A Team Effort for Treating Depression in Dementia

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SUMMARY. Managing depression or other challenging behaviors in people with dementia requires a team effort for optimal treatment outcomes. Developing a team approach in a dementia unit requires planning and coordination. Teamwork concepts and practical guidelines are described including: (a) Why a team approach is necessary, (b) Deciding who should be involved in a team effort, (c) When to involve the team in developing behavior management programs, (d) Using formal versus informal mechanisms to coordinate teamwork, (e) Focusing team based behavior management planning by using basic categories of intervention strategies, and (f) Different team dynamics to consider when developing or troubleshooting team functioning.

KEYWORDS. Team, depression, dementia, behavior management

Caring for people with dementia, by its very nature, requires a team effort. The need for teamwork is even further emphasized when dementia is complicated by issues such as depression or behavior problems (Lichtenberg, 1994). When consultants are called upon to intervene with

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depression or other behavioral difficulties, the process is team focused from start to finish, beginning with assessment based on input from caregivers, followed by intervention strategies formulated from this input, and finishing with intervention efforts which are carried out largely by caregivers (Zarit & Zarit, 1998).

Slone and Gleason (1999) describe the critical role that the dynamics of the caregiving team have on the success or failure of intervention efforts. Despite the impact team dynamics can have on treatment outcomes for people with dementia, teamwork issues often seem to be overlooked. This article is designed to emphasize, first, that a coordinated team effort is critical to optimal treatment outcomes. Second, once the nature of teamwork is understood, the very nature of clinical practice must change to provide optimal treatment for behavioral complications of dementia. Lichtenberg (1994), in his review of efforts to create interdisciplinary teams in nursing homes, points out that an effective team requires a combination of elements. The lack of one component may render other components ineffective.

The topic of teamwork is complex in both theory and practice. For purposes of discussion, two approaches will be used to simplify this topic. First, the issue of depression in nursing home residents with dementia will be used as a focal point to illustrate teamwork concepts. The teamwork concepts and processes apply equally well to other behavioral challenges of dementia.

Next, the teamwork concepts and practical guidelines will be organized according to issues of why, who, when, how, and what.

a. Why? The reasons teamwork is necessary will be discussed.
b. Who? Some key team members in a nursing home and their unique contributions to the overall team effort will be considered.
c. When? Time frames for engaging a team effort will be described.
d. How? Formal versus informal mechanisms for coordinating teamwork will be contrasted.
e. What? A practical method for breaking down different aspects of dementia behavior to consider when developing intervention strategies will be offered.
f. What? Eight components of effective teams will be distinguished as a framework improving or troubleshooting dementia caregiving teams.

WHY? THE NEED FOR A TEAM EFFORT

Mary was a persistent complainer with drawn out, whining speech. She was overweight and had weakness in her arms and legs,

making personal care difficult. Staff tended to avoid her except when absolutely necessary. A psychologist, new to the team, realized that Mary was depressed. The diagnosis of depression, along with pharmacological treatment for depression, had somehow been dropped during her prolonged hospitalization. During efforts to discuss her depression it became apparent that her somatic complaints were used to divert attention from her more painful issue of depression. Treatment involved psychotherapy with patient efforts to refocus conversation from somatic complaints to depressive topics. Mary was taught more appropriate ways to ask that her needs be met. Staff were educated and encouraged not to avoid her persistent demands as she learned more appropriate ways to ask that her needs be met. Efforts to re-institute antidepressant medication were pursued. Recreation staff helped her write letters to her husband, who she desperately missed. Upon her successful discharge she was happier, more functional, and much more pleasant to be around.

An understanding of teamwork begins with the question of "why?," or "Do we really have to?" The case of Mary demonstrates that a coordinated team effort is sometimes needed for effective treatment outcomes. However, attempts to coordinate a team effort are not always successful. Experience shows that working with a dysfunctional team can result in a state of "team purgatory," where the team dysfunction ". . . may cause the entire team to feel like they are spending time in purgatory, a place or state of temporary suffering or misery where people wait with uncertainty and a restricted sense of control over their final destiny" (Drinka & Streim, 1994, p. 541). Efforts to improve teamwork may not meet with success. Teamwork can become a struggle for influence, where team meetings are boycotted and the focus on patient care is lost in the struggle (Lichtenberg, 1994). Team members may become discouraged and develop a sense of helplessness regarding any ability to influence the team process in a constructive direction. It becomes easy to understand the temptation to just focus on one's specific duties and avoid issues that involve a team process.

Unfortunately, effective teamwork is inextricably linked to such issues as quality of care, staff satisfaction, productivity, and staff turnover (Lichtenberg, 1994). It is important to understand why working together with other team members becomes so critical when caring for a depressed, demented nursing home resident. Both the complexity of the illness and the dynamics of the caregiving situation demand a team approach for optimal care.

The complex nature of depression in dementia and the relationship of this to teamwork can be illustrated by four basic principles of dementia care. First, there is no simple formula for treatment. A behavioral problem in dementia can have multiple potential causes (Robinson, Spencer, & White, 1989). Intervention efforts begin with a catalog of potential causes to consider. The same behavior problem, when manifested by 10 different dementia residents, may easily require different solutions for each resident. Treatment solutions for depression or other problems in this population must be unique and individualized. Finding solutions becomes an exercise in creativity. The implication for teamwork is that this problem solving process is accomplished much more effectively as a team, rather than having each team member working in relative isolation.

A second principle is that there is no single cure. Geriatric issues tend to be complicated. Treatment is no longer regarded as a search for a single cause, but as a combination of multiple contributing variables (Blazer, 1995). These multiple variables are likely to fall within the purview of several different team members. Given that multiple team members are involved, it becomes unavoidable that treatment planning is best accomplished as a coordinated team effort.

A third principle involves the diversity of approaches by different staff members. In a nursing home environment, a given resident will be approached by a number of different caregivers, each with their own personality, caregiving style, expertise, training, and experience. It is typical that one staff member will be the first to discover an intervention strategy that a given resident responds positively to. It is also common that this staff member tends to enjoy problem-free interactions with this resident, while other team members remain frustrated and unaware that an effective intervention strategy has been discovered. With multiple caregivers attempting multiple caregiving strategies, the result may be a more efficient discovery of effective intervention strategies. However, more effective and efficient overall treatment will result only to the extent that these discoveries are shared with other team members. Otherwise, having an effective overall treatment program must wait until team members discover effective interventions on their own.

The fourth principle is that managing behavioral complications in dementia residents typically requires more observation, expertise, and time than any one caregiver has to offer (Tsukuda, 1990). Again, the implication is that a team effort is required. Considering the implications that these four principles have for teamwork, working together well becomes more than a workplace pleasantry. An integrated team intervention is necessary for effective treatment.

The second set of issues that illustrate why teamwork is necessary might best be described as the dynamics of the caregiving situation. These dynamic issues might be grouped according to team dynamics, resident dynamics, and the dynamics of the illness. First, of course, is the issue of team dynamics. As discussed previously, team dynamics can either help or hinder efforts to provide optimal dementia care.

The second dynamic factor involves the resident. In general, nursing home residents have distinct personalities. This may involve clear preferences for working with one staff member rather than another. This, in turn, may facilitate or hinder caregiving efforts. Different staff may be faced with very different caregiving scenarios depending on these resident preferences. A resident dynamic which is more specific to depression in dementia is manifested by responses such as, "Of course I'm depressed. I'm old." Overcoming strongly held beliefs that depression is an inevitable consequence of aging is often a critical first step in treating depression in this population. Instilling hope and the belief that depression is a treatable illness can be a challenge. Similarly, other resident variables such as personality, belief systems, or preferences can impact efforts to provide treatment.

The third dynamic is that of the illness itself. Depression in general has a more subdued presentation in older adults. When depression exists in addition to dementia, the characteristics of the dementia such as poor insight, poor memory, and expressive deficits result in an even more poorly defined presentation of depression (Bungener, Jouvent, & Derouesne, 1996; Jenkins et al., 1996). In addition, mood fluctuations in dementia mean that depression in dementia may not be as apparent at some times as others. This is especially troublesome when the depression is not apparent when the psychiatrist visits. As a result of these characteristics of depression in dementia, depression is often overlooked in this population. Whether or not observations that may indicate the presence of depression are reported to team members who might play a role in assessment and intervention is a matter of teamwork. Hughes and Medina-Walpole (2000), for example, found that one clear outcome of better teamwork on a dementia specialty unit was more effective detection and treatment of depression.

If we can accept that treating depression in residents with dementia is a complicated and dynamic task which is best accomplished by caregivers who work effectively as a team, how does this affect our practice? The critical next step is to realize that effective teamwork is a complex and challenging task and is unlikely to happen by accident. A program for working with dementia residents must be redesigned to include the team-

work component. The remainder of this article will focus on the issues of how to incorporate teamwork into a dementia program. This will include who to include, when to involve the team, how to structure this, and what factors need to be considered when developing intervention strategies. Finally, key elements of effective teams will be described as a guide to developing and troubleshooting dementia caregiving teams.

WHO? KEY TEAM MEMBERS AND THEIR UNIQUE CONTRIBUTIONS

Every afternoon at about 3:00 Elizabeth would stand by the entrance to the Alzheimer's Special Care Unit, crying and desperately pleading with anyone entering or leaving the unit. She insisted on going home to care for her children, because they were due home from school. Staff knew that, in reality, her children were long since grown. The unit social worker and the nurse manager were at their wits' end due to both the mournful pleas and the time consuming task of passing through the door where Elizabeth waited. A consultant was called in. During the course of the evaluation, the consultant happened to ask a nurse's aide, Larry, about Elizabeth. Larry was somewhat surprised by this question, but patiently explained. "That's no problem. She likes to help. I ask her to come help me in the kitchen. We have a cup of coffee, chat for a few minutes, and she forgets all about it." Larry's solution was easily implemented by all concerned, and needed only to be shared with other team members.

Deciding who to include as a part of the team when working with depressed dementia residents in a nursing home setting requires some consideration. This may involve core team members or extended team members. Extended team members may include those not normally involved as everyday team members, such as psychologists and psychiatrists. Ultimately, teams should be formed on the basis of who is needed to solve the problem at hand (Tsukuda, 1990). The list of potential team members and their roles could become lengthy. However, as Lichtenberg (1994) points out, a poor understanding of the roles of other disciplines on the team becomes a major barrier to effective team functioning. Knowing who to involve in a given issue depends upon a familiarity with the roles and potential contributions of other team members. Also, being familiar with roles is important because working with a dementia population usually requires that professional staff redefine their roles somewhat.

Working in an institutional setting means some degree of role overlap with other disciplines, which requires that roles and tasks must be negotiated at times (Tsukuda, 1990). Although deciding which team members to involve depends upon the situation, it may be helpful to highlight the roles of a few key team members in a nursing home setting. This is not intended to be a comprehensive list or to exclude any potential team members. The roles of a few common nursing home team members were chosen as examples in order to highlight some of the unique contributions that different team members can have.

Nursing Assistants (NAs) are often overlooked as key team members. Lichtenberg (1994) points out how NAs are often discouraged from verbalizing ideas about patient care and are not regarded as a part of the team. Yet, quality of care is improved when the NAs are included in decision making processes. The NAs are the team members who spend the most time with residents. They have the greatest observational baseline for resident behaviors, including signs of depression that may become evident. Also, they have the most experience with trying different ways of working with residents and, ultimately, will be the ones to implement many intervention strategies. Involvement of the NAs is essential to assessment and to developing intervention strategies. Programs must be designed to include input from these team members.

Activities staff often spend considerable time with residents and offer a unique perspective. Engaging residents in activities is a major component of a program for treating depression in dementia residents (Teri & Logsdon, 1991). Activities staff tend to have the most experience with exploring the upper limits of what residents are able to do and with attempting to engage residents in activities. Activities programming for dementia is a specialized field. Dementia residents are unable to participate in many standard nursing home activities. Yet, when activities are based upon an assessment of a resident's abilities and are designed so that dementia residents are able to engage in activities, the payoff includes happier and less anxious residents (Orsulic-Jeras, Judge, & Camp, 2000). Ultimately, the expertise and efforts of activities staff are critical to designing and implementing intervention programs for depression in dementia residents.

A third group who deserves special mention as team members is family members. Family members are often not considered as part of the team. They may be seen as intrusive or contentious. Yet, family members can be invaluable assets to nursing home programs. Their knowledge of premorbid personality, history of depression, and intervention strategies used before admission can be invaluable, and their willingness to help can be incorporated into the overall treatment program. Gladstone and Wexler

(2000) offer guidelines as to how families and nursing home staff can work together to form a collaborative working relationship.

A fourth person who deserves special consideration is the team coordinator. In order to have a coordinated team intervention, someone must have the coordinator role (Tsukuda, 1990). In general, the team coordinator should be capable of working with others in a collaborative way where each member is regarded equally with consideration given to their particular knowledge, experience, expertise, and observational opportunity (Lichtenberg, 1994; Tsukuda, 1990). A caution should be given to nurse supervisors, who are in an authority role. It is important that an authoritarian style does not dominate the team coordinator role, as this may quash the input from subordinates that the team coordinator role is designed to facilitate. Otherwise, the team coordinator can be any team member who has the talent and inclination to perform this role.

Many other team members have unique contributions to make and could be considered in this discussion. It becomes clear that many people may be involved in the care of a depressed dementia resident. The task of coordinating an overall treatment effort may seem to be daunting and time consuming. It may help to weigh this against the costs of not performing this task, which may include excess disability for the resident, increased stress and effort for the caregivers, and increased overall costs from a resident who requires more staff time than is necessary. Overall, the time spent in this effort is a good investment.

WHEN? TIME FRAMES FOR ENGAGING A TEAM EFFORT

Norma was being evaluated for depression subsequent to a stroke which left her with mild cognitive impairment. During the course of the evaluation, the medication nurse reported that Norma's mood brightened every day when the nurse asked for stories about the farm Norma was raised on. The consultant included a recommendation that this strategy be continued. The Director of Nursing, upon receiving a copy of the report, looked askance at this recommendation, wondering why this would be expected of her staff. The consultant explained that one of her staff was already using this approach effectively, and that the intent was to encourage others to try it also. Obviously, this is not an intervention that was within the abilities or conceptual models of all of the staff. Further implementation of this strategy would probably depend on how well it fit the model of the Director of Nursing.

As described by Zarit and Zarit (1998), the time frames for engaging a team in the process of treating depression in dementia residents involves three points. First, input from key team members must be sought when assessing the resident and when formulating possible treatment approaches. As described earlier, different team members may have unique perspectives to offer. Second, the team needs to be considered when making recommendations for a treatment program. Third, the team needs to be consulted to monitor implementation of treatment recommendations and the resident's response to these. These three points are important to observe. However, the greater challenge for effective teamwork is in the second step: recommendations. It is easy to make recommendations that are consistent with one's own discipline and training. To coordinate a team effort, treatment interventions must target the entire team. Three points may be helpful to consider when formulating an overall treatment program.

First, it is important to include all good strategies, regardless of the source. The expert model and the authoritarian model of leadership both suggest that the team leader should be the source of ideas. In a team oriented model, it does not matter whose idea it was. If all the team coordinator does is share a working solution so that others may use it, this coordinator has been successful. Oftentimes an NA may know how to manage a problem behavior, or may have a critical observation, but the solution is never implemented because the information is not shared.

Second, intervention strategies should be phrased in a brief, concise format that is useable by line staff as much as possible. Basic interventions for depression in dementia include activities, medication, and some adaptation of psychotherapy. As a psychologist, this author has struggled with the idea of translating psychotherapeutic interventions into a form useable by NAs. Some situations are complex and require a trained psychotherapist. However, assessment sometimes reveals strategies that may be implemented by NAs. For example, one resident could be consistently redirected from a depressive mood simply by changing the topic to one that cheered her up. This strategy worked and could easily be used by caregivers. Of course, different team members have varying levels of talent as lay psychotherapists, so some knowledge of staff abilities is essential. After due cautions are considered, it is important to attempt to tailor basic "talking cure" interventions for use by NAs and other team members (Zarit & Zarit, 1998). The best interventions for dementia are often those that can be utilized consistently by multiple caregivers throughout the day (Feil, 1992; Feil, 1993).

Third, it is important to consider the potential roles of different disciplines and to develop intervention strategies for those who may help in a given situation. For example, activities, or pleasant events, are a key component of treatment for depression in dementia (Teri & Logsdon, 1991). Yet, depressed residents can be irritable and withdrawn, giving the distinct impression that they are not interested in activities. It is important to be sure that activities staff understand this. A resident's right to choose should be respected, but irritability, withdrawal, and poor initiative to become involved in activities are part of depression. Some consistent encouragement may play a critical role in treating this resident. Likewise, it is important to consider other disciplines that might help and to convey information necessary to engage them in the treatment effort.

Developing intervention programs that are based on input from all staff, that have concise strategies that are useable by all, and that are targeted to all potential disciplines will help build intervention programs that harness the potential of the entire team.

HOW? MECHANISMS FOR TEAMWORK COORDINATION

Unit nursing staff were reluctant to attend a meeting to discuss ways to manage behavior problems. Staff reported that they had worked together on the unit for a long time, they socialized together, and they had active discussions about behavior management strategies. At the first meeting, they discussed a resident named Richard. Richard would grab staff firmly by the arm and attempt to pull them along with him. If staff resisted, he would strengthen his grip so it became painful, and would become assaultive if staff continued to pull away. Staff were uniformly frustrated, concerned, and at a loss as to how to manage this behavior. Debbie, a nurse's aide, came late to the meeting. When asked for her input, she was somewhat shy and reluctant to offer input. However, she reported no difficulty in managing this behavior. She would let Richard take her arm, would walk with him a short distance, and talk conversationally. She could then easily redirect his attention to another activity of interest, such as the television. He would release his grip and she could be on her way. Debbie's colleagues were surprised to hear that she was able to manage this behavior so easily.

Developing team based intervention programs for depression or other behavioral issues in dementia depends on team members sharing observa-

tions and ideas. Typically, staff do this on an informal basis, sharing ideas as conversational opportunities present themselves. This informal process has the advantage of requiring no planning. However, both clinical experience and research suggest that ideas are often not shared and that communication in nursing home settings tends to be very limited (Lichtenberg, 1994).

Team based interventions are likely to be better developed if a more formal process for team coordination is utilized. The standard process of treatment planning conferences is, theoretically, the appropriate process for gathering and consolidating input from different team members about treatment related issues. This has advantages over an informal process for developing a team based intervention program, and has the major advantage of being a familiar component of all facilities. In practice, however, two limitations often emerge in treatment planning conferences. First, NAs and other hands-on caregivers are often not included among the team members present at these conferences. Second, the focus may be more on producing a good document than on encouraging a sharing of ideas. For these reasons, it may be preferable to set up a separate meeting, sometimes referred to as behavior rounds, as a mechanism for collecting team input. This information, once gathered, can easily be transcribed into treatment plans.

Conducting a behavior rounds meeting is not difficult. In general, behavior rounds are scheduled at a time that will allow NAs and other nursing staff to attend. They are scheduled through the nursing supervisors to assure that nursing staff can fit this meeting into their schedule, and to assure that staff know attendance is authorized. Schedules of other key team members can usually be accommodated to fit this schedule. Basic guidelines for behavior rounds are straightforward. First, they are kept short, typically 30 to 45 minutes once per week, to assure that staff have time to attend. Second, it is essential that key team members can attend, especially NAs who tend to spend the most time observing and working with residents.

The process of a behavior rounds meeting involves first describing any symptoms or behavioral issues of concern for the resident under discussion. Then participants describe any observations, ideas, or intervention strategies that may help with either understanding problems or developing intervention strategies. One person typically takes notes from the meeting, so that others may focus on the discussion, and ideas are then written up for each resident who is discussed. It helps if this write-up is then put in the form of minutes to be circulated so that team members who are not present may read them. The more team members present, the more effective the sharing of ideas can be. The minutes can be reviewed at future meetings to

track any changes or progress. Key team members who may not be present, for example, primary care physicians, should be informed of observations that may affect them, such as the possibility of previously undetected pain.

The behavior rounds process in clinical practice has been an effective means of encouraging and consolidating input from various team members, and tends to have a more active participation and a much more enthusiastic tone than traditional treatment conferences. Also, the emphasis on the behavior management aspect of staff-resident interactions not only supports treatment efforts, but it highlights an aspect of team members' duties about which they tend to have much pride and work satisfaction. In any case, having a mechanism for gathering, documenting, and disseminating intervention strategies is essential for a team treatment effort.

WHAT? BASIC COMPONENTS OF INTERVENTION STRATEGIES

Ralph presented a complex and challenging behavior management scenario. He was known for sudden outbursts with accusations toward certain staff, demands for immediate attention, physical pursuits of targeted staff, and assaultive behavior. In confidence, he offered that his mood was "down," but this was not something he shared with his treatment team, seeming to prefer angry outbursts. He had a surprising amount of insight about his cognitive deficits and his need for assistance. He seemed willing to accept assistance, suggesting that a working relationship with him could be built and that he could learn to trust and rely on staff for help. However, his very brief tolerance for waiting for assistance made this difficult to implement. Despite his gruff manner, his history as a boxer, and his history of verbal and physical abuse of his wife, he seemed genuinely surprised when asked about becoming angry and assaultive, insisting that this was not like him. He said he would want to know if he became angry. When he did become overwhelmed during an interview and suddenly glared with anger, he easily accepted a plan to handle this by continuing the interview later. He made ambiguous reports of pain, possibly related to a prior hip injury, but it was unclear how effective his pain medication was in managing this. Obviously, developing an overall management plan for Ralph was a complicated matter which would require consideration of multiple facets of his situation.

Whether an informal style, a traditional treatment planning conference, or a behavior rounds type meeting is used to structure team input about depression or other behavioral issues, the next consideration is the content. What types of interventions should be considered? Lichtenberg (1994) emphasizes that simply assembling staff together is not enough. "The focus of teams should be on the services to be delivered" (p. 60).

A classic compilation of the types of interventions that have been found to be useful for dementia residents has been prepared by Robinson, Spencer, and White (1989). This is a comprehensive reference list, but may be too much to consider in a brief meeting. On the other hand, psychologists tend to recommend the antecedent-behavior-consequence (ABC) model (Zarit & Zarit, 1998). While this model is certainly concise, it tends to put diverse categories such as hunger, boredom, and interactions with caregivers all in one category as antecedents.

A more beneficial format for focusing a discussion about behavioral issues might have several features. The list should be moderate in size, with a manageable number of items. It should be developed from everyday conceptualizations of behavior problems so that it has a familiar, common sense quality for line staff. It should have categories that stimulate caregivers to think about a diverse array of potential causes and solutions of behavior problems. One example of such a list, which has been described in detail elsewhere (Slone & Gleason, 1999), will be reviewed briefly with reference to applications to depression in dementia. Each of these categories has potential causes of behavior problems as well as corresponding intervention strategies.

Comfort Needs. Comfort needs includes issues such as hunger, feeling cold, pain, and medical conditions. Providing physical comfort, recognizing and treating medical conditions, and treating pain are important components of a treatment program for depression in dementia. Morrison (1997), for example, offers a checklist with 42 common medical conditions that are associated with depression. Also, remember that depressed older adults tend to emphasize somatic complaints more than psychological symptoms as a manifestation of depression (Jenkins et al., 1996), so that the physical and psychiatric issues are closely related in depression.

Mood. Assessing for the presence of depression is, obviously, a critical step in the treatment of depression in dementia. This is not a simple task, however, given that the manifestation of depression tends to be less distinct in older adults and even less distinct in dementia (Bungener, Jouvent, & Derouesne, 1996; Jenkins et al., 1996). Also, consider that depression in the elderly may present as dementia. This is referred to as pseudodementia, and differentiating dementia from depression may be

difficult or impossible (Jenkins et al., 1996; Peskind & Raskind, 1996). Both the recognition of depression and treatment are best accomplished as a team effort. Remember that team input should include a consideration of whether symptoms of depression have been observed. If so, a referral for assessment may be necessary. Possible intervention strategies should be considered, including medications, activities, and an appropriately adapted form of psychotherapy.

Anger. The general issue here is, if the resident makes anger based responses such as assaultiveness, threats, or verbal abuse, do they see this as appropriate? If so, helping them learn more appropriate responses is indicated. In relation to depression, it is important to realize that the current generation of elderly was raised at a time when depression was not seen as a biochemical imbalance for which treatment is indicated. Many viewed depression as a character flaw for which the solution was to "pull yourself up by your bootstraps." Being depressed, therefore, may be personally unacceptable. Depressed feelings may be channeled into angry feelings and responses, which, though not laudable, may be more fitting with a strong self image. If this appears to be occurring, strategies for both managing anger and identifying symptoms of depression may be necessary. Also, working with the resident for a more acceptable definition of depression, which includes identified symptoms, may be helpful.

Resident's Perception of the Problem. This general strategy refers to efforts to understand the resident's explanation of the problem behavior in question. Depressed dementia residents may believe that being depressed is how an older person in a nursing home is supposed to feel. Challenging this belief, if present, is a critical first step in an overall treatment program. It is important to instill a sense of hope and the idea that depression is a very treatable illness.

Activities. Decreased interest or pleasure in activities and decreased energy for activities are both key symptoms of depression. Also, increasing involvement in activities is a basic intervention strategy for depression in dementia (Teri & Logsdon, 1991). Therefore, assessing current activities, both potential for activities and actual involvement in activities, is a critical component of developing intervention programs for depressed dementia residents.

Triggers and Pattern of Escalation. These two general intervention strategies often work together. Triggers refers to events that may precede an episode of a behavioral problem, and represents a lay person's understanding of antecedents. Pattern of escalation refers to the observation that behavioral episodes in dementia often escalate over time, rather than being instantaneous. Implications for treatment programs are to eliminate or

minimize triggers, and to learn to recognize the escalation pattern and intervene as early as possible for better results. These strategies may apply to depression, depending on the specific behavioral manifestations.

Relevant Personal History. Understanding a dementia resident's past history, activities, and premorbid personality is often useful in both understanding and developing intervention strategies for behavioral issues. With depressed residents who have a milder dementia, helping them to identify something in their life that they are proud of may be the first positive turning point in psychotherapy. For more impaired residents, discovering topics from their past that are associated with a positive emotional state may be helpful. Caregiving staff can then refer to these topics when working with the residents in an attempt to redirect residents toward a more positive mood and to enhance their cooperation with caregiving procedures.

Staff Intervention Style. Asking "Who works best with the resident?" and "What do they do?" is probably the single best method for identifying the individualized approaches that are effective for particular residents. Intervention programs are developed by identifying effective approaches and sharing them with other team members. Sometimes other team members can use these strategies directly. However, often it is necessary to modify these strategies to fit either different personal styles or different caregiving situations of other team members. Of course, simply calling upon the team member who has discovered a successful strategy and asking them to intervene with the resident is acceptable as a short-term strategy. However, having an overall treatment program demands that other caregivers ultimately learn how to intervene effectively in their own interactions.

Level of Cognitive Functioning. This general strategy refers to determining what the resident's cognitive abilities are, then comparing this to the level of performance that is being expected of the resident to determine whether these two are consistent. Often, caregivers become frustrated because they are expecting the resident to perform activities that exceed the resident's abilities. It becomes necessary to design approaches to match abilities so the caregiving experience is positive and successful for all. Depression changes this equation because depression superimposed upon dementia may cause excess disability (Pearson, Teri, Reifler, & Raskind, 1989). The extent to which a resident's disability is exacerbated by the presence of depression must be considered so that an optimal functional level can be targeted.

These ten categories of intervention strategies can be used within the context of team problem solving efforts to facilitate consideration of a broader range of intervention strategies.

WHAT? BASIC ELEMENTS OF EFFECTIVE TEAMWORK

Karen had been an RN for many years, but she was relatively new to the Alzheimer's unit. She was very conscientious about her nursing duties and made sure that her patients received good medical care. She tended to stay to herself, as she had plenty to do. She was somewhat impatient with the amount of time other nursing staff spent socializing with the residents or with other staff. When the team started having behavior rounds she was skeptical and was usually too busy to attend. After all, what these residents needed was good, basic nursing care. After hearing some of the ideas that came out of these meetings, she eventually began to attend. Other team members noticed that Karen became more open to their input. She reluctantly started sharing her input during behavior rounds, which often was quite valuable to her team members. Her interactions with residents became noticeably more therapeutic, and she was overall much more pleasant to work with.

The final aspect of teamwork to consider when formulating a team approach to the treatment of depression in dementia is the issue of how to build or maintain an effective team process. A number of authors have addressed the issue of how to diagnose and intervene with team dynamics in a geriatric treatment team (Drinka & Streim, 1994; Heinemann, Farrell, & Schmitt, 1994; Lichtenberg, 1994; Tsukuda, 1990). All agree that (a) treatment in geriatrics should be a collaborative team effort, and (b) teamwork can be effective or ineffective depending on how it is conducted. Exactly what constitutes an effective team process in geriatrics is an emerging concept that is difficult to define precisely at this time. Given the importance of this issue, it seems prudent to outline some general aspects of a functional team.

Eight key elements of effective teamwork will be presented here. These elements were synthesized from both the geriatric teamwork literature and clinical experience with teamwork. They are intended as a guide for diagnosing team functioning and for developing strategies to improve teamwork. The eight elements to be considered are a specialist mentality, foundational themes, basic training, understanding team roles, barriers to

teamwork, team coordination, conflict resolution, and maintaining morale. Examples of symptoms of team dysfunction and types of corrective strategies will be offered for each.

A Specialist Mentality. A pervasive belief about dementia is that nothing can be done about it, so why bother trying? A day of caregiving with dementia residents presents many opportunities to wonder whether anything can be done about the challenges that present themselves to the caregiver. The first and most important indicator of team health is the extent to which the team members believe that something can be done. A specialist mentality involves distinguishing what can be treated, such as medical complications, behavior problems, and depression, from what cannot be changed, such as loss of brain functions from dementia.

Signs of a poor specialist mentality include pointing the finger at other team members to intervene when problems occur, expressing a sense of helplessness about intervention possibilities, or simply failing to consider how to intervene when challenging behaviors occur. A healthy team has a positive sense of its ability to solve challenging behaviors and has an open and active stance toward understanding and developing interventions when challenging behaviors occur. A healthy team should build and develop a repertoire of success stories to remind team members of past successes in managing challenging situations.

Foundational Themes. A number of underlying assumptions form the foundation for effective teamwork. Four basic assumptions will illustrate this aspect of teamwork. First, of course, is whether or not the team members believe teamwork is an essential component of dementia care. Many talented team members believe that just focusing on their specific role constitutes effective dementia care, and that collaborating with team members is not important.

A second underlying theme is the realization that caring for dementia residents requires a special talent. Many people find a true purpose for themselves in their work with dementia, and others abhor this role. Working effectively with dementia residents means focusing on and utilizing remaining abilities. However, this requires caregivers, ". . . to value what is still there and not dwell on functions the person has lost" (Raia, 1999). This shift in focus from deficits to abilities is not always easily done. Lichtenberg (1994) points out how this task can raise personal issues that may cause some to avoid working with elderly populations.

The difference in those who are and are not able to make this shift in focus is easily observed in practice. Teams who fail to appreciate team members or family members who have this talent may not be honoring this specialist talent. Likewise, team members who fail to thrive in this

work should be free to transfer elsewhere, and family members who find it difficult to interact with these residents should not receive excessive pressure to do so.

A third underlying theme is evidenced by an atmosphere of creative experimentation. A caregiver who believes that a truly competent caregiver should know how to manage a challenging behavior, or who believes that they should have known sooner, is showing signs of weakness in this theme. There is no clear guideline for intervening with a given resident. Finding the solution is a creative effort, and a healthy team should appreciate and support the process. Finding an intervention that works should be regarded as an important discovery, something to be appreciated and shared with others.

A fourth underlying theme is expectations for change. For example, some challenging behaviors change slowly, and change in small increments. Recognizing and appreciating the changes as they occur, however slowly, is important for effective teams.

A shared understanding of these underlying beliefs in teamwork, a specialist mentality, an atmosphere of creative experimentation, and realistic expectations for change forms the foundation for effective teamwork.

Basic Training. Perhaps the simplest component of effective teamwork to remedy is whether or not the team shares a common knowledge of dementia and commonly accepted intervention strategies. Having a team member express exasperation that a resident is being "manipulative" is, for example, typical evidence that the cognitive deficits of the residents are not well understood or accommodated. Failure to report sudden changes in the resident's level of alertness or functioning may be a sign that the impact of medical illness is not appreciated. Assuring that the team members have a basic knowledge of dementia, and refreshing this from time to time, may be the best starting point for improving team functioning.

However, Lichtenberg (1994), in his review of nursing home training efforts, cautions that, ". . . training for nursing home staff is a necessary, but not sufficient, condition for improving psychological care" (p. 52). Other teamwork components must be present, such as ongoing contacts to guide the creation of practical interventions, communication mechanisms, and team conflict management. An absence of other teamwork components can, ". . . overwhelm any training effort and make the knowledge to nursing assistants seem remote and unimportant" (pp. 51-52).

Understanding Team Roles. The previous discussion of who to include in team problem solving processes emphasized the different roles that various dementia team members have. Team members are trained primarily

in the roles of their own discipline. Learning the roles of other team members is essential to becoming an effective team (Lichtenberg, 1994). In addition, roles overlap somewhat in an institutional setting where many team members work together. Team members must learn to flex, adapt, and negotiate their respective boundaries and roles (Tsukuda, 1990).

Team symptoms of poor role recognition may appear in several forms. First, team members must learn where they can complement and support each other's roles. As in the case of depression in dementia, the team members who observe signs of depression must know to report these signs to team members whose role it is to act on these observations. Another classic example of this is with pain in dementia. The staff who provide direct care are most likely to observe signs of pain, and may not realize the importance of reporting these signs to medical staff whose role it is to diagnose and treat the pain.

A second symptom of poor role recognition is disrespect for other's roles. Recreation staff, for example, may be the least respected members of the dementia team. Yet, experience shows that engaging residents in well suited recreational activities enhances their quality of life and can decrease the frequency of behavior problems. This, in turn, makes everyone else's job easier. Other team members can do much to support the efforts of activities staff, such as escorting residents to activities or scheduling personal care prior to activities.

Finally, a symptom of poor role recognition is failing to find time to collaborate with other team members. Time is at a premium on a dementia team, but team members who appreciate the value of collaboration are more likely to find time.

Barriers to Teamwork, or "One Way–My Way!" There are many potential barriers to effective teamwork on a dementia team. The impact of these barriers can be illustrated by focusing on a few which warrant special mention. Consider the following case scenario of teamwork gone astray. The nursing staff are annoyed by the seemingly perpetual disruptive vocalizations of one resident who has hearty vocal assets. One day they decide enough is enough and they take action. They place this resident right outside the nurses' station, only a few feet from where the physician normally sits. They know that once he becomes annoyed by her yelling he will finally take action and prescribe something for it. Aside from the fact that the nursing staff seem unaware that there is no specific anti-yelling medication, this case scenario helps illustrate several common barriers.

First, the classic medical model is accompanied by an authoritarian model, which dictates that communication occurs primarily in one direc-

tion, from the top down. This expectation is in place for these staff so much that they do not even consider more direct communication with the physician, as a collaborative model would suggest. It would be surprising if the physician would manage to deduce their intended message.

Second, this is a classic example of finger-pointing. Rather than consider what role they might play in managing the disruptive vocalizations, they assume that it is the task of another team member and delegate the entire task of developing an intervention program to the physician.

A third classic teamwork barrier, which is not apparent in this example, is the "One way–My way!" scenario. Team members who are untrained in behavioral interventions may make a classic error. Once they discover one way to intervene with a behavior problem, they may assume that it is the only way. If they are forced to admit that someone else's intervention strategy is effective, they secretly assume that their method is actually more effective. In fact, there may be many ways to manage a given behavior problem. Different methods may work better for different caregivers or at different times. It is especially important to consider what others do because someone must be the first to discover a successful strategy. When this occurs, the remainder of the team should consider how they might use this strategy, or how to adapt the lessons learned to their style or task. The value of having many caregivers with different styles is that someone is likely to discover the answer sooner, but this only helps the resident's program if other team members know, appreciate, and implement this solution.

These are just a few classic examples of barriers to teamwork. It is clear, however, that barriers such as these have a direct impact on the quality of resident care. It is important to teach team members to recognize such barriers, and to build an expectation of how teams should function, so that teams are better prepared to intervene as barriers occur.

Team Coordination. The mechanism for team coordination has already been discussed in some detail. This is a critical aspect of effective teamwork, but it is necessary here only to reemphasize that some type of mechanism for coordinating team input, intervention efforts, and overall treatment program is essential.

Conflict Resolution. The point has also been made that a good dementia team will generate a diversity of perspectives and ideas, so that learning how to manage the inevitable conflicts and to maintain a constructive direction in the face of these differences must become a routine task of the team (Lichtenberg, 1994). While overt conflict is not difficult to recognize, it is also important to recognize indirect conflict. Less obvious but equally destructive processes include a consistent lack of support of cer-

tain team members, intolerance of dissenting opinions, or acceptance of ideas without due consideration of potential drawbacks (Heinemann, Farrell, & Schmitt, 1994). A few conflict management strategies to consider include the following:

a. Remember that some degree of conflict is necessary and healthy.
b. Team members may express ideas in a way that is offensive, vague, or awkward. Restating these ideas in a manner that is more diplomatic, clear, or task focused may facilitate the team process. Offering such diplomatic assistance should become a routine expectation of team members.
c. Seek out opinions from key team members on important issues.
d. When disagreement is voiced, ask whether other team members share similar concerns before weighing pros and cons.
e. If tensions are high, consider whether an immediate decision is necessary. It may take time to formulate the best solution. Keeping minutes of meetings helps assure that issues are not simply forgotten.
f. When in doubt, err on the side of trying new ideas. Incorporate precautions and reevaluate the effectiveness of ideas as soon as possible.
g. If a team becomes stagnant, start by acting on small ideas to build momentum and develop teamwork.
h. Make a special effort to help new team members adjust. Offer support, education, guidance, and patience.

Maintaining Morale. A final element in the effectiveness of a team process is morale. Dementia work can be slow, difficult, and frustrating. Indications of poor morale may include statements indicating that dementia caregiving is an impossible and pointless task, or statements indicating a lack of pride in one's work. Finding ways to improve and maintain morale is important for the long-term maintenance of dementia teams.

Morale maintenance methods can be creative. The starting point is to realize that the best source of emotional support is usually fellow dementia caregivers. Fellow caregivers understand the nature, frustrations, and value of the work. Simply sharing frustrations with a colleague may help. Staff get-togethers, such as potlucks, or attending conferences about dementia, provide opportunities for supportive connections with colleagues.

Another strategy goes back to the question of "Why bother?" When friends, family, colleagues, visitors, or others ask this question, it helps to have a good response. The team can develop a sales pitch. The sales pitch might include the nature of dementia, the challenge of managing related problems, and the special talent the team has that enables them to accom-

plish this. Once this sales pitch is developed and practiced, having an opportunity to deliver it can be uplifting to team members.

A third strategy to consider is developing hospitality guidelines. It does well for the team to remember that the impression that others have of their work may depend largely upon how the team members treat visitors or callers. Basic telephone courtesy, greeting visitors, and being hospitable all convey a positive impression. Having others appreciate the talents of the team, in turn, helps support team morale.

Together, these eight elements of teamwork provide a basis for diagnosing the effectiveness of team processes and for formulating strategies to address specific team issues.

CONCLUSIONS

Teamwork is, in the best of circumstances, a complicated proposition. Whether working with depression or other behavioral issues in dementia residents, teamwork becomes necessary for effective treatment. This overview of teamwork in the treatment of dementia residents has included a description of the complex and dynamic nature of dementia that makes teamwork a necessity, a discussion of who should be included in the team effort, different times in the process to engage a team effort, how to coordinate a team effort, an outline of what aspects of intervention to consider in the overall treatment program, and a description of a model for diagnosing a dementia team along with some suggestions for improving teamwork.

In closing, it may help to consider that working effectively as a team allows us to accomplish what others may have thought impossible. Our teamwork allows even those with the most distressing experience of dementia to come to a comfortable and caring existence. Most of all, being part of an effective team, and sharing in the remarkable accomplishments of that team, is perhaps the most personally fulfilling aspect of dementia caregiving.

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