

PROBLEM SOLVING MODULE

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PART 1: GUIDELINES FOR THE USE OF PROBLEM SOLVING WITH THE CAREGIVER LEADING TO THE CREATION OF BEHAVIORAL PRESCRIPTIONS

The goal of this intervention component is for the interventionist and caregiver to engage in joint problem solving with the objective of creating a behavioral prescription targeting a specific caregiving problem. The interventionist is the “manager” of these therapeutic interactions and must possess excellent problem solving skills. To facilitate the interventionist’s problem solving abilities, he/she should carefully read this entire section of the MOP, complete required reading listed in the Certification Checklist for REACH II Interventionists, and view the Problem Solving video provided by the coordinating center.

A Behavioral Prescription is developed when a target behavior or problem is identified from the Caregiving Skills section of the Risk Appraisal (items 15 - 22), the Social Support section of the Risk Appraisal (items 23 – 29), the baseline administration of the RMBPC and on items 1-5, 9, 11-13 of the Personal Appearance (PA) observation checklist. This process is begun in Session 3 (see Session-by-Session Description). A common intervention approach leading to a standardized prescription format should be used for all problems/deficits identified from these sources. Interactions between the caregiver and interventionist are guided by a problem solving approach.

Problem solving is the means by which the interventionist and the caregiver attempt to find effective and workable solutions to a specific problem behavior. Problem solving strategies and techniques are used to generate relevant information about the target problem and the overall caregiving situation, with special emphasis placed on the context in which the target behavior is displayed. The problem solving process used by the interventionist and caregiver is defined by four core skills (see below). When used effectively, these four core skills maximize the probability of finding the best solution for a problem behavior. They also frame problem solving into a “step-by-step” process. Embedded within each of the four skills are behavioral techniques that enrich the problem solving approach. For example, the “ABC Process” is critical to the problem solving approach and is executed in the first step of the problem solving process. The “ABC Process” consists of 8 sets of questions the interventionist can use within the overall problem solving model to develop and modify the prescription. In general, problem solving should be thought of as a “mindset” or guiding strategy that the interventionist uses when working with the caregiver to develop and to modify prescriptions over the intervention sessions.

Problem solving requires the interventionist to follow a step-by-step process when working with caregivers. The four primary skills in our approach are presented below:

- 1.) Define the problem and gather information. The essential task at this point in the process is to create a well-defined targeted problem that is described by objective behaviors. The interventionist will formulate, in words, a) what is the specific problem being addressed, and b) how success will be measured (setting goals). The interventionist will also gather information relevant to the problem, the context of the problem behavior, and the caregiver’s feelings about and reactions to the problem behavior.

a) Defining the problem is an important step in determining the caregiver’s perceptions and feelings regarding the problem. This process helps to establish “Where is the caregiver coming from” and “What are his/her feelings about the behavior”. As a practical step, the interventionist will start formulating the definition of the problem by re-stating out loud what the caregiver is reporting. This step will force the interventionist to actively listen to the caregiver and will reassure the caregiver that the interventionist is indeed listening to him/her. The end result of this process is an objectively defined problem that both the caregiver and interventionist consider to be the most appropriate focus of the prescription.

For example, “My CR is ornery” is not sufficient because it does not provide you with enough information to instruct the CG what to do to change the targeted behavior. Upon probing, an interventionist can almost always get the CG to target-in on what is meant by “ornery”. For example, “ornery” might translate into, “He gives me a hard time when I try to dress him.” This is better, but still not specific enough. A much better definition is, “My CR hits and verbally abuses me when I try to dress him.” This allows you to target the problems of physical aggression and verbal abuse during assistance in care. This also allows more precise measurement (data recording) by the CG. It corresponds to Section 1 on the prescription and Question 1 of the “ABCs of Problem Behaviors”.

Box from Behavioral Prescription Template:

Target Behavior Problem:

b) Setting goals for how the behavior will change is also part of this initial step. Goal setting provides direction for the generation of possible solutions. Goals should provide a concrete, realistic expression of the caregiver’s expectations. Two types of goals are possible: problem-focused and emotion-focused. Problem-focused goals focus on the actual changes in the targeted problem. Emotion-focused goals are aimed at managing the emotions or feelings of the caregiver that are linked to the target problem. It is not unusual that the actual changes in behavior may be difficult to achieve. Thus, changing the caregiver’s feelings about the behavior would be a worthwhile and necessary goal. A brief statement of the goal is place in the second box on the behavioral prescription template.

Box from Behavioral Prescription Template:

Overall Goal of this Prescription:

c) Gathering information about the context of the behavior is accomplished via the ABC Process. This process provides critical information about the antecedents and consequences of the target behavior. To facilitate the development of an individualized prescription with the greatest likelihood of success, the interventionist will work with the caregiver to obtain relevant information regarding the context of the problem – i.e., information on the time of day, specific setting where the problem occurs, and what has been tried in the past. The “ABCs of Problem Behaviors” Form structures this process. Interventionists must be very familiar with this document before working with caregivers.

FIRST SEGMENT OF PROBLEM SOLVING VIDEO PROVIDES A DEMONSTRATION OF AN INTERVENTIONIST USING THE “ABCs OF PROBLEM BEHAVIORS” FORM.

Regardless of the target behavior, the antecedent/consequences format is useful and applicable. The “ABCs of Problem Behaviors” form and a blank prescription form are included at the end of this section of the MOP.

The target behavior in the video was Risk Appraisal item number 20, “Is it hard for CR to understand what you are saying or want him/her to do”? Based on the problem definition process performed with the caregiver, the target problem was individualized to, “*Getting Vera (CR) to understand you (CG) during dressing activities*”.

- 2.) List possible solutions. This step has also been termed “Brainstorming” because the goal is to generate as many solutions as possible – regardless of their apparent feasibility. Sometimes a solution generated either by the interventionist or caregiver that initially appears “outlandish”, can actually be an effective and “do-able” solution. This is also an opportunity to demonstrate the knowledge that you the intervention can bring to the issue. Use this time to provide encouraging statements as well as strategies. By providing strategies to the caregiving during this time, you will encourage your credibility with the caregiver.

The interventionist and caregiver will work together to generate a list of all possible solutions or choices that could be made in response to the problem. The interventionist should praise any response at this stage and assist by providing possible solutions. As described in the suggested reading, three principles lead to effective brainstorming: quantity, deferment of judgment, and variety. This simply means that the interventionist and caregiver are challenged to generate and record as many diverse solutions as possible **without judging the feasibility or acceptability of the solution.** Listing solutions without judging can be difficult. Caregivers will often insert the statement “yes, but...” during this process. When possible, stop the caregiver from criticizing or negating solutions until the next step. Be careful that your language does not encourage critical comments. For example, DO NOT use statements such as, “What do you think about...”, or “Do you think XX will work?”.

Initially, the interventionist may need to help the caregivers by providing possible solutions/strategies. Interventionist can be prepared for any brainstorming session by knowing how to apply basic behavior management skills. For example, effective communication strategies and use of distraction/diversion strategies can be applied to most any problem behavior.

The goal is joint problem solving between the interventionist and the caregiver. Admittedly, some choices will sound rather “off the wall” and/or unfeasible when stated out loud. The idea, however, is to generate as many possible solutions with the hopes that one or a combination of solutions will be implemented by the caregiver and will result in management of the problem.

The interventionist can facilitate the brainstorming session by established “ground rules”. Ground rules are flexible, but should include the following elements:

- ◆ A specific amount of time in which the caregiver and interventionist will recite possible solutions (i.e., “let’s spend 5 minutes on this brainstorming activity”).
- ◆ Guidance for how the exercise will proceed. For example, “Let’s take turns” or “When an idea comes to one of us, we’ll just say it and I’ll write it down.”
- ◆ The #1 rule of brainstorming: no answer should be discussed or criticized until after the brainstorming session is over. Assure the person that they will have an opportunity to discuss each idea and to rule out ideas that they strongly feel are unacceptable.
- ◆ Reassurance that the activity often proceeds slowly and that there may be periods of silence while each person is thinking (and that these periods of silence are ok).

SECOND SEGMENT OF PROBLEM SOLVING VIDEO PROVIDES A DEMONSTRATION OF A BRAINSTORMING EXERCISE.

- 3) Decision making and prescribe solutions to be used.

Decision Making: After the brainstorming activity is completed, the solution(s) to be attempted will be negotiated by the interventionist and the caregiver (using the information obtained during the ABC process). The interventionist should allow the caregiver to express if any of the

solutions are “**unacceptable**” due to strong feelings about the nature of the solution (i.e., the caregiver and the interventionist can rule out certain solutions that are listed). DO NOT allow the caregiver the opportunity to rule out strategies that they “think won’t work”, or that “they have tried”. Often it is necessary to encourage caregivers to try strategies that they don’t believe in, and/or strategies that they have ineffectively implemented in the past. With assistance from the interventionist and the REACH team, many of these formerly ineffective strategies will be effective. To repeat, **ONLY rule out strategies that caregiver refuses to consider**. Basically, the solution list will be refined to strategies with the greatest likelihood of implementation and utility.

The interventionist should inform the caregiver that he/she will be using the expertise of the REACH team to identify additional solutions, emphasizing the amount of experience that the team possesses in working with caregivers on these types of problems.

Prescribe solutions to be used: After collecting this information with the caregiver, the interventionist will return to the office and, with input from the team, use core prescriptions and resource materials to generate an individualized prescription. The prescription will be presented to the CG on the following home visit.

- 4.) Solution implementation and tracking progress towards stated goal. Upon the return visit, the interventionist will review the program with the caregiver, making sure that the CG understands and is willing to try the prescribed strategies. Role playing and demonstration techniques should be used when possible in the presentation of the prescription to the caregiver. As a general rule, any activity that you expect the caregiver to implement should be demonstrated during this initial review of the behavioral prescription. At the very least, multiple examples of how the behavior might be manifested, and how the caregiver should respond, should be presented. Assessment of the caregiver’s implementation of solutions and strategies listed on the prescription and the caregiver’s satisfaction with the prescription as well as necessary modifications to the prescription will be made during future home visits and telephone calls.

Follow-up visits are characterized by four tasks that should be completed by the interventionist and caregiver, a) assessment of the caregiver’s use of the solutions and strategies delineated on the behavioral prescription, 2) review the Weekly Recording Form used by caregiver to document the occurrence of the targeted behavior, 3) evaluate the usefulness/success of the solutions, and 4) praise caregiver for trying/using solutions and strategies. *All of these tasks are described further in PART 6: Guidelines for Creating a Weekly Recording Form.*

Getting the CG to implement the solutions and strategies is the most critical step in the problem solving approach. Tracking progress towards the established goal (i.e., is the problem under control or has the goal been reached?) is also necessary. There are really two dimensions to tracking progress: How good was the caregiver’s effort in the implementation of the prescribed strategies? and How good was the result? Data to inform these fundamental questions can be collected with a “Weekly Recording Form”. The Weekly Recording Form can be introduced to caregivers as a way of monitoring progress towards management of the target behavior. Use of the weekly recording form also induces the caregiver to focus on the problem situation, and its natural antecedents and consequences.

Interventionists are encouraged to implement the use of forms if applicable to the target behavior and if acceptable to the caregiver. Interventionists may find some caregivers resistant or unwilling to use the Weekly Recording Form. As with other aspects of the intervention, do not force the issue. Tracking the target behavior is an “intervention process” technique to help achieve change. Data will not be considered formal outcome data.

The interventionist should praise any effort the caregiver makes to achieve the goal whether or not it has had the desired effect. Feedback will be provided regarding the next step, how the current effort could be modified to increase effectiveness, or perhaps how a completely different tact could be more beneficial. Information from the Interventionist Notes can be used to determine the extent of interventionist and caregiver efforts on a given goal, and can be used to help the interventionist decide whether a goal should be maintained or if another goal should be adopted.

THIRD SEGMENT OF PROBLEM SOLVING VIDEO PROVIDES DEMONSTRATION OF INTERVENTIONIST PRESENTING BEHAVIORAL PRESCRIPTION TO THE CAREGIVER (please note that the Weekly Recording Form has been modified since this video was recorded)

PART 2: FORMAT OF THE BEHAVIORAL PRESCRIPTION

A behavioral prescription is written when a targeted behavior problem, such as “Repeated Questions”, is identified. The prescription has six sections. You will note that the “Probes for the ABC Process” is geared towards completing all sections.

Section 1: **Target behavior problem** (see parts 1, 2 and 3 of the ‘ABCs’ form)

The target behavior is presented in objective, behaviorally defined terms that are meaningful to the caregiver. Presenting the problem behavior in specific, concrete terms helps the interventionist and CG to see the problem in the same way.

Section 2: **Overall Goal of this Prescription**

Desired change in target behavior is defined as the “goal” of the behavioral prescription and presented in general terms such as “reducing”, “increasing”, and “enhancing” (i.e., Reducing the burden of bladder accidents).

Section 3: **Well-being Module**

Standardized text is presented to provide integration of the well-being module with the target behavior problem. This box links the components of the intervention in a continually reinforcing loop by providing guidance to the CG about when to integrate stress management and problem solving strategies. This information is especially important for stressed CGs. This box should be customized for each CG.

Section 4: **Strategies for preventing a behavior problem from occurring**

Problem behaviors and challenging situations created by caregiving usually do not emerge from a vacuum. There are events in the environment that often trigger the target problem. These triggers are called “antecedents” because they occur before the target problem occurs. There are often things that the CG or other individuals in the setting do to trigger a CR behavior problem; however, the trigger might be something like the ambient temperature (too hot or cold) or even something internal to the CR, such as pain. Parts 4 through 8 of the ‘ABCs’ help you to discover possible triggers. For example: Does the problem happen only at certain times (hunger related)? Only with certain people (grandchildren could be over-stimulating the CR)? Could the problem be related to the manner in which the CG interacts with the CR (multi-step commands; approaching from behind the CR)?

Section 5: **Strategies for guiding how you respond during or after a problem behavior occurs**

The behavior problem might be triggered by a specific event or situation, but how the CG or other family members respond to the problem (the consequences, or what follows the behavior) could either make the problem worse or better. The caregiver’s response can take multiple forms. Caregivers can have behavioral, cognitive and affective responses to the target behavior. A behavioral response is defined by the actions that the caregiver takes. For example, if verbal abuse is the target problem, the consequence may be that the CG is arguing with the CR or cursing back when the CR curses. The therapeutic approach may have less to do with changing the CR’s cursing and more to do with helping the CG respond in a non-argumentative way when the CR curses. This is actually not as easy as it sounds and requires closely tracking the problem, providing feedback and fine-tuning the prescription over time.

Often, the most appropriate strategy is to change the CG’s cognitive/affective response to the target behavior. Cognitive restructuring techniques can be used to elicit a more benign appraisal response from the caregiver. For example, memory related problems (such as repetitive questions) might not change due to the cognitive deficits that cannot be remediated. However, the CG can learn to appraise these problems differently (e.g., Remind yourself that your husband has a memory problem and his confusion and repeated questions are not meant to be a problem; he is doing his best).

Another therapeutic consequence might be to involve the CR directly, for example, involving the CR in an activity when the target problem occurs, or getting the CR to talk about a “happy event” to stop a challenging behavior. These are ways of distracting the CR from a downward spiral. Parts 4 through 8 of the ‘ABCs’ can help you identify consequences that might be making the problem worse or that might be making the problem more stressful to the CG.

Section 6: **General Information**

This section serves multiple purposes. First, it serves to refer the CG to supplementary information – i.e., the Caregiver Notebook and the Caregiver Network. Second, it provides the CG with encouraging statements and reaffirms the project’s commitment to working with the caregiver. Third, it encourages use of the Weekly Recording Form. Use the standard text provided on the template, but please individualized to each CG as indicated on the template.

The General Information box is another way to tie all the pieces of the intervention together and to provide final instruction to the CG (who may not exactly remember what you said after you are gone). It reinforces the fact that you are working together on these problems, another source of hope and encouragement.

Information for the Interventionist

There is a packet of prescription resources that include sample prescription for each item of the RMBPC. Remember that this packet of prescription resources should be used as a resource for therapeutic behavioral prescriptions that you will individualize for each caregiver (based on information gained from the ABC Process). For some problems you might be able to “cut-and-paste” from with minimal modification needed. For other more idiosyncratic problems/situations you might need to devise a unique prescription tailored to the very specific needs of a CG.

All prescriptions will be reviewed at your site and you will receive input from the team in a weekly meeting. Also, regular phone conferences will be scheduled across sites so that suggestions can be shared by personnel struggling with similar problems at their own sites. The interventionist discussion board on the REACH II website provides an additional venue for posting questions and exchanging ideas.

More specific guidelines on developing behavioral prescriptions can be found in Part 3 of this section of the MOP.

PART 3: GUIDELINES FOR DEVELOPING BEHAVIORAL PRESCRIPTIONS

I. Step-by-Step Instructions for Generating Content of Behavioral Prescriptions

These guidelines provide the interventionist with a step-by-step process for synthesizing strategies listed in the prescription resources and other resource materials into a behavioral prescription that is customized to the individual needs and circumstances of the caregiver. Strategies can be extracted from any resource and should not be limited to resource materials provided. These guidelines assume that the target problem has been appropriately named and defined and that the interventionist has collected relevant information using problem solving techniques (e.g., “ABC Process”, “Brainstorming”) (See Part 1 and 2 of this section).

Each step in the process is linked to a “box” on the Behavioral Prescription template. The template can be found in “Part 6: Forms” of this section.

A. Step 1: “Target Behavior Problem” (Box 1)

1. Describe the target behavior using simple and precise wording that is meaningful to CG.
2. Typically, the problem is framed as a behavior exhibited by the CR. However, some problems may be framed as a caregiver issue (e.g., obtaining social support).
3. Text should be in Bold and Italics.

B. Step 2: “Overall Goal of this Prescription” (Box 2)

1. Describe the goal of the strategies listed in this prescription using simple and precise wording that is meaningful to CG. Generally this goal is presented in terms such as “reducing”, “increasing”, and “enhancing” (i.e., Reducing the burden of bladder accidents).

C. Step 3: Well-being Module Text (Box 3)

1. Use standard wording that is provided on the template.
2. Insert information regarding CG’s name and problem behavior where indicated. The second and third sentences reflect the specific stress reduction technique that is most appropriate for the caregiver and provide specific instruction in which the stress reduction technique should be used (e.g., immediately after the problem behavior occurs).

D. Step 4: “Strategies for preventing a behavior problem from occurring” (Box 4)

1. The interventionist should review core behavioral prescriptions and other resource materials, including information on the Caregiver Network (CTIS), which are relevant to the problem behavior defined in Step 1. Appendix A in the Intervention MOP provides a list of selected resource material by problem behavior.
2. Using knowledge of the problem behavior, caregiving situation and other contextual factors, the interventionist selects the most appropriate **ANTECEDENT** strategies – that is, strategies that might **PREVENT** the behavior from occurring.
3. Additional strategies that were identified during the brainstorming session but not listed in the resource materials can also be included in the list of strategies.
4. Whenever possible, customize the prescription by using the names of the caregiver and CR, and by including facts and information that are unique to the caregiving situation.
5. Use the following format when listing a strategy:
 - State the strategy in direct, easy-to-understand words.
 - Begin the strategy with an action word (e.g., Eliminate, Use, Say, etc.).
 - Provide a brief rationale for the strategy. Caregivers use strategies more effectively if they have some idea of why the strategy is being prescribed.

- If necessary, provide additional instructions or steps for carrying out the strategy as “bullet” points below each strategy.
6. A maximum of four (4) strategies should be listed in this section of an individual prescription. Others can be added as the intervention progresses.
 7. After strategies have been listed in the box, carefully consider the order of presentation. **Strategies that are easy for the caregiver to implement and strategies that would appear to have the greatest chance of successfully managing the problem should be listed first.**

E. Step 5: “Strategies for guiding how you respond during or after a problem behavior occurs” (Box 5)

1. Follow same instructions as in Step 3, but list strategies that are associated with the **CONSEQUENCES** of the behavior. That is, strategies that are most appropriate after the behavior has been exhibited. Typically, this section will include strategies that deal with cognitive restructuring on the part of the caregiver. Also include strategies that instruct the caregiver what not to do, i.e., responses that could make the problem worse. These include instruction such as “avoid arguing” and “avoid rationalizing” with the CR. A maximum of four (4) strategies should be listed in this section of an individual prescription. Others can be added as the intervention progresses.

Remember these CRITICAL points when writing strategies:

1. Strategies MUST be written in easy-to-understand words.	<u>Rationale.</u> CGs need to understand what you are asking them to do. Don’t assume that all caregivers can understand written words.
2. Action words MUST begin the description of each strategy.	<u>Rationale.</u> These are action-oriented strategies that require the CG to be actively involved. Strategies are MORE than just “tips”. We want the CG to learn and use new skills.
3. Avoid using absolute terms such as “Never”, “Should not”, etc.	<u>Rationale.</u> These terms can be associated with feeling of shame and may make the CG feel overly negative about his/her actions.
4. A rationale for each strategy MUST be included in the description of the overall strategy. Thus, placement of the rationale statement should be the “number level” and not at the “bullet” level.	<u>Rationale.</u> CGs need to understand WHY a strategy is being prescribed.
5. No more than four antecedent and four consequence strategies can be listed in a single prescription.	<u>Rationale.</u> Too many strategies may overwhelm the CG. If you suspect that the CG may not be able to process information at the normal rate due to depression, age, low education, low motivation, etc., consider using a smaller number of strategies. You can add more strategies over time.

F. Step 6: “General Information” (Box 6)

1. Use the standard text provided on the template.
2. Modify standard text as indicated on the template.

II. Guidelines Relevant to Wording and Formatting of Behavioral Prescriptions.

The wording and formatting of prescription and content of the strategies are equally important. Interventionists should consider each of the following points:

- A. Be cognizant of the caregiver's educational background and level of literacy.
 - 1. Consider the caregiver's literacy level (from baseline battery).
 - 2. If Caregiver demonstrates low literacy, consider the following:
 - a. Limit prescription strategies to a TOTAL of 2 or 3.
 - b. Simplify language where appropriate in the prescription (e.g., use fewer words).
 - c. Use pictures and symbols to describe strategies (see Clip Art feature of Microsoft Word for ideas).
 - d. Conduct multiple verbal presentations of the strategies.
 - e. Provide caregiver with an audiotape recording of the prescription.
 - f. Consider doing an "off schedule" telephone contact to follow-up with verbal reminders about the strategies.
 - g. Identify another family member with a higher literacy level. Include this family member in home visits.

- B. Be cognizant of caregiver vision problems.
 - 1. Increase font size of behavioral prescription.
 - 2. Decrease number of words used in prescription.
 - 3. Use as few written words as possible to describe strategies.
 - 4. Use pictures and symbols to describe strategies (see Clip Art feature of Word for ideas).
 - 5. Conduct multiple verbal presentations of the strategies.
 - 6. Provide caregiver with an audiotape recording of the prescription.
 - 7. Consider doing an "off schedule" telephone contact to follow-up with verbal reminders about the strategies.

- C. Working with severely depressed and/or burdened caregiver.
 - 1. It may be necessary to limit prescriptions to 1 or 2 strategies.
 - 2. Focus on strategies that are easy to implement and that have a very high probability of providing immediate help.
 - 3. The interventionist may need to help caregiver obtain necessary materials to implement the strategies. Limited funds are available to purchase strategy related materials.

PART 4: Guidelines for Presenting Behavioral Prescription to the Caregiver

I. Orient Caregiver to Behavioral and Environmental Approaches to Interventions

- A. Review Target Behavior Problem and discuss definition of what “success” would be to the caregiver (from Part 3 of ‘ABCs of Problem Behaviors: Probes for the ABC Process’).
 - 1. Read the Target Behavior Problem aloud to make sure that you and the caregiver have a similar understanding/concept of the problem.
 - 2. Most of the time the caregiver will agree to Target Behavior Problem. However, from time to time a caregiver may forget what was discussed in the previous session or may no longer agree with the Target Behavior Problem. In this situation, discuss the discrepancy with the caregiver with the goal of bringing him/her back to the previously agreed-upon Target Behavior Problem.
 - 3. Discuss what would make the caregiver feel better about this problem or what it would take for him/her to consider the problem “solved” (i.e., complete elimination of the problem vs. management of consequence of problem). Make sure that goals are consistent with goals that were defined in previous sessions.
- B. Introduce the concept of Behavioral and Environmental Approaches to problem solving.
 - 1. Remind the caregiver that the intervention strategies listed in the prescription require new learning and frequent practice. Explain that the process will unfold over the next few weeks as you work together on these and other strategies.
 - 2. Explain what the program isn't (e.g. “I won't be asking you to try new medications or go out and buy a lot of things”) and what it is (e.g. “I'll be talking to you more about things like communicating better with your [CR] and making changes in your living space to make caregiving easier”).
 - 3. Encourage the caregiver to be open to new ideas/strategies.
 - 4. Describe working relationship with the caregiver as a partnership in which you will continue to work together to refine and reshape ideas that are listed in the program.
 - 5. Reiterate that we do things this way because we've worked with lots of caregivers over the years and have found these strategies to work most often. Remind them that this is a continuation of a 6-year project and that many other initially reluctant caregivers have found success using these strategies.
 - 6. Own up to the fact that changes may feel awkward initially because of caregiver/CR long history of interaction in set ways. With practice, however, attempting these strategies will become easier.

II. Step-by-Step Presentation of Strategies Listed in the Behavioral Prescription

- Complete steps A, B, & C (below) for each strategy until all strategies in the Behavioral Prescription have been discussed.
- A. Verbal Review of Strategies
 - 1. Review each strategy in the prescription **in order**; include the rationale for the strategy. Begin with the Well-Being Module text (Box 2 on Behavioral Prescription).
 - 2. Assess caregiver's understanding of the strategy and its rationale, as well as his/her acceptance of the strategy.
 - 3. Recap strategy and ensure that caregiver fully understands each strategy before moving on (e.g. “I just need to make sure I explained this correctly. Describe for me what it seems I'm asking you to do.”).

- B. Solicit Feedback from Caregiver
 1. Use open-ended questions to assess caregiver's acceptance of and satisfaction with strategies. For example, "Tell me when you will use this strategy." "What will keep you from using this new skill?" "What are the potential benefits from using this techniques?" etc.
 2. Avoid questions with yes/no responses (e.g., "Do you like this idea?")
- C. Negotiate with Caregiver
 1. Attempt to get "buy in" from the caregiver asking him/her to try each strategy for at least one week.
 2. If caregiver refuses, don't get defensive. Ask him/her to try it for one week. Try the following statement, "I can understand your not wanting to use this technique. Because we have seen this work with so many people, I want to ask you to first try it XX times before I return next week."
 3. After further discussion with the caregiver, you may determine that some strategies are inappropriate or the caregiver may completely refuse to try the strategy. Acknowledge that the strategy should be eliminated and make the change on future prescriptions that are delivered to the caregiver.

III. Demonstration and Role Playing of Strategies

- **Conducted after all strategies have been verbally reviewed**
- **Demonstrate each Strategy INDIVIDUALLY**

- A. Interventionist Provides Demonstration
 1. You should demonstrate each technique listed in the program. Some strategies may require a physical demonstration (e.g., how to move CR's arm during dressing) other may only require a verbal demonstration (e.g., I want you begin the dressing activity with the following statement, "John, stand up").
 2. Consider the following language, "Watching someone do an activity or skill is often the best way to learn. Please watch how I demonstrate the strategy. I will pretend to be you, the caregiver."
- B. Engage Caregiver in Role Play
 1. Role Play is a more elaborate form of demonstration. They can be useful when a strategy is especially bothersome or challenging to the caregiver. Role-plays require the interventionist to take on both the role of the caregiver and the role of the CR. Likewise, the caregiver is asked to play the role of the CR.
 2. Set up the scenario. To introduce a role play, you might say, "This strategy may be a bit more difficult for you to use, so let's practice. First I'll be you, and you be your [CR]. Then we'll switch." Describe a specific scenario within which to practice the strategy.

IV. Practice and Feedback

- **Practice and provide feedback for each strategy**
- A. Caregiver practices/implements strategies or skills outlined in prescription.
 1. Language to consider, "Often it helps to have someone watch what you're doing so you can remember what works and what is difficult. Practicing with someone can really help you find ways to improve. Show me how you will actually carry out this strategy. Let's go straight through the whole thing and talk about it afterwards."

B. Interventionist Provides Feedback

1. When the practice exercise has been completed, highlight good points and points that need improvement. "I really liked the way you NAME PARTS THAT WENT WELL. I have some suggestions about how things might go better in a few places. Can we try those parts again and do something a little different? RETURN TO SPECIFIC STEPS WITH CORRECTIONS.

C. Interventionist and Caregiver go to actual location/setting in which problem is occurring for practice demonstration by caregiver.

1. Elicit caregiver reactions to the strategy, concerns, and questions with probes. Consider the following probes:
 - "How would you say that went?"
 - "What parts went better or worse than others?"
 - "What, if anything, causes you concern about this strategy?"
 - "What parts seem unclear?"
 - "What other questions do you have about doing this?"

V. Making Assignments and Contracting with Caregiver

A. Interventionist makes specific assignments

1. Instruct caregiver to begin using the strategies immediately and to "stick with it" until your next home visit.

B. Interventionist encourages caregiver implementation by contracting with Caregiver

1. Emphasize that we know things need to be tried repeatedly and consistently in order for them to be helpful

VI. Weekly Recording Form is presented as a way to track caregiver use of strategies.

- A. The Weekly Recording Form can be a way for the caregiver to learn things about the occurrence of behavior that they didn't notice before. It is also the way the interventionist and REACH team can follow what happens in order to make adjustments.
- B. If caregiver refuses, don't get defensive. Ask them to try it for one week. Try, "I can understand your not wanting to. Because we have seen this work with so many people, I want to ask you to first try it XX times before I return next week."

VII. Provide Words of Encouragement and Express Commitment to Working with Caregiver

- A. Interventionist should provide specific words of encouragement like, "I know this is tough situation, but I do think these strategies will help, and I'll be here to provide support and guidance."
- B. Express Commitment to a Working Partnership.
 1. Remind the caregiver of the timeline, pointing out the numerous home visits that you have to work on the problem.
 2. Commit to revising the prescription as many times as necessary in order to find at least one strategy that works.
 3. Remind the caregiver that you, the interventionist, are always available by telephone.

PART 5: GUIDELINES FOR WITHDRAWING, MODIFYING AND STARTING BEHAVIORAL PRESCRIPTIONS

At this point of the behavioral prescription process the interventionist has negotiated with the CG in targeting a behavior problem. The targeted behavior problem should be one that is causing stress and burden for the CG, but it should also be a behavior that the interventionist, in consultation with the treatment team, considers “changeable”. For example, if the CG enjoyed dining in fancy restaurants with the CR prior to the onset of memory loss, but is now embarrassed by the CR’s behavior, it is unlikely that a behavioral prescription would succeed in changing the CR’s embarrassing behavior. Thus, “embarrassing restaurant behavior” should not be considered a “changeable” behavior. However, using problem solving to write a prescription to obtain a sitter for one night a week so that the CG could eat at a restaurant would be considered a “changeable” behavior. After an appropriate target behavior has been identified, a behavioral prescription is created and presented to the caregiver. Once the behavioral prescription has been presented to the caregiver, the interventionist must monitor strategy implementation by the caregiver, and resulting effect of strategy use on the targeted behavior (i.e., are the strategies being used and do they work?). The following information should be used to help determine when to withdraw or modify the behavioral prescription, and when to begin a new behavioral prescription.

Withdrawing or Modifying the Behavioral Prescription

In general, a behavioral prescription should stay “in-force” for the duration of the study. The prescription can and usually will be modified (i.e. strategies added and subtracted) frequently if it is found to be ineffective or to meet new challenges. Modifications to behavioral prescriptions should only be done after consultation with the REACH II team during weekly team meetings. All modifications should be documented and a new, updated behavioral prescription should be taken to the caregiver on the next home visit. New strategies should be in **bold** font.

It is important to remind yourself and the CG that:

- Behavioral strategies can take from 2-3 weeks to begin to show a positive effect.
- The more consistently the CG applies the strategies, the more likely it is for the prescription to work, and the faster a positive effect will be found.
- It is not unusual to find a temporary worsening of a behavior problem when a new behavioral prescription is employed. It is important then, that the CG is prepared for this. For example, let’s say the target problem is repeated questions. In the past, the CG might have given the CR attention after each question. The prescription could be to no longer provide attention, but to respond with a statement such as “Look at your memory book”. Because the CR is accustomed to receiving attention, he or she might initially increase questions until the “memory book” intervention “kicks-in”.

So, again, we want to keep a behavioral prescription “active” for the duration of the project. However, there are exceptions:

Exception #1: Persistent worsening of the problem. This criterion for stopping can be quantified by referring to the Interventionist Notes Form in the “Problem Status” column. If the CG answers “a little worse” or “a lot worse” for 3 successive weeks since the behavioral prescription was initiated, then a prescription should be stopped. A response card can be used to obtain this information.

Exception #2: CR resistance. This is a bit more difficult to quantify. You can expect some resistance from CGs in doing behavioral prescriptions as a matter of course. You are asking them to do some things differently, and executing behavioral strategies in a consistent manner can be difficult. Thus, the interventionist’s job is to provide understanding and encouragement. Encourage the CG to persevere with the prescription. However, from time-to-time the CG will present with marked resistance to conducting the prescription. In this case, the program should be stopped. “Marked resistance” can often be an interventionist’s judgment call

(after consultation with the team). An easy rule of thumb is if the CG bluntly states that he or she does not want to do the program, stop the program.

Beginning a Second or Even Third Behavioral Prescription

It is relatively rare for a prescription to be stopped altogether; prescription modification is much more likely. However, a CG might ask for an additional problem to be addressed. Also, if the original problem appears to be under control and a second stress-producing problem is looming, the interventionist may suggest working on a second problem.

A second, and eventually, even a third problem can be addressed with a prescription if:

- The CG expresses sincere interest in working on the problem, and the interventionist (and team) believes that working on a subsequent problem will not be too burdensome for the CG.

PART 6: Guidelines for Creating a Weekly Recording Form

A single Weekly Recording Form should be created as a companion for each Behavioral Prescription. The target behavior defined in the Behavioral Prescription should be the focus of the Weekly Recording Form. Tracking information about the target behavior and caregiver's use of the prescribed strategies is an important therapeutic process. Numerous studies have demonstrated that the process of tracking a behavior is an intervention in and of itself. The REACH II Weekly Recording Form has been designed to minimize the burden on the caregiver while providing interventionists with critical information regarding the frequency and time of occurrence of the target behavior, as well as general information regarding strategy implementation by the caregiver. The form also provides caregivers with a reminder of the detailed strategies presented in the behavioral prescription.

Interventionist should prepare the Weekly Recording Form immediately after the behavioral prescription is finalized. The Form should be presented to the caregivers immediately after presentation of the behavioral prescription as a formal mechanism to monitor progress toward the stated goal. Caregivers are encouraged but are not required to complete the form. Completion of the Weekly Recording Form by the caregiver is most critical during the first weeks after Behavioral Prescription introduction. After the target behavior is under management (i.e., stated goal is obtained) by the caregiver, use of the form may be discontinued.

Follow these guidelines when creating a Weekly Recording Form:

1. Record the target behavior in the "Problem Behavior" box. List the behavior exactly as presented on the behavioral prescription.
2. Provide caregivers with a reminder of each of the strategies listed on the behavioral prescription in the box labeled, "Strategies from the Behavioral Prescription". Each strategy should be summarized in a brief statement or sentence. When possible, use the same wording as used on the Behavioral Prescription.

3. Describe the behavior that you are asking the caregiver to track or record.

Example One: Target Behavior - Repetitive Questions.

The behavior to be tracked may be described as, "Please record each time your husband ask to be 'go home' in the appropriate space below".

Example Two: Target Behavior – Caregiver Isolated from Family/Friends.

The behavior to be tracked may be described as, "Please record each time you miss an opportunity to be with family and friends due to your caregiving responsibilities."

Generally, it is best to track the same behavior that is listed as the target behavior; however, in some case it may be more logical to track the desired behavior.

Example Three: Target Behavior – Caregiver Isolated from Family/Friends.

The behavior to be tracked may be described as, "Please record each time you make a telephone call to or visit with your friend Betty".

4. Write in the appropriate date in the Day and Date column. Always provide the caregiver with multiple copies of the form to cover each day between the current visit and the next home visit. HINT: Provide the caregiver extra forms incase the caregiver cancels the scheduled visit.

Guidelines for Reviewing Completed Weekly Recording Form with the Caregiver

Reviewing the information recorded on the form is an important step in the therapeutic process and should be conducted in two steps.

Step One:

The first step in the review process is assessment of strategy use by the caregiver. Begin review of the complete Weekly Recording Form by asking the caregiver if he/she implemented the strategies. Ask about each strategy individually. Gather as much information as possible about strategy usage. This information will help you (the interventionist) assess the caregiver's efforts to implement and satisfaction with the behavioral prescription. In the narrow column, record a simple "Yes" or "No" to indicate if the caregiver implemented the strategy during the period cover by the Weekly Recording Form.

Step Two:

Use occurrence information recorded by the caregiver to obtain information on the frequency of the behavior and the time of occurrence. Look for patterns in the information recorded by the caregiver. For example, the behavior is more frequent in the mornings, the behavior is infrequent, the behavior never occurs on Sundays, etc. If patterns are noted, play detective using the ABC process in an attempt to identify triggers or antecedents to the behavior. For example, the target behavior may be infrequent, but very upsetting to the caregiver. Use information gathered from the caregiver to revise the behavioral prescription, or to emphasize caregiver use of certain strategies. Collect the form and place the form into the caregiver's clinical file. You may also find it helpful to share information from the form with team members during weekly team meetings.

ABCs of Problem Behaviors Probes for the 'ABC Process'

1	<p><u>What is the behavior?</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> "Take a minute and describe what CR does." <input type="checkbox"/> Listen for irrational thoughts, misunderstandings about AD (dementia), unrealistic expectations of the CR 	<u>Notes</u>
2	<p><u>Why is this behavior a problem?</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> People react differently to behaviors. What about this behavior really gets to you? <input type="checkbox"/> What bothers you? <input type="checkbox"/> Why does this get on your nerves? <input type="checkbox"/> Can you list the reason(s)? <input type="checkbox"/> What effect does this behavior have on you? <input type="checkbox"/> How does it make you feel? 	<u>Notes</u>
3	<p><u>How would you like this behavior to change?</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> When would you consider the problem "solved"? <input type="checkbox"/> What would make it seem to you that it was better? ("tolerable") <input type="checkbox"/> What would make you feel better about this problem? 	<u>Notes</u>
4	<p><u>Why do you think this behavior happens?</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Do you see any causes or triggers? 	<u>Notes</u>
5	<p><u>When does the behavior happen?</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Time of day? <input type="checkbox"/> Days of the week? <input type="checkbox"/> When does the behavior begin? <input type="checkbox"/> Can you recognize any cycles or patterns? <input type="checkbox"/> What happened right before the problem behavior occurs? <input type="checkbox"/> Does behavior happen constantly? <input type="checkbox"/> How often does the behavior happen? 	<u>Notes</u>

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6	<p><u>Where does the behavior happen?</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> <u>Is there a unique place in the house?</u> <input type="checkbox"/> <u>Does it only happen in certain places?</u> <input type="checkbox"/> <u>Are there places where it does not happen?</u> <input type="checkbox"/> <u>Have you changed the surroundings of your family member? If yes, did it get worse or better when this happened?</u> 	<p><u>Notes</u></p>	<p>← Formatted: Bullets and Numbering</p>
7	<p><u>Who is around when the behavior occurred?</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> <u>Do other people help care for your family member?</u> <input type="checkbox"/> <u>Do you care for other people? children?</u> <input type="checkbox"/> <u>Is the behavior influenced by other family members/friends?</u> <input type="checkbox"/> <u>How do other people react to your family member's problem behavior?</u> <input type="checkbox"/> <u>Any special sleeping arrangements?</u> 	<p><u>Notes</u></p>	<p>← Formatted: Bullets and Numbering</p>
8	<p><u>What have you tried?</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> <u>What do you do when she/he does this?</u> <input type="checkbox"/> <u>Have you tried anything that hasn't worked?</u> <input type="checkbox"/> <u>Have you tried anything that seems to help?</u> <ul style="list-style-type: none"> <input type="checkbox"/> <u>How often have you tried doing that?</u> 	<p><u>Notes</u></p>	<p>← Formatted: Bullets and Numbering</p>
9	<p><u>Additional information</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> <u>Has your doctor been told of this behavior?</u> <input type="checkbox"/> <u>If yes, what has your doctor recommended?</u> <input type="checkbox"/> <u>Does care recipient have hearing problems?</u> <input type="checkbox"/> <u>Does care recipient have vision problems?</u> 	<p><u>Notes</u></p>	<p>← Formatted: Bullets and Numbering</p>

Brainstorming Sheet

Target Behavior Problem:

Possible Solutions:

*Note all solutions that are unacceptable to caregiver

Behavioral Prescription

Target Behavior Problem:

Overall Goal of this Prescription:

Insert CG's name, please remember that dealing with behavior problems can be stressful. The brief relaxation strategies will help you deal with stress when *Insert target behavior problem*. In particular, we recommend using the signal breath technique immediately before you use the strategies suggested in this behavioral prescription.

Strategies for preventing a behavior problem from occurring:

Strategies for guiding how you respond during or after a problem behavior occurs:

General Information:

There is additional information on this behavior problem in your **Caregiver Notebook** and as one of the options on the **Caregiver Network Telephone System**. Some of the strategies found in these two resources may be useful to you, especially as we fine-tune the strategies listed in this behavioral prescription in the coming weeks. Feel free to look over this information and we encourage you to talk with your interventionist about the information you find in the **Caregiver Notebook** and the **Caregiver Network Telephone System**.

You are a dedicated caregiver for *Insert CR's Name* and you are doing a great job. We understand that *Insert target behavior problem* can be very upsetting to you and are committed to helping you with this problem. We believe these strategies will help and look forward to working with you in the coming weeks.

If you would like additional information on any of these strategies, or would like us to demonstrate these strategies, please ask. Your interventionist, *Insert Interventionist's name*, can help you learn more about these strategies and can practice these techniques with you.

Also, please complete the **Weekly Recording Form** each day. The information you record on this form will help you and your interventionist to find solutions to the problem behavior, and will help you to know if the strategies listed in this Behavioral Prescription are working. The Weekly Recording Form will be reviewed during our next home visit.

Weekly Recording Form

Problem Behavior:

Strategies from the Behavioral Prescription:

Please use these strategies. Your interventionist will ask if you used these strategies during your next visit.

Please Keep Track of the Problem Behavior Below

Please indicate the _____ in the appropriate space below:

<u>Day and Date</u>	<u>Midnight to 8:00 AM</u>	<u>8:00 AM to 4:00 PM</u>	<u>4:00 PM to Midnight</u>
<u>Sunday, _____</u>			
<u>Monday, _____</u>			
<u>Tuesday, _____</u>			
<u>Wednesday, _____</u>			
<u>Thursday, _____</u>			
<u>Friday, _____</u>			
<u>Saturday, _____</u>			