

# AGITATION, AGGRESSION, AND VIOLENCE

## BEHAVIORAL DEFINITIONS

1. Frequent, unpredictable, or restless movements that are not goal-directed, accompanied by irritable mood state.
2. Thrashing or kicking movements.
3. Inability to maintain focus on activity, accompanied by “bursts” of movements or verbalizations with no clear goal.
4. Strikes out physically at staff, family, or others such that physical injury nearly occurs.
5. Strikes own body in ways that threaten or cause injury.
6. Hits, kicks, bites, or scratches rehabilitation professionals, family, friends, or other patients.
7. Verbally threatens physical injury.

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## LONG-TERM GOALS

1. Coordinate actions in order to make them goal-oriented.
2. Protect integrity of own body, terminating all self-imposed injury.
3. Manage behavior so that others do not fear for safety.
4. Tolerate experience of frustration, anger, and upset while using socially acceptable methods to resolve difficulty.

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5. Understand and accept restrictions or limitations imposed to protect safety.
6. Use words or problem-solving methods to resolve emotional distress.
7. Demonstrate ability to successfully participate in fundamental social interactions.

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#### SHORT-TERM OBJECTIVES

1. Cooperate with efforts to identify the circumstances surrounding episodes of agitated, aggressive, or violent behavior. (1, 2)
2. Allow staff to observe activities so that they might identify the factors associated with increased or decreased agitation or aggression. (3, 4)
3. Provide access to information concerning neurological, psychiatric, or other medical factors that might be influencing behavior. (5, 6)
4. Family and friends demonstrate understanding that current agitation represents a time-limited stage of brain-injury recovery. (7)
5. Family (legally designated decision maker) and reha-

#### THERAPEUTIC INTERVENTIONS

1. Consult with the patient's rehabilitation team, physician, family, or other pertinent persons to identify specific agitated, violent, or aggressive behaviors that have occurred. Determine the circumstances surrounding the activity, the frequency of the activity, and the consequences.
2. Interview persons who know the patient well to determine whether significant episodes of violence or aggression had occurred prior to the neuropsychological impairment.
3. Observe the patient's social interaction during an activity that has been associated with agitation, aggression, or violence. Attend to triggers that precede the pa-

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- bilitation staff agree on a plan to assure safe management of agitated or aggressive behaviors. (8, 9)
6. Tolerate interventions that will allow safe freedom of movement and decrease need for physical restraints. (10, 11, 12)
  7. Cooperate with actions designed to maintain an optimal level of environmental stimulation. (11, 12, 13)
  8. Reduce agitation that is stimulated by environmental cues. (11, 12, 13, 14, 15)
  9. Reduce agitation or aggression that has been maintained through environmental conditions and through reinforcing responses of others. (16, 17, 18, 19, 20)
  10. Sign a contract describing the goals of rehabilitation and what is expected of all parties. (21)
  11. Reduce the impact of fatigue on mood, agitated or aggressive behavior, and performance. (22, 23)
  12. Acknowledge successful accomplishment of therapeutic activities and demonstrate willingness to work on increasingly more challenging rehabilitation tasks. (24, 25, 26)
  13. Accept positive comments about successful task accomplishment and appropriate conduct. (25, 27)
- tient's dyscontrol, the response of the person who is the target of the aggression, and the effect of the response on the patient's behavior.
4. Observe the patient interacting with a person who rarely or never experiences the patient as agitated, aggressive, or violent. Determine, if possible, what allows this person to maintain effective interaction with the patient.
  5. Review medical records and consult with physician to determine how the patient's brain impairment, medications, medical factors, or psychiatric conditions may be contributing to the agitation, aggression, or violence.
  6. Determine the patient's level of brain injury recovery using the Rancho Los Amigos Levels of Cognitive Functioning Scales (Hagan, Malkmus, and Durham).
  7. If the patient is at the Rancho Level Four stage of recovery, educate the patient's family, friends, and other pertinent individuals about the agitation that occurs during this phase of recovery from severe brain injury. Inform them that this agitation typically passes with time.
  8. Consult with the patient's rehabilitation team, physician, family, and other per-

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14. Maintain rapport and working relationship with the rehabilitation therapist despite frustration with activities. (28)
  15. Give best efforts to cognitive evaluations. (29)
  16. Agree to evaluation for medications to improve cognition, mood, or behavior. (30, 31, 32)
  17. Take medications regularly as prescribed and report effectiveness and side effects. (33, 34)
  18. Cooperate with psychometric testing to determine how cognitive, affective, or other neuropsychiatric factors might be affecting ability to manage behavior. (35, 36, 37)
  19. Family or legally designated decision maker, (the patient), and rehabilitation professionals agree on actions to reduce risk of injuries should the patient become violent. (38, 39)
  20. Recognize authority of local police or safety officers and follow their directives to restore a safe environment. (40)
  21. Family, friends, and staff position themselves in ways that reduce opportunities for the patient to inflict injuries. (41, 42)
  22. Describe understanding of medical condition, changes in functioning, and purpose
9. Coordinate efforts to identify institution or other setting that can provide necessary level of security and assist with the patient's transfer to that facility.
  10. Recommend that the patient have a trained attendant present constantly during those hours in which the patient's agitated or aggressive behavior poses a threat to the health or safety of himself/herself or others.
  11. Recommend use of Vail bed, Craig bed, or other "bed" that will keep the patient safely confined during period of agitation, avoiding use of posey vest or other physical restraints, if possible.
  12. Reduce the level of stimulation to which the patient is exposed (e.g., placing the patient in private room, lowering light level, keeping the television turned off, directing telephone calls to a location outside the patient's room).
  13. Educate family and friends about ways to avoid overstimulating the patient (e.g., limiting visitors to no more than three persons at a time, assuring that only one person talks at a time,

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- of rehabilitation interventions. (43)
23. Verbalize an understanding of the debilitating medical event, imminent implications, and what is required for improvement. (44)
  24. Family and others show skill in using redirection rather than logical argument at earliest sign of irritation. (45, 46)
  25. Implement physical or cognitive relaxation strategies to reduce levels of arousal. (47, 48, 49)
  26. Engage attention as much as possible in constructive conversations and activities in order to avoid ruminating about upsetting topics. (10, 50, 51, 52)
  27. Honestly describe thoughts, intentions, and plans to cause injury or death to specific persons. (53)
  28. Accept measures to prevent injuries/death and to protect welfare of self and others. (54, 55)
  29. Obtain inpatient psychiatric or neurobehavioral care. (56, 57, 58)
  30. Willingly listen to others' opinions about one's effectiveness in communicating and interacting. Verbalize an understanding of how they arrived at this point of view. (59)
  31. Implement positive social and conflict resolution skills speaking slowly, using short sentences, speaking in a calm tone).
  14. Consult with rehabilitation team, (the patient), and the patient's family regarding visitation policies (e.g., how many visitors allowed at a time, specific persons who should be prohibited from visiting, etc.) and establish a mechanism to manage visitation (e.g., sign on the patient's door stating that all visitors must check in at nursing station).
  15. Assess the environmental cues to which the patient is being exposed (e.g., television news coverage of a disturbing incident, mesh covering around bed that might make the patient feel like being in a jail cell); eliminate, if possible, what might be misinterpreted by the patient and/or contributing to agitation.
  16. Add or emphasize environmental cues that will help the patient realize that he/she is in a medical care setting (e.g., a sign posted at the patient's eye level reading "X Hospital," a sign with a photo of a physician using a stethoscope, a photo showing a physical therapist helping someone walk with a walker).
  17. Develop a behavioral plan describing how the environment is to be arranged, and

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- in interaction with staff and family. (60, 61, 62)
32. Accept referral for and begin psychotherapy focused on building self-esteem. (63)
  33. Accept referral to social worker or case manager to identify resources required for ongoing therapy. (64)
  34. The patient and/or legally designated decision maker agree to intensive therapy for patient to replace violent behaviors with those that are socially appropriate and also effective in meeting the patient's needs. (65)
  35. Family report understanding of the reasons for the aggression, the plan for addressing this problem, and the likely prognosis. (7, 37, 66)
  36. Family obtain support to help members maintain good family functioning while coping with the patient's aggression and/or violence. (67, 68)
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- how others are to respond to specified agitated or aggressive behaviors of the patient (e.g., calmly orienting the patient by saying, "You are in a rehabilitation center where the staff will help you get well"; redirecting patient's attention to neutral stimulus by saying, "Let's look at this television program"; telling patient when stressful task will end, such as, "When you finish two more problems, we will stop and you can rest").
18. Develop a simple charting mechanism that will allow staff, family, and others to record occurrences of designated agitated or aggressive behaviors.
  19. Communicate behavioral plan to the patient's rehabilitation team, (the patient), family, and others involved in the patient's recovery.
  20. Educate family and friends about the importance of responding consistently to targeted behaviors.
  21. Prepare a contract specifying the patient's rehabilitation goals, responsibilities of all parties (e.g., the patient, [family], physician, and rehabilitation therapists), and the consequences for not adhering to the points of the agreement. Have all involved sign the

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- contract. Post a copy in a noticeable place in the patient's room.
22. Schedule the most challenging activities into times when the patient is likely to be most rested.
  23. Point out to the patient and family specific ways in which the patient acts, feels, and performs differently when rested versus when fatigued.
  24. Recommend that rehabilitation therapists begin therapy session with an activity on which the patient is almost certain to succeed.
  25. Point out the patient's success on activity.
  26. Advise the patient that the difficulty level is about to increase and enlist his/her agreement by statements such as, "Are you ready to try something harder?" or "Now I'll give you something more difficult," or "You might find this hard, but would you be willing to try?"
  27. Reinforce the patient's cooperation, participation, or other positive aspects of his/her behavior during recent activity.
  28. If the patient becomes agitated and terminates an activity, instruct the rehabilitation therapist to make a short statement implying that the therapist remains

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in charge of the treatment session and is labeling the previous participation as successful (e.g., “Let’s stop now; you’ve done enough,” or “That’s enough for now; I can see you are getting tired”).

29. Conduct or refer for periodic bedside or brief cognitive evaluations to monitor the patient’s cognitive recovery by assessing orientation, insight, memory, and other pertinent cognitive functions.
30. Consult with the patient’s physician regarding the use of medications to enhance the patient’s level of alertness or ability to sustain attention.
31. Consult with the patient’s physician regarding the use of medications to reduce the patient’s irritability without impairing cognition or recovery.
32. Suggest or coordinate a referral to a psychiatrist, psychologist, or neurologist with expertise in the treatment of brain injury, for medical management of behavioral problems.
33. Consult with the patient’s physician regarding how medications will be prescribed, monitored, and managed.
34. Monitor the patient’s use of prescribed medications and their effectiveness; address

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issues affecting compliance and side effects.

35. Conduct or refer for neuropsychological testing to identify cognitive factors that may be contributing to the patient's difficulties with insight or self-control, and to determine what cognitive strengths might be used as resources in rebuilding acceptable social behaviors.
36. Conduct or refer for a psychological evaluation to identify psychiatric conditions underlying or contributing to the patient's aggressive or violent behavior.
37. Give feedback to the patient, (the patient's family), physician, rehabilitation team, and other designated persons regarding assessment results and recommendations.
38. Considering legal, ethical, and institutional policies, develop and communicate a plan for how the patient will be restrained if this is necessary to prevent danger to self or others.
39. Guided by institution's policies, develop a plan for use of a time-out room during violent episodes.
40. Alert the institution's security staff to the potential for violence and specifics concerning the patient's behavior so that they may be

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prepared to assist quickly and appropriately in interrupting aggression.

41. Remind rehabilitation staff, family, and others to keep at a greater than arm's length distance from the patient, if possible.
42. Recommend that the rehabilitation staff, family, and others have a clear path of egress from the patient's room in the event of a violent episode.
43. Interview the patient to determine the degree to which he/she is aware of cognitive deficits or other functional changes associated with injury or medical illness.
44. Orient the patient frequently to medical condition (e.g., brain injury, aneurysm, stroke), immediate implications (e.g., hard to remember what's happened recently, doesn't pay attention to things on one's left, has hard time knowing how to put shirt on), and purpose of therapies (e.g., to help patient's memory to get stronger; to help patient pay attention to things on his/her left as well as on right; to help patient improve the way he/she works with shapes).
45. Teach family, caregivers, and rehabilitation therapists to avoid using arguing, joking, convincing,

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- confrontation, or any other “logical” efforts to change the patient’s point of view.
46. Teach staff and family that at first signs of agitation, they should direct the patient’s attention to a neutral topic using a calm yet firm voice.
  47. Calmly and firmly tell the patient to “Take a deep breath. Hold it. Good. Relax.” Repeat three or four times.
  48. Engage the patient in a conversation about a neutral topic, or direct his/her attention to neutral activity (e.g., a nonviolent television program such as a baseball game).
  49. With adequate supervision in place, take the patient for a walk or involve him/her in other physical activities that will help to decrease level of physical arousal.
  50. Develop a 24-hour plan outlining the patient’s activities at all times.
  51. During waking hours, engage the patient’s attention with specific topics as much as possible (i.e., avoid many periods in which the patient is left alone in room with nothing to do).
  52. Arrange for designated family members and friends to spend time “in shifts” with the patient

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in order to keep his/her attention occupied.

53. Evaluate the seriousness and consistency of the patient's threat against a specific individual(s).
54. Consult with other colleagues and legal counsel, if necessary, about seriousness of threat, the patient's ability to enact it, and need to warn intended victim(s). Document the major points of conversation, the impression, and the plan.
55. If the patient has the ability to carry out a serious threat against an individual's life, warn the potential victim, in accordance with state laws.
56. Talk with the patient about the importance of protecting own and other's welfare and urge him/her to sign self into a psychiatric hospital or other secure setting.
57. Coordinate plans to arrange involuntary psychiatric hospitalization for patient.
58. Identify and address the patient's (and family's) questions and concerns regarding inpatient psychiatric or neurobehavioral care.
59. Refer the patient to participate in group activities in which he/she will have an opportunity to get feedback about the social appropriateness of various behaviors.

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60. In group or individual setting, teach the patient to rebuild positive social relationship skills (e.g., starting and maintaining a conversation, giving a compliment, asking someone for a date).
61. Teach the patient in group or individually to build or rebuild skills necessary to manage conflict or frustration (e.g., counting to 10 before reacting, assertiveness skills, "I" statements).
62. Use role-playing to model ways to handle disagreement, confrontation, or other difficult social interactions.
63. Conduct or refer the patient for psychotherapy to build self-esteem.
64. Coordinate the patient's referral to social services or case manager to identify resources for long-term therapeutic interventions (e.g., residential neurobehavioral rehabilitation, neurobehavioral day program, life-skills coaching services, intensive individual and/or family psychotherapy) for persistent aggression and violence.
65. Coordinate the patient's referral to long-term facility in which he/she can receive longer-term, intensive therapy targeted toward reducing aggressive or violent behavior and building prosocial behaviors.

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66. Educate the patient's family about the neurological reasons behind chronic aggression, the plan for management, and the prognosis for resolving this problem.
67. Perform or refer the family for therapy to facilitate family's positive adaptation to the emotional and behavioral changes in their family member.
68. Refer the family to brain injury, stroke, or other support groups, respite care resources, or advocacy organizations.

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### DIAGNOSTIC SUGGESTIONS

<b>Axis I:</b>	293.0	Delirium Due to (General Medical Condition)
	294.1	Dementia Due to (General Medical Condition)
	310.1	Personality Change Due to (General Medical Condition)
	293.9	Mental Disorder NOS Due to (General Medical Condition)
	309.3	Adjustment Disorder With Disturbance of Conduct
	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct

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<b>Axis II:</b>	301.0	Paranoid Personality Disorder
	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis

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# ANXIETY/FEAR

## BEHAVIORAL DEFINITIONS

1. Persistent worry or fear that exceeds the level typically seen for that situation.
2. Symptoms of motor tension such as restlessness, tiredness, shakiness, or muscle tension.
3. Symptoms of autonomic hyperactivity (such as rapid heartbeat, shortness of breath, sweating, dizziness, dry mouth, nausea, diarrhea) not explained by other medical condition or medication.
4. Hypervigilance such as feeling constantly on edge, concentration difficulties, trouble falling or staying asleep, and a general state of irritability.
5. A specific fear that significantly interferes with daily functioning.

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## LONG-TERM GOALS

1. Reduce frequency and intensity of anxiety symptoms so that daily functioning is not impaired and acceptable comfort level is achieved.
2. Stabilize the anxiety level while increasing the ability to function on a daily basis.
3. Resolve underlying issues that may be creating or contributing to the anxiety.

4. Enhance ability to effectively handle the full variety of uncertain situations in life.
5. Patient and/or responsible party is able to identify signs of possible recurrence of anxiety, and is aware of behavioral, cognitive, and/or medical actions to take to reduce symptoms.

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### SHORT-TERM OBJECTIVES

1. Identify type, frequency, severity, and circumstances surrounding occurrence of anxiety symptoms. (1, 2, 3)
2. Cooperate with psychological testing to assess cause and severity of anxiety symptoms. (4, 6)
3. Cooperate with a neuropsychological assessment. (5, 6)
4. Tell the story of the anxiety, the attempts to resolve it, and the suggestions others have given regarding resolution. (7, 8)
5. Identify major life conflicts from the past and present that are associated with feelings of anxiety. (9, 10)
6. Complete anxiety exercises that identify cognitive distortions that generate anxious feelings. (11, 12, 13)

### THERAPEUTIC INTERVENTIONS

1. Arrange for or conduct a psychodiagnostic evaluation to determine if an anxiety disorder is present, and to make treatment recommendations.
2. If the patient is a poor historian, obtain permission from patient or legally responsible party to interview person(s) familiar with his/her history.
3. Review medical records and/or consult with the patient's physician to identify medical conditions and medications that might be affecting his/her symptoms.
4. Arrange for or conduct psychological testing to identify severity of anxiety, and to rule out depression or other disorders as primary or co-existing conditions.

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7. Report on the success of substituting positive, realistic thoughts for the distortions that precipitate and maintain anxiety. (14)
8. Implement thought-stopping techniques to interrupt anxiety-producing thoughts. (15)
9. List the advantages and disadvantages of the anxiety. (16)
10. Verbalize positive principles that reduce anxious thoughts. (17, 18)
11. Utilize paradoxical intervention to reduce anxiety response. (19, 20)
12. Identify problems that appear unmanageable and that threaten sense of survival or self-esteem. (21, 22)
13. Replace vague impressions about medical condition with accurate understanding of medical condition, treatment options, prognosis, and lifestyle implications. (23, 24, 25)
14. Complete physical evaluation for medications. (26, 27)
15. Take medications as prescribed and report on effectiveness and side effects to appropriate professionals. (27, 28)
16. Identify existing effective skills and preferences for relaxation. (29)
17. Apply physical relaxation techniques to lower physio-
5. Arrange for or conduct neuropsychological testing to identify cognitive problems affecting the patient's thought processes or behavior.
6. Give feedback to the patient (and family), treatment team, and other designated persons regarding assessment results and recommendations.
7. Actively build the level of trust with the patient in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
8. Probe with questions (see *Anxiety Disorders and Phobias* by Beck, Emery, and Greenberg) that require the patient to produce evidence of the anxiety and logical reasons for it being present.
9. Ask the patient to develop and process a list of key past and present life conflicts that have created feelings of fear and anxiety.
10. Assist the patient in becoming aware of unresolved life conflicts related to anxiety feelings and in starting to work toward their resolution.
11. Providing assistance if necessary, have the patient complete the anxiety sec-

- logic arousal levels.  
(30, 31, 32, 33, 36)
18. Use imagery, memories, and/or music to lower physiologic arousal.  
(33, 34, 35, 36)
  19. Trigger relaxation response with cue. (37, 38, 39)
  20. Utilize “alternative medicine” interventions to produce and maintain sense of relaxation. (40)
  21. Develop or use hobbies or other activities to decrease level of anxiety.  
(41, 42, 43, 44)
  22. Increase the level of physical exercise sanctioned by medical personnel. (45, 46)
  23. Identify a specific fear that interferes with daily functioning as well as the reinforcement contingencies that maintain the fear. (47)
  24. Implement reinforcers that support improvement of functional skills. (48)
  25. Clarify realistic and irrational components of this fear. (49)
  26. Identify and attempt approximations to the feared activity, using relaxation techniques to keep arousal at moderate levels.  
(50, 51, 52)
  27. Note success and congratulate self on progress in overcoming fear. (53, 54)
  28. Verbalize insight into how past traumatic experiences
- tion exercises in *Ten Days to Self-Esteem* (Burns).
12. Have the patient record in a journal thoughts associated with anxiety episodes.
  13. Assist the patient in identifying catastrophizing, “what if” statements, fortune-telling, and other distorted thoughts that precipitate or maintain experience of anxiety.
  14. Help the patient develop reality-based, positive cognitive messages that will increase self-confidence in coping with irrational fears.
  15. Teach the patient to implement a thought-stopping technique (e.g., thinking of a stop sign and then a pleasant scene, or snapping a rubber band on the wrist) that cognitively interferes with distorted cognitive obsessions; monitor and encourage patient’s use of technique in daily life between sessions.
  16. Have the patient complete (or assist patient in completing) the “Cost-Benefit Analysis” exercise (see *Ten Days to Self-Esteem* by Burns) in which he/she lists the advantages and disadvantages of the negative thought, fear, or anxiety.
  17. Read and process with the patient a fable from *Friedman’s Fables* (Friedman) that pertains to anxiety.

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- are causing anxiety in present unrelated circumstances. (55)
29. Report tolerance for experiences that cannot be controlled. (56, 57)
  30. Report increased confidence in ability to spontaneously handle situations effectively. (58, 59)
  31. Verbalize an understanding of how the use of alcohol, marijuana, and other substances are ineffective as long-term solutions to anxiety and can interfere with effective problem solving. (60)
  32. Accept referral for substance abuse treatment. (61)
  33. Report understanding of own anxiety and ways to manage it using relaxation techniques, cognitive techniques, daily activities, and medications. (62)
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18. Assist the patient in identifying philosophies that reduce anxieties (such as “The universe is a friendly place,” and “Everything occurs as it should”) and encourage him/her to think of these statements during times of anxiety.
  19. Develop a paradoxical intervention (see *Ordeal Therapy* by Haley), in which the patient is encouraged to have the problem (e.g., anxiety) and then schedule that anxiety to occur at specific intervals each day in a specific way and for a defined length of time. Include in the schedule times of the day/night when the patient would clearly want to be doing something else.
  20. Assign the patient to “worry on purpose” at specific times about specific topics that may or may not normally precipitate anxious thoughts.
  21. Assist the patient in identifying problems that seem outside of his/her ability to solve or manage and then either develop a plan to enlist the help of others to solve the problem or turn it over to a higher power.
  22. Identify need for resources and facilitate patient referral to appropriate professionals in the facility or community, such as social worker, social service agen-

- cies, Social Security disability office, and so forth.
23. Assess the patient's need for education regarding medical condition, symptoms, and actions that patient can currently take to improve condition; coordinate with other treatment professionals in providing educational information.
  24. Provide the patient and family with educational materials regarding medical condition and its treatment and/or refer to reliable Internet resources.
  25. Inform the patient and family of support groups or advocacy organizations dealing with patient's particular medical condition.
  26. Assess need for medications to reduce symptoms of anxiety and then refer to and consult with the patient's treating physician regarding how medication will be prescribed, monitored, and managed.
  27. Address the patient's (and family's) concerns about medications and assist them in getting answers to questions about medication and side effects.
  28. Monitor the patient's use of and results from prescribed medications; address issues affecting compliance and side effects, including habituation and dependence, if applicable.

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29. Inquire into things that the patient has done in the past to relax that have been successful, and encourage their continued or renewed implementation.
30. Instruct the patient in deep breathing techniques.
31. Train the patient in progressive muscle relaxation techniques.
32. Perform or arrange for biofeedback to develop relaxation skills.
33. Select or allow the patient to select a chapter in *The Relaxation and Stress Reduction Workbook* (Davis, Eshelman, and McKay); then work with patient to implement the chosen technique.
34. Instruct the patient in guided imagery for anxiety relief.
35. Encourage the patient to identify and use music that promotes relaxation.
36. Facilitate the patient's obtaining audiotope of favorite relaxation technique(s).
37. Assign the patient to practice relaxation technique one to three times per day.
38. Have the patient select a verbal (e.g. "calm," "relax"), visual (e.g., beach scene), or other cue. Instruct patient to bring this specific cue to mind at the point of deepest relaxation.

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39. Instruct the patient to bring the relaxation cue to mind during the session and have him/her notice how the cue is effective in facilitating a sense of relaxation.
40. Encourage the patient to explore potential benefits of yoga, massage, aromatherapy, tai chi, or meditation and support continued participation if effective for him/her.
41. Inquire into hobbies and other activities the patient has used in the past to create pleasure or enjoyment, and reinforce their continued or renewed implementation.
42. Encourage the patient to resume recreational activities that are within his/her medical or cognitive capabilities.
43. Facilitate referral to recreational therapist to assist the patient in resuming previous recreational activities, with adaptations, if necessary, or developing new activities suited to patient's current skills.
44. Assist the patient in working through loss or other emotions that interfere with him/her accepting adapted or new activities.
45. Identify exercises (e.g., water exercises, stationary bicycle, mall walking, armchair exercises) appropriate to patient's physical and

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- cognitive abilities, and support participation.
46. Assign the patient to read and implement programs from *Exercising Your Way to Better Mental Health* (Leith).
  47. Assist the patient in specifying fear and contingencies surrounding occurrence of fear (e.g., antecedent and subsequent events, location, time, intensity, and duration).
  48. Design reinforcements to support increases in functional activity and to minimize reinforcement of fear-related behavior.
  49. Assist the patient in verbalizing both realistic risks and irrational concerns.
  50. Use systematic desensitization methods to break the targeted activity into components that successively approximate the desired goal.
  51. Enlist the patient's agreement to attempt the least risky components.
  52. Direct the patient to use deep breathing or other rapid relaxation procedure before commencing activity.
  53. Have the patient point out (or name for patient) the success in accomplishing component(s).
  54. Direct the patient to acknowledge the courage demonstrated in working through fear.

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55. Reinforce the patient's insights into past emotional issues and present anxiety.
56. Inquire into the patient's world view, life philosophy, or religious beliefs concerning what in life can and cannot be controlled.
57. Identify religious rituals and other practices from which the patient might draw strength, and support participation in them.
58. Utilize a brief solution-focused therapy approach in which the patient is probed to find a time or situation in his/her life when he/she successfully handled the specific anxiety or an anxiety in general. Clearly focus the approach he/she used and then encourage the patient to increase the use of this approach. Monitor and modify the solution as required.
59. Inquire into times in which the patient was impressed by his/her ability to handle unplanned for, difficult situations, and reinforce this resourcefulness.
60. Educate the patient (and family) about the impact of alcohol and other mood-altering substances on attempting to resolve anxiety disorders.
61. Assess the patient's substance abuse patterns and, if necessary, coordinate re-

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ferral for therapy addressing substance abuse or dependence.

62. Refer the patient to written information about anxiety and its management, such as *Thoughts and Feelings: Taking Control of Your Moods and Your Life*, (McKay, Davis, and Fanning), *The Anxiety and Phobia Workbook* (Bourne), *An End to Panic* (Zuercher-White), and *The Relaxation and Stress Reduction Workbook* (Davis, Eshelman, and McKay).

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## DIAGNOSTIC SUGGESTIONS

<b>Axis I:</b>	300.01	Panic Disorder Without Agoraphobia
	300.21	Panic Disorder With Agoraphobia
	300.29	Specific Phobia
	300.23	Social Phobia
	308.3	Acute Stress Disorder
	300.02	Generalized Anxiety Disorder
	293.84	Anxiety Disorder Due to (Axis III Condition)
	291.89	Alcohol-Induced Anxiety Disorder
	292.89	Substance-Induced Anxiety Disorder (Specify Substance)
	300.00	Anxiety Disorder NOS
	309.24	Adjustment Disorder With Anxiety
	309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood

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	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
	316	Psychological Factor (Specify) Affecting (General Medical Condition)
	_____	_____
<b>Axis II:</b>	301.4	Obsessive-Compulsive Personality Disorder
	301.9	Personality Disorder NOS
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

# ATTENTION AND CONCENTRATION IMPAIRMENT

## BEHAVIORAL DEFINITIONS

1. Fails to notice significant stimuli in the environment.
2. Slow to detect and process pertinent information.
3. Unable to maintain focus on task until it is completed.
4. Unintentionally interrupts work on designated task when competing stimuli occur; distractible.
5. Requires unusual investment of energy and time in order to complete task.
6. Difficulty alternating between tasks.
7. Displays poor accuracy on primary task when working in a noisy or otherwise busy environment.
8. High error rate despite preserved skill (e.g., generates incorrect financial reports despite preserved mathematical skills; work is returned because it is incomplete).
9. Errors are inconsistent or explained by omission of details (e.g., gets multiplication problem wrong due to failure to place decimal point; misspells words at elementary school grade level while spelling several college-level words correctly).
10. Shifts topic of conversation abruptly.
11. Unable to follow two- or three-step commands.
12. Self-report of or described by others as having poor memory.

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## LONG-TERM GOALS

1. Perceive and process essential information.
2. Persist in directing effort to specified task until it is complete.
3. Possess insight into residual attention and concentration problems.
4. Use compensatory strategies effectively to enhance performance.
5. Adjust environment to enhance performance.
6. Request necessary modifications in an assertive manner.
7. Refrain from activities that have potential to harm self or others because of changed attention or concentration skills.
8. Emotionally accept need to use strategies, adapt environment, and adjust goals.

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## SHORT-TERM OBJECTIVES

1. Cooperate with evaluation of attention and concentration abilities. (1, 2, 3, 7)
2. Participate willingly in neuropsychological testing. (4, 7)
3. Agree to assessment procedures to identify psychiatric conditions that might be affecting attention and concentration. (5, 6, 7)
4. Cooperate with efforts to use medications to optimize attention. (8)
5. Provide information about typical and recent sleep patterns and problems. (3, 9, 10)

## THERAPEUTIC INTERVENTIONS

1. Review the patient's medical record to identify or rule out neurological conditions, learning disabilities, prior brain injuries, medications, substance-related disorders, psychiatric disorders, pain, or acute medical conditions (e.g., delirium) that might be affecting the patient's ability to focus attention and maintain concentration.
2. Interview the patient (patient's family) regarding the patient's ability to attend and concentrate prior to the most recent injury or medical event.

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6. Implement changes designed to improve sleep quality. (11, 12)
7. Report on the impact of interventions on satisfaction with sleep and with daytime energy level. (13)
8. Agree to and participate in actions designed to address coexisting psychiatric disorders. (14)
9. Agree to temporarily eliminate sounds, sights, or other stimuli that might distract one from the main task. (15)
10. Family members consciously select sentence structure, speech rate, and intonation to help the patient concentrate. (16, 17, 18, 19, 20)
11. Verbalize accurate information about person, place, and time orientation. (21)
12. Provide information regarding positive and negative effects of visitors on mood and behavior and agree to arrange visitation to promote recovery. (22, 23)
13. Implement the visitation plan and provide information about the effectiveness of the plan. (24, 25)
14. Family members verbalize an understanding of a "catastrophic reaction" as a common response to overstimulation and demonstrate at least three actions they can take to help the
3. Consult with the patient (patient's family) and rehabilitation professionals regarding the adequacy of the patient's sleep.
4. Refer for or conduct a neuropsychological evaluation to identify the patient's ability to focus and maintain attention under various conditions, to identify other cognitive deficits affecting attentional skills, and to determine cognitive strengths that can be utilized in the rehabilitation process.
5. Refer for or conduct a psychodiagnostic evaluation to identify delirium, depression, bipolar disorder, anxiety, substance abuse, schizophrenia, or other disorders that might affect the patient's attention and concentration abilities.
6. Refer for or conduct psychological testing to assist in the diagnosis and clarification of psychiatric disorders that might impact the patient's attention and concentration abilities.
7. Give feedback to the patient (patient's family), physician, rehabilitation team, and other designated persons regarding assessment results and recommendations.
8. Consult with the patient's physician regarding adjustments in medications that might enhance his/her at-

## ATTENTION AND CONCENTRATION IMPAIRMENT 43

- patient regain a sense of control. (26, 27)
15. Accept the need for cognitive rehabilitation therapy and cooperate with the therapists in assessing and treating attention/concentration deficits. (28)
  16. Acknowledge the potential of leisure activities to rebuild attention/concentration skills, and participate in recreational therapy. (29, 30)
  17. Family members describe activities that they can do with the patient that will challenge him/her to pay attention without being overtaxing. (31, 32)
  18. Challenge self to improve performance on computer and video games requiring attention to changing stimuli. (33)
  19. Agree to have therapists, family members, and friends point out attentional lapses and to redirect to the topic of conversation. (34, 35)
  20. Give best effort to understand and participate in structured therapy sessions in ways to accommodate limited concentration skills. (36, 37, 38)
  21. Attempt to expand the length of time during which attention is focused. (39, 40, 41)
  22. Describe ways in which participation in work, household responsibilities, and attention (i.e., discontinuing medications that interfere with attention or adding medications to enhance the patient's ability to focus).
  9. Inquire into the patient's typical, preinjury/preillness sleep patterns and routines, and identify any sleep abnormalities.
  10. Consult with the patient (patient's family) and rehabilitation therapists to identify environmental factors (e.g., noise from the nurses' station, roommate who moans, patient too cold and unable to pull blankets up), medical factors (e.g., pain, unable to position self in preferred sleeping position due to hemiparesis, poor bladder control), or activity-related factors (e.g., misses evening bath, can't get back to sleep after being awakened for medication, naps during the day) that interfere with the patient's sleep.
  11. Consult with the patient's physician about medical interventions to reduce hindrances and to improve the quality of the patient's sleep.
  12. In consultation with the patient (patient's family) and rehabilitation team, develop and coordinate implementation of a plan to structure the patient's activities and environment in ways to be conducive to uninterrupted, restful sleep.

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- hobbies might be affected by attention deficits. (42)
23. Practice tasks that are designed to improve performance on relevant employment, household, and hobby skills. (43)
  24. Tolerate background noise and other distractions while demonstrating concentration. (44)
  25. Utilize external aids to remind self to accomplish important daily tasks. (45)
  26. Implement and describe the benefits of rehearsal and repetition in maintaining concentration throughout a task. (46)
  27. Implement a technique of reminding self prior to giving attention to the task of the consequences of successful/unsuccessful task completion. (47)
  28. Schedule shopping, medical appointments, and other community activities to avoid crowded peak times or other situations that would be cognitively overtaxing. (48, 49)
  29. Gradually attend community activities at busier (but not the busiest!) times in order to increase tolerance for stimulation. (50)
  30. Incorporate behavioral strategies to reduce the chance of making errors. (51)
  13. Monitor the implementation of actions to enhance the patient's sleep and assess the effectiveness of these interventions on both sleep quality and behavior during waking hours.
  14. Initiate or arrange for treatment for depression, anxiety, substance abuse, or other psychiatric conditions that might be reducing the patient's ability to focus and maintain attention. (See Depression/Grief, Anxiety/Fear, Substance Abuse, and/or Posttraumatic Stress Disorder chapters in this Planner.)
  15. Reduce or eliminate auditory stimuli (e.g., turn off radio, use private quiet room for therapies, allow only one conversation in the patient's room at a time) and/or visual stimuli (e.g., turn off television, close blinds to eliminate view of activities in courtyard) that interfere with the patient's ability to focus and maintain attention.
  16. Teach the need for—and model for the family—speaking to the patient in short sentences having simple grammatical structure (i.e., subject, predicate, object).
  17. Teach the need for—and model for the family—minimal use of sentences with negatives (e.g., instead of

## ATTENTION AND CONCENTRATION IMPAIRMENT 45

31. Demonstrate an increased degree of productivity due to more focused concentration and less distraction. (52, 53)
  32. Cooperate with a referral to evaluate the potential benefit of EEG biofeedback procedures on concentration ability. (54)
  33. Cooperate with an evaluation to determine the need for supervision and/or accommodations to perform usual daily activities that may be dangerous or lead to self-defeating consequences. (55, 56)
  34. Accept the recommendations of rehabilitation professionals regarding necessary modifications in daily activities to ensure personal safety and welfare. (57)
  35. Work cooperatively with a vocational counselor to identify how to most successfully return to school or to work. (58)
  36. Describe the accommodations that will likely be necessary in order to perform most successfully at school or at work. (59)
  37. Verbalize knowledge of relevant laws regarding the right to accommodations and the procedures to follow to have them implemented. (60, 61)
  38. Utilize legal counsel to pursue the right to accommodations. (62)
18. Teach the need for—and model for the family and visitors—the use of a slowed, deliberate speech rate to give the patient sufficient time to process information.
  19. Teach the need for—and model for the family—interaction with the patient that is calm, firm, and nonthreatening.
  20. Instruct the family and visitors to allow only one conversation at a time when visiting with the patient.
  21. Provide orientation information frequently and display it prominently in the patient's room.
  22. Observe the patient's behavior with visitors and identify whether he/she has difficulty tolerating large numbers of visitors, specific visitor behaviors (e.g., children who are very active, friend who talks in a loud voice, brother who is hyper-talkative), or visitation at certain times of the day (e.g., in the morning before completing usual grooming activities, in the afternoon when scheduled to go to therapy, in the late evening when fatigued).
- saying what is *not* going to happen, indicate what *will* be happening) in their communications with the patient.

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39. Engage in psychotherapy to deal with the emotional issues associated with changed abilities, changed lifestyle, and changed relationship roles. (63)
40. Family members report an awareness of the patient's residual attention/concentration deficits and their implications for the patient and all family members. (64)
41. Family members describe their emotional acceptance of the patient's cognitive changes and the ways in which their family life has been altered. (64, 65)
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23. Create guidelines for visitation that suit the patient's needs and are congruent with the institution's policies.
24. Inform the rehabilitation staff about visitation guidelines and determine how these will be implemented (e.g., placing sign on the patient's door, having family member call the patient's friends and ask them to visit in small groups, have family member request that friends indicate when they will visit to avoid having excessive numbers of visitors on any day).
25. Monitor the effect that the visitation plan has on the patient's mood and behavior and adjust visitation guidelines to suit his/her abilities and needs.
26. Discuss the signs of a "catastrophic reaction" (e.g., agitation, abrupt anger, sudden crying) with the patient and the patient's significant others and indicate that this is likely an indication that his/her ability to pay attention has been exceeded.
27. Identify specific steps that family members and significant others can take to restore the patient's sense of comfort in the event of a "catastrophic reaction" (e.g., stopping a conversation and calmly and firmly saying, "Take a deep breath; good;

## ATTENTION AND CONCENTRATION IMPAIRMENT 47

that's enough [name of activity that had been ongoing] for now; let's take a break"; or taking the patient's hand or rubbing the patient's back in an effort to soothe him/her while arranging for the level of stimulation to be reduced).

28. Refer for and/or reinforce the patient's participation in cognitive rehabilitation therapy to increase his/her attention and concentration abilities.
29. Refer the patient to a recreational therapist for recommendations regarding leisure activities that can help build his/her attention and concentration abilities.
30. Teach the patient the value of recreational activities and address the possibility that he/she may believe that time spent on leisure activities might be better spent on "real" therapies.
31. When the patient is able to concentrate for at least five minutes, suggest activities that family or friends could do with him/her that would require focused attention without being too demanding (e.g., looking at photographs in an album or a magazine, reading headlines or brief news summaries, playing checkers).
32. When the patient is able to concentrate for 15 minutes or more, recommend addi-

## 48 THE REHABILITATION PSYCHOLOGY TREATMENT PLANNER

tional activities that the family might enjoy with him/her (e.g., reading short human-interest stories, playing simple card games, planting and caring for potted plants).

33. Recommend that the patient play games on the computer that build attention span (e.g., video games requiring the patient to detect a target, solitaire, etc.).
34. Obtain the patient's permission for others to interrupt when he/she strays off topic to remind him/her of the topic of conversation.
35. Instruct the family to redirect the patient to the topic in a matter-of-fact, nonjudgmental way (e.g., "Let's go back to talking about the baseball game").
36. Schedule psychotherapy and other therapy sessions to be short (within the patient's concentration span) and perhaps more frequent.
37. Instruct the patient to take a brief rest break in the middle of a task when it is apparent that his/her attention is waning.
38. Plan the patient's therapy schedule so as to avoid putting cognitively demanding sessions back-to-back, without a rest break.
39. Using a stopwatch, time how long the patient is able to remain focused on a task.

## ATTENTION AND CONCENTRATION IMPAIRMENT 49

Ask him/her to set a new goal, and challenge him/her to continue working until reaching or exceeding that goal.

40. Reinforce the patient's ability to stay on task for a specified period; gradually lengthen the amount of time that must go by before reinforcement is provided.
41. Graph or otherwise chart the length of time that the patient is able to concentrate on a task, and post this graph where he/she can refer to it frequently.
42. Assist the patient in identifying the negative impact that his/her attentional deficit has on his/her safety, accuracy, and productivity within the work or home setting or while pursuing a hobby; reinforce the patient's insight and encourage focused effort on overcoming this deficit.
43. Assign the patient therapy exercises and homework tasks requiring focused attention that are clearly relevant to his/her work or interests (e.g., make sure patient knows how a task will be personally beneficial; use cognitive exercises that relate to patient's profession, home responsibilities, or hobbies).
44. Build the patient's tolerance to distractions by gradually introducing com-

## 50 THE REHABILITATION PSYCHOLOGY TREATMENT PLANNER

peting stimuli while he/she is working on a task (e.g., turn television on while patient is attempting to read a newspaper article; go grocery shopping when a moderate number of other people are also shopping; balance checkbook while listening to music).

45. Train the patient in the use of external aids (e.g., checklists, alarms, computerized reminder systems) to cue himself/herself as to what needs to be done and when to do it.
46. Recommend that the patient use verbal or visual rehearsal to maintain concentration (e.g., picturing a cheese sandwich and a glass of milk when writing "milk, bread, and cheese" on the list of groceries to be purchased; using a person's name several times in the conversation that follows the initial meeting; counting out loud when counting money).
47. Suggest that the patient cue himself/herself about the personal benefits of maintaining good attention just before beginning a task (e.g., considering how proud one's family will be if one can pay the bills accurately and on time; thinking about the inconvenience associated with failing to write expenditures in a checkbook ledger; imag-

## ATTENTION AND CONCENTRATION IMPAIRMENT 51

ining how pleased the patient's spouse will be if the patient is able to follow his/her conversation) in order to heighten the patient's arousal and interest and therefore increase the likelihood of performing the task accurately.

48. Recommend that the patient schedule outings to public areas (e.g., shopping, attending church) during those times that are typically least crowded.
49. Minimize the patient's exposure to situations where divided attention is required for success (e.g., noisy party, driving, social hour following church service).
50. When the patient is able to tolerate public situations under the quietest of conditions, obtain his/her agreement to go into the community at times when there will be an increased, but still moderate, level of activity.
51. Train the patient in the use of behavioral strategies to increase accuracy (e.g., using calculator; establishing habit of double- or triple-checking work; setting a timer to remind self to check on food that is cooking).
52. Reward the patient for sustained concentration (e.g., pay per unit of accurate work produced rather than

**52 THE REHABILITATION PSYCHOLOGY TREATMENT PLANNER**

- for the amount of time spent at a job, provide reinforcement for completed accurate work, reinforce for persisting on task).
53. Monitor the patient's level of productivity and provide feedback on a regular basis.
  54. Coordinate a referral for evaluation of the patient's potential to benefit from EEG neurofeedback to increase his/her ability to concentrate.
  55. Refer the patient for an occupational therapy evaluation to assess the impact of his/her attentional deficits on safety and accuracy in performing everyday activities (e.g., cooking, paying bills, using knives to cut vegetables, etc.).
  56. Refer the patient for a driving evaluation to assess his/her ability to drive safely under various traffic conditions and to assess the need for accommodations.
  57. In consultation with the treatment team, identify those activities which the patient (1) should not perform at all, due to safety concerns, (2) should perform with supervision, or (3) can perform independently.
  58. Refer the patient to a vocational counselor to identify his/her potential to return to the same or a different job or academic program,

## ATTENTION AND CONCENTRATION IMPAIRMENT 53

and to identify necessary accommodations.

59. Discuss accommodations that could be made at school or in the workplace to help the patient perform at his/her best (e.g., providing a quiet area in which to work, eliminating interruptions, allowing frequent rest breaks, simplifying tasks so that the patient attends to only one aspect of a task at a time).
60. Discuss with the patient the implications of the Americans With Disabilities Act (ADA), other legislation, or judicial rulings affecting his/her entitlement to accommodations at school, in the workplace, or in other areas.
61. Identify steps that the patient should take in order to request accommodations from a school, employer, or other entity, and determine that he/she has the knowledge and confidence to pursue obtaining necessary accommodations.
62. Discuss the possible utility of the patient obtaining legal counsel to compel school administrators, employers, or others to comply with legal guidelines regarding reasonable accommodations; make a referral to an attorney knowledgeable in this area of the law.

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63. Refer for or conduct psychotherapy to support the patient in adjusting to changed abilities and the impact of these changes on self-image and on relationships.
64. Educate the family about the patient's residual deficits in attention/concentration, recommended activity changes, compensatory techniques, and accommodations, using examples that relate specifically to the patient's and family's life together.
65. Refer the family to resources (family therapy, support groups, reading materials, etc.) to assist them in coming to terms emotionally with the changes in their family life.

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## DIAGNOSTIC SUGGESTIONS

<b>Axis I:</b>	294.9	Cognitive Disorder, NOS
	314.xx	Attention Deficit/Hyperactivity Disorder, (state type)
	314.9	Attention Deficit/Hyperactivity Disorder NOS
	_____	_____
	_____	_____

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**Axis II:** V71.09 No Diagnosis or Condition  
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