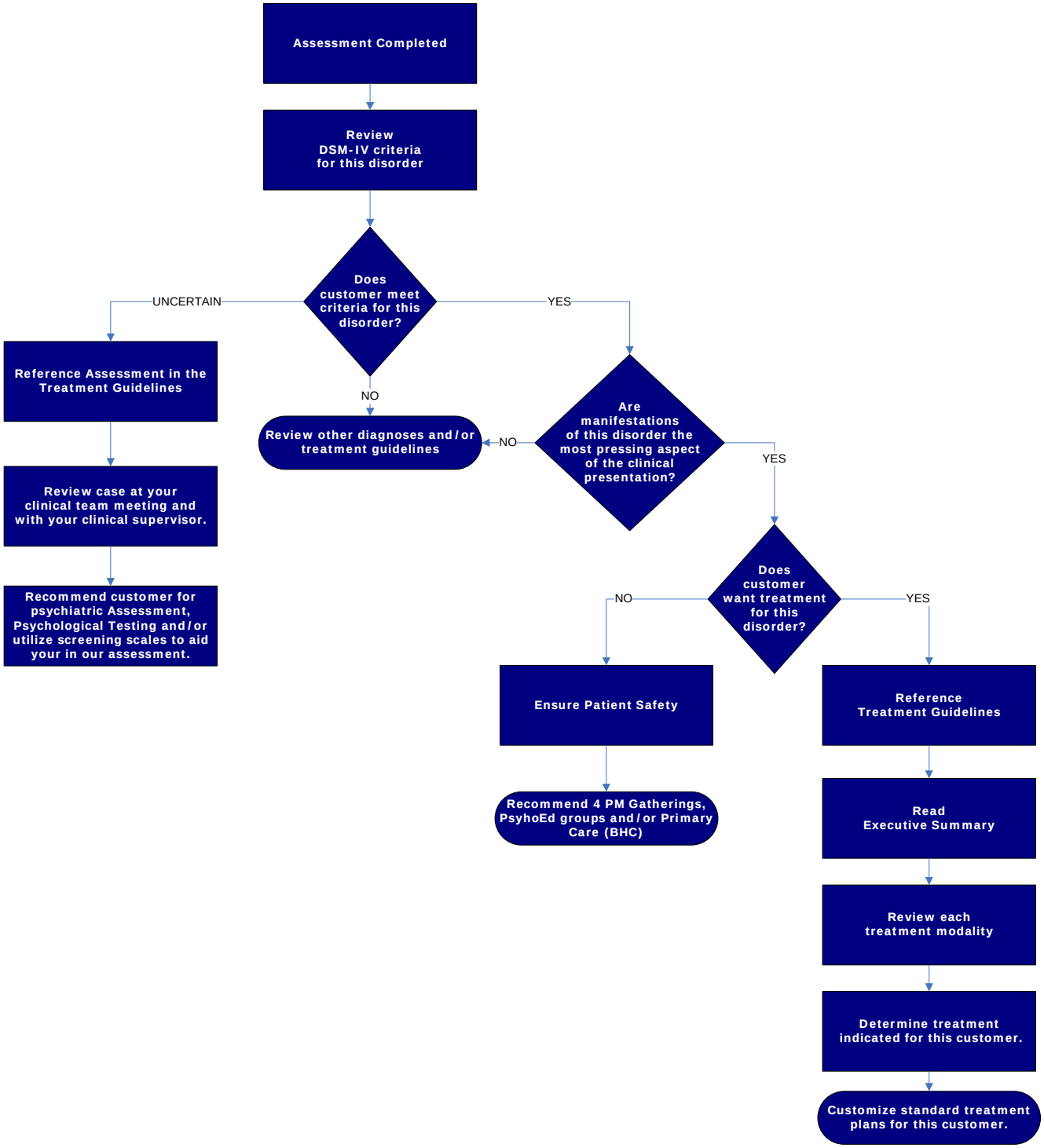
Summary of 1st, 2nd and 3rd line treatment

- Given the diverse nature of cognitive disorders, each patient will be handled on a case by case basis, with Case Management as the first line for referring out or transferring to appropriate services.
- Group/Individual therapy and medication management will be the secondary line of treatment for particular presenting problems.
- Support for family members and psychoeducation groups will be the third line of treatment.
- Consensus guidelines indicate a multi-disciplinary team is most effective for assessment, treatment, and case coordination with dementia and TBI populations. However, our clinic does not have the resources to provide such a team for these patients, nor are these resources readily available in the community.

Clinical and demographic issues that influence treatment planning

To benefit from the services we have, a patient would need to be relatively high functioning. Parents with children of any age or functional level may benefit from supportive services. Aggression towards self or others, or other behaviors disruptive to the care of other patients in the clinic may disqualify some patients with these disorders from personal participation in services. We do not have a full range of rehabilitative services.

Flow Diagram



Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patient is already on psychotropic medication and is requesting continuation ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out alternate organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by MD, PCP or ANP in mental health, pediatrics or neurology. ▪ Referral question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Used only to establish a baseline for emotional symptoms such as depression or anxiety and/or to monitor treatment effectiveness • Clarify symptoms
Contraindications	▪ Collateral information not available (e.g. caregiver/ significant other, appropriate records) ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Alternate organic causes of the disorder have not been ruled out ▪ School or other source has already conducted psychological testing within the last year	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Screening scales may be provided to clinician/case manager after consultation with a testing psychologist.

Modalities & Treatment Models

Group Therapy

This modality can be helpful for some of the behavioral or mood symptoms commonly associated with cognitive disorders.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Customer is 6 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Acute intoxication or withdrawal from alcohol or other substances	• Diagnosed social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services • Untreated substance dependence

STRUCTURE

- Groups will be facilitated by a Master's Level Therapist and Case Manager
- For 17 years old and younger, some developmental age grouping is recommended
- For 18 years old and above consider adult services

Duration	60 to 90 minutes. May be brief or long-term depending on treatment goals or treatment progress.
Frequency	Once a week
Size	▪ 6 to 9 years old 4 customers per provider ▪ 10 years old and over 6-8 customers per provider (no groups larger than 12)
Open vs. Closed	Open or Closed with windows

TREATMENT MODEL

Rehabilitative, with the exception of dementia.

Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Group therapy contraindicated or not available • Sufficient verbal and/or cognitive ability to benefit from treatment • Mild to Moderate severity • Unable to tolerate affect without behavior destructive to group ▪ Customer is 6 years old or older • Recent sexual, physical, abuse and/or neglect • For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from patient and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Active substance abuse or dependence in patient ▪ No progress on treatment goals after 3 months

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

Rehabilitative

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Adjunctive treatment for any age. ▪ First line of treatment for 0 to 5 year old ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Caregiver has sufficient verbal and/or cognitive ability to benefit from treatment	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with insufficient participation from child and/or guardian ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Custody dispute ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Active substance abuse or dependence in family member

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

Behavioral, psychoeducation, skills building, and supportive/expressive models.

Where appropriate, family and/or couples therapy should address grief issues, exploration of realistic expectations, and acceptance of deficits.

Individual Medication Management

Cognitive disorders have multiple etiologies. Most treatment is targeted at associated behavioral or mood problems. An exception is dementia where some treatments have been able to slow progression, though not restore lost function.

The majority of patients with dementia and TBI are treated by neurology rather than behavioral health in our practice setting. We have chosen to follow the American Academy of Neurology recommendations[1] on pharmacologic management of dementia:

Pharmacologic treatment of Alzheimer's Dementia (AD):

- Cholinesterase inhibitors should be considered in patients with mild to moderate AD, although studies suggest a small average degree of benefit
- Vitamin E (1000 I.U po bid) can be considered in an attempt to slow progression of AD, but cardiovascular risk in high dose vitamin E must be weighted against potential benefits to AD
- Selegiline (5mg po bid) is supported by one study, but risks-benefit ration must be weighed
- There is insufficient evidence to support the use of other antioxidants, anti-inflammatories, or other putative disease-modifying agents specifically to treat AD because of the risk of significant side effects in the absence of demonstrated benefits
- Estrogen should not be prescribed to treat AD

Mixed populations or patients with mixed dementias:

- Some patients with unspecified dementia may benefit from ginkgo biloba, but evidence-based efficacy data are lacking

Ischemic vascular dementia:

- There are no adequately controlled trials demonstrating pharmacologic efficacy for any agent in ischemic vascular dementia.

Behavioral Health personnel are more frequently asked to intervene in behavioral or mood problems related to cognitive disorders. There is insufficient evidence to recommend particular agents for the management of most psychiatric disorders or symptoms in the presence of a particular cognitive disorder. An exception is agitation in dementia and TBI. At the writing of these guidelines, low doses of second generation antipsychotics are generally considered first line. Antidepressants and anticonvulsants are second line.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available. ▪ Recommended concurrent with psychoeducation for patient and family	▪ Refuses Medication Management ▪ Acute intoxication or withdrawal from alcohol or other substances ▪ Patient not competent to consent and Legal Guardian is unwilling or unavailable (situation is not a crisis).	▪ Documented history of medication non-compliance ▪ Disorder is caused by an untreated physiological disorder.

STRUCTURE

Duration	30 minutes
Frequency	Monthly

TREATMENT MODEL

Disease management, not curative

[1] R.S. Doody, et al., "Practice Parameter: Management of Dementia (An Evidence-Based Review), Report of the Quality Standards Subcommittee of the American Academy of Neurology" Neurology 2001;56:1154-1166

Group Medication Management

Need for parent and/or guardian presence makes group medication management impractical for customers 0 to 18 years old. Depending on the relative independence of an adult with a cognitive disorder, this same caveat may apply. For example, if the patient cannot provide meaningful interim history on which to base decisions about medications, and this information is collected from a caregiver instead, group medication management may not be practical.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ If symptoms stable and patient cannot return to primary care for maintenance treatment, group medication management should be considered. ▪ History of non-compliance ▪ Able to tolerate affect without behavior destructive to group ▪ Frequently misses scheduled appointments	▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ Severe untreated hyperactivity	• Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services • No child care available

STRUCTURE

Duration	▪ Indefinite
Frequency	As indicated by clinical stability.
Size	4 to 6 patients per provider
Facilitators	One psychiatrist or ANP, and one Registered Nurse or Case Manager
Open vs. Closed	Open

TREATMENT MODEL

Routine medication management could be combined with psychoeducation and support in a group format.

Psychoeducational Groups

This modality can be extremely helpful for families of customers with cognitive disorders. Psychoeducation should be considered for the family even if the customer cannot participate. Our clinic currently does not have psychoeducation groups on dementia, traumatic brain injury, or cognitive disorders other than FASD. See referral section for community psychoeducation services.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers or the FASD Parent Navigator.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs. Closed	Open

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records (especially IEP, previous school testing, neurological report, and radiology) ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Lead orientation to services (if appropriate) ▪ Review and/or conduct client initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system and needed treatment is available

Primary Care

INDICATIONS

- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
Adaptive functioning/behavior:	The domain that considers how well an individual is able to take care of their activities of daily living and function independently at home, in their community, at school or at work.
Affect	This word is used to describe observable behavior that represents the expression of a subjectively experienced feeling state (emotion). Common examples of affect are sadness, fear, joy and anger. The normal range of expressed affect varies considerably between different cultures and even within the same culture. Types of affect include: euthymic, irritable, constricted; blunted; flat; inappropriate and labile.
Agitation	(psychomotor agitation) Excessive motor activity that accompanies and is associated with a feeling of inner tension. The activity is usually nonproductive and repetitious and consists of such behavior as pacing, fidgeting, wringing of the hands, pulling of clothes and an inability to sit still.
Agnosia	Failure to recognize or identify objects despite intact sensory function. This may be seen in dementia of various types. An example would be the failure of someone to recognize a fork placed in their hand while keeping their eyes closed
Agraphia	The loss of a pre-existing ability to express one's self through the act of writing.
Akathisia	Complaints of restlessness accompanied by movements such as fidgeting of the legs, rocking from foot to foot, pacing or an inability to sit or stand still. Symptoms can develop within a few weeks of starting or raising the dose of traditional neuroleptic medications or of reducing the dose of medication used to treat extrapyramidal symptoms. SSRI's and other medications can also, sometimes cause akathisia.
Alexia	Inability to read.
Alexithymia	Difficulty in describing or recognizing one's own emotions, a limited fantasy life and general constriction in affective life.
Alogia	An impoverishment in thinking that is inferred from observing speech and language behavior. There may be brief and concrete replies to questions and restriction in the amount of spontaneous speech (poverty of speech). Sometimes the speech is adequate in amount but conveys little information because it is overconcrete, overabstract, repetitive or stereotyped.
Alzheimer's disease	A degenerative brain disorder that first appears as a progressive memory loss and later develops into a generalized dementia.
Amnesia	Loss of memory. Types of amnesia include • anterograde – loss of memory of events that occur after the onset of the condition or agent. • retrograde – loss of memory of events that occurred before the onset of the condition or agent.
Anomia	Loss of the ability to name objects.
Anosognosia	The apparent unawareness of or failure to recognize one's own functional defect (e.g., hemiplegia, hemianopsia).
Aphasia	An impairment in the understanding or transmission of ideas by language in any of its forms – reading, writing or speaking – that is due to injury or disease of the brain centers involved in language.
Apraxia	Inability to carry out previously learned skilled motor activities despite intact comprehension and motor function; this may be seen in dementia.

Term or Acronym	Term Definition
Ataxia	Partial or complete loss of coordination of voluntary muscular movement.
Attention	The ability to focus in a sustained manner on a particular stimulus or activity.
Avolition	An inability to initiate and persist in goal-directed activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, self-care).
Bradykinesia	Neurological condition characterized by a generalized slowness of motor activity.
Broca's aphasia	Loss of the ability to comprehend language coupled with production of inappropriate language.
CBT	Cognitive Behavioral Therapy
Closed Group	Patients may enter only at initial formation of group.
Closed Group with Windows	Patient enrollment available intermittently
Cognitive	Pertaining to thoughts or thinking. Cognitive disorders are disorders of thinking.
Concrete thinking	Thinking characterized by immediate experience rather than abstractions. It may occur as a primary and developmental defect, or it may develop secondary to organic brain disease or schizophrenia.
Confabulation	Fabrication of stories in response to questions about situations or events that are not recalled.
Constructional apraxia	An acquired difficulty in drawing two-dimensional objects or forms, or in producing or copying three-dimensional arrangements of forms or shapes.
Contralateral	Residing in the side of the body opposite the reference points.
Diplopia	Double vision due to paralysis of the ocular muscles; seen in inhalant intoxication and other conditions affecting the oculomotor nerve.
Dysarthria	Imperfect articulation of speech due to disturbances of muscular control or incoordination.
Dyslexia	Inability or difficulty in reading, this includes word-blindness and a tendency to reverwe letters and words in reading and writing.
Dystonia	Disordered tonicity of muscles.
Echolalia	The pathological, parrotlike and apparently senseless repetition (echoing) of a word or phrase just spoken by another person.
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Encephalopathy	Any abnormal condition of the structure or function of brain tissues. This includes chronic, destructive or degenerative conditions.
Intervention	Any thoughtful action taken by a clinician or patient with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
Long-term memory	The final phase of memory in which information storage may last from hours to a lifetime.
Memory consolidation	The physical and psychological changes that take place as the brain organizes and restructures information that may become a permanent part of memory.
Mental retardation	A disorder characterized by intellectual functioning that is significantly below average (IQ of 70 or below), that is manifested before the age of 18 and includes impaired adaptive functioning (ability to take care of one's activities of daily living and function independently in one's community).
NOS	Not Otherwise Specified
Nystagmus	Involuntary rhythmic movements of the eyes that consist of small-amplitude rapid tremors in one direction and a larger, slower, recurrent sweep in the opposite direction. Nystagmus may be horizontal, vertical or rotary.
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Perseveration	Tendency to emit the same verbal or motor response over and over.
Play Therapy	

Term or Acronym	Term Definition
Prosopagnosia	Inability to recognize familiar faces that is not explained by defective visual acuity or reduced consciousness or alertness.
Pseudodementia	A syndrome in which dementia is mimicked or caricatured by a functional psychiatric illness. Symptoms and response of mental status examination questions are similar to those found in verified cases of dementia. In pseudodementia, the chief diagnosis to be considered in the differential is depression in an older person vs. cognitive deterioration on the basis of organic brain disease.
Psychiatric Assessment	Formal assessment by psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the patient or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate test conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief easily administered screening and scales which do not require advanced training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Tic	An involuntary, sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization.
Treatment Modality	For purposes of this guideline, we have defined “modality” as the structure in which the patient receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the “model” of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the patient is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder, or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a patient with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each patient.
Untreated Substance Dependence	Because “dual diagnosis” is the norm, rather than the exception in behavioral health settings, patients with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Patients with current substance dependence may not be appropriate candidates for some forms of treatment.

Term or Acronym	Term Definition
Wernicke's aphasia	Loss of the ability to comprehend language coupled with production of inappropriate language

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
Cognitive Disorders

Diagnosis: This is a broad category that included for this project the following:
Dementia: The development of multiple cognitive deficits including memory deficits arising from any number of causes.
Delirium: A change in the clarity of awareness of the environment including reduction in focus, attention and recognition.
Traumatic Brain Injury: This category is a potential source for both dementia and delirium. It is a complex phenomenon with acuity, levels of severity, problems of locality and developmental issues. This paper will describe the literature in the most general way

General Information: This review searched the following data bases: Cochrane Reviews, American Psychological Association, American Psychiatric Association, The Journal of Empirical Mental Health, The National Guideline Clearinghouse, The Texas Algorithm Project, The Harvard Algorithm Project and SAMHSA, NIMH, Evidence Based Mental Health, Medline Abstracts and Evidence Based Clinical Reports. The keywords for this search were: Dementia, Delirium, Cognitive Deficits, Traumatic Brain Injury, Post Concussive Syndrome, Mild Brain Damage, Group Therapy, Evidence Based Therapy/Treatment/Interventions, Empirically Supported Therapy/ Treatment or Interventions, Treatment Guidelines, Psychotherapy in numerous combinations.

The search provided very limited evidence-based protocols or manuals. Dementia and Delirium guidelines were found and represented. In general, this area requires careful assessment of strengths and deficits, strong environmental planning and structure, increased clinical patience, smaller steps and clear/real expectations (McCallister, 2004, personal communication). The role of the therapist in the literature is two fold: 1) provide clear information at appropriate times in measured packets, and 2) work to support the caregivers and treatment team. Those working with this population must realize that having good information to guide any and all interventions is essential to not overwhelming the client and family, poorly allocating resources or creating a negative expectation situation.

Group Therapy and Cognitive Disorders: By extension, Heyn et al, (2004) would allow exercise group for patients to be held in small groups. Fitness work was shown to have universal benefit for this population. Doody et al, (2001) noted that group education with Dementia clients helped delay hospitalization, placement in nursing home and the health and wellbeing of caregivers but had no effect on the progression or symptomology of the disorders. This same review noted that multi-strategy group therapy utilizing reality orientation (see Spector et al, 1998), sensory stimulation and integration, motivation planning and self management protocol demonstrated modest effectiveness. Further, this review noted that interventions for problems behaviors (agitation, aggression, etc,) music and pets, bright light therapy or exercise (Teri, et al, 2003) are effective in selected clients. Again, by extension, some of these modalities could be conducted in small, select groups.

Individual Therapy and Cognitive Disorders: There were no empirically supported traditionally understood therapies noted in this review for these disorders. A strong need for primary medical/emergency interventions is outlined in the guidelines. Responding to the underlying causes and making physical/medical adjustments is tantamount. Secondary roles await typical mental health professional. For Dementia, guided imagey, relaxation sessions, activity therapy and direct care seemed to be the only researched procedures (Doody, 2001). Cognitive Rehabilitation and cognitive training sessions have shown very limited effectiveness in individual therapy (Clare, 2003). Burns, (2004), noted psychosocial interventions with dementia demonstrating effectiveness when behaviorally oriented and focused on caregivers. (Also see

Slone and Gleason, 1999). For TBI, the role and extent of individualized treatment arises based on the severity of the injury, the time frame of the intervention in relation to the injury, the nature of the injury, the assessed deficits and the resources available. Generally, case management is the best model utilizing cognitive rehabilitation (Laatsch et al, 2004). For the mild TBI and attending problems particularly psychiatric, practice suggests traditional and evidence based interventions follow the evaluation and diagnosis of such disorders. Behavioral issues such as personality changes resulting in hypersexuality, aggression or withdrawal should be met with CBT and behavioral interventions. Again, McCallister 2004, (the State TBI expert from Dartmouth) suggests that support of the environment and caregivers is a significant role for the therapist. Education, skills development and function rehabilitation are the goals. Reality testing around expectations should be part of the ongoing relationship with the client. Support of the caregiver, spouse and family is important. (Stoler & Hill, 1998; Wad et al, 2004). Individual work with Delirium is mostly supportive and functional/safety/ environmental. (see guidelines APA, 2001)

Brief Therapy Models and Cognitive Disorders: There were no citations for brief therapy. Dementia is many time progressive therefore needing more intervention. In TBI, the majority of rebound happens within the first year. The regaining of skill, abilities, and cognitive processes slows considerably after that.

Professional Status in Brief Therapy: Specific training in dementing disorders would be appropriate. Participation in the State TBI trainings and agency protocols would be important for dealing with TBI. This would necessitate trained individuals.

Multi-Cultural Considerations: The literature on multi-cultural adaptation of evidence based treatments was less than complimentary. Nagayama Hall, 2001, reviewing the empirically supported literature plainly states: “there is not adequate empirical evidence that any of these empirically support therapies is effective with ethnic minority populations” (p.502). Bernal and Scharron-Del-Rio, (2001) earlier noted the same conclusion and called for a more “pluralistic” methodology in developing evidence based and culturally sensitive treatments. The overall consensus is that, even lacking specific cultural treatments, the application of evidence supported interventions is better than using non-supported techniques. There were no citations about cultural considerations directly related to this group. Family dynamics and worldview must be considered in the assignment of interventions. Since this group of disorders is very brain-based, the interventions appear to be universal.

Pharmacological Interventions: See the guidelines. SSRI are used for TBI depressive and anxiety disorders and dementia (Bains et al, 2002). Antipsychotics like risperidol and haldol are used across this category for aggression, agitation and poor reality testing.

Manuals: None.

Appendix C: References

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Appendix D: Sample Treatment Plans

Treatment Plan for Cognitive Disorders

PROBLEM #1:
Cognitive Disorders

GOAL:
Reduce or manage symptoms of Cognitive Disorder by giving caregiver the necessary tools.

Objectives:
1. Identify any previous testing results
2. Case management will make referrals to appropriate services
3. Identify Adjunctive groups to give caregivers additional tools.