Connecting minds

Dementia care newsletter

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Techniques for successfully communicating with elders in various stages of Alzheimer's

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The need to communicate with others is obvious, and is a basic human need. What may not be so obvious is that just having someone else pay attention can fulfill communication needs. Even though you may not understand what the person with Alzheimer's disease (AD) is trying to say, he or she may feel that you are listening and trying to understand. **This is called "attentive listening" and it sends a reassuring message to the elder**.

To better meet the needs of individuals with AD, and thus potentially reduce challenging behavioral symptoms, and increase quality care, special effort must be aimed at receiving and interpreting both verbal and non-verbal messages. Careful interpretation of communication messages can assist care givers in planning purposeful interventions, and enhancing the quality of care delivered. Pathological brain changes that occur in persons with AD negatively impact their ability to function within the environment and effectively communicate. Difficulties with communication begin early in AD. As they progress, they become perhaps the most distressing symptoms of the disease for family and other care givers, not to mention the stress it causes for the individual with AD. This decreasing ability to communicate, at least in what we refer to as "usual ways," gives a sense that the person is "lost." Ways of maintaining communications are vital, particularly to overcome the danger of depersonalization - treating the person with AD as if he or she were not there. Skills and abilities may vanish; however feelings, and the person do not. Vulnerable, frail people who are treated impersonally, with negative expectations, most often act to fulfill the negative expectations. Therefore, it is important to remember that the "idea" can exist separately from the word. Words are learned through a variety of associations, and though the word may be lost, the idea may remain.

MRM Theory

The framework for discussion is based on the Modeling and Role-Modeling (MRM) theory. The theory for nursing that uses the perspective of the patient, even the cognitively impaired individual, as the primary source of information. In other words, reality as perceived by the patient constitutes the reality of the situation. In MRM terms, modeling a patient's world entails building a mirror image of the patient's perspective of the situation. Role modeling is using the patient's model of the world along with theoretical information to formulate patient-centred interventions.

Unmet needs

The MRM theory rests in the perspective that all humans have needs, and all unmet basic needs interfere with growth and self development. When basic needs remain unmet, individuals may experience aggravation of physical or mental distress and illness. It is also based on the fact that "all behaviour has meaning."

Because the MRM theory maintains that a person's perspective of a situation constitutes the reality of the situation, basic needs can only be satisfied within the framework of the individual, even if that person has dementia. Thus, careful interpretation of communication from individuals with dementia is extremely important.

In a 1999 study done by nurse researchers action and colleagues, their study using the MRM theory, demonstrated that individuals with dementia are able to transmit meaningful communication. Others can interpret this communication, making patient centred interventions possible with persons with dementia. To better meet needs of individuals with dementia, care givers should focus on receiving and interpreting verbal and non-verbal messages conveyed by persons with AD.

Communication losses

As with other symptoms of AD, communication losses do not follow a predictable course. The losses vary from person to person, even in the same stage of the disease; one type of communication skills to another for the same person; and one time to the next, depending on the person's mood, health status, and environment. Persons with AD have difficulty both in understanding what others are saying to them and in expressing themselves to others, because some portions of language skills are preserved while others are seriously affected, it is very easy to be frustrated in attempts to communicate. It is common, for instance, for the person to be able to read but be unable to understand what the written message says.

Based on care giver reports, the most prevalent linguistic symptoms are difficulty with word finding, thinking of names, and writing a meaningful letter. Other communication barriers experienced by individuals with AD include difficulty with reading, inappropriate conversation content, failure to recognize humour and failure to complete sentences.

Usually language and communication skills are lost in reverse order to the way they were acquired in childhood. However the ability to interpret the emotional message of tone of voice, facial expression, eye contact, body posture and touch remains with persons who have AD until late in the disease. The individual with AD also continues to communicate non-verbally with facial expression, tone of voice, touch, gestures and other behaviors such as fidgeting, pacing, singing, crying, laughing and shouting.

Early stage communication losses

In the early stage of AD, memory loss is the greatest source of communication difficulties. Frequently individuals attempt to cover the losses by using several techniques. Standard conversational responses and social skills that are exemplified by bland party phrases such as "isn't that interesting" or "I'm so glad to hear that" are often used. Confabulation, the making up of a response or explanation that is totally fictitious, is used when the person cannot think of the correct response to make. By complementing or charming another person, the use of flattery, the individual with AD very skillfully throws the other off guard and his or her communication deficits may be overlooked. Some individuals cover their deficits in abstract thinking by using their sense of humor.

Social conversation remains well preserved, but those who know the person well may begin to notice peculiar things, such as more than normal difficulty in recalling names. The main difficulties, at this stage, are in recalling names and in communicating information about plans, events, appointments and taking pills.

During this time it is usually possible to make use of calendars, charts, written reminders and "talking" watches or clocks, as long as these are consistent with the methods the person used before the disease. In this early stage the person is usually very aware of the difficulties, tries to cover up mistakes, and appreciates tactful suggestions on how to overcome the problems.

Middle-stage losses

As AD advances, word finding difficulties become more pronounced and obvious.

1. More complex, frequently used words disappear first; i.e. the name of the colour fuchsia will be forgotten before the colour red.
2. Nouns and proper names are replaced by pronouns (i.e. it, he, she, they) or generic terms (i.e. the thing or whatchamacallit)
3. Requests to repeat questions or directions are frequent.

4. The individual has great difficulty in following verbal directions. Language becomes increasingly "hollow."
5. Vocabulary and structure may be present, but what is said does not make much sense. There is increasing reliance on standard social phrases.
6. The individual has difficulty in understanding figures of speech and expressions. Problems with interpreting written directions increase.
7. Concentration efforts and the ability in initiating conversation are limited and the individual may forget some of the accepted rules of social conversation, like the accepted distance from another person.

Advanced-stage losses

In the end stages of AD, verbal communication is extremely difficult. The person may be primarily mute speaking, if at all, in short phrases or single words. Usually much prompting is required to assist an individual with verbal communications. Perseveration (getting "stuck" and repeating something over and over) is common and the person may get stuck on a single word, phrase or sound. The ability to even understand simple words is diminished, but to what degree is unknown. Even though verbal communications of persons with AD may be extremely limited, care givers need to be cognizant of times when the individual is capable of "responding appropriately," either verbally or non-verbally.

Know the differences

Frequently, persons with AD are treated as a homogeneous group with identical needs. Failing to recognize unique differences in persons with AD may prevent identification of individual deficits and special needs that may be used in planning interventions that enhance meaningful communication. Although communication loss is inevitable in persons with AD, the use of effective strategies to encourage and maintain skills will make the loss less devastating to the person and care giver.

Validation as a Means of Communication and Problem Solving

Care givers are in need of developing effective ways to best communicate with those who have dementia. When verbal abilities decline, other methods of communicating may be instituted, but often with limited success. Such communication methods include reality orientation, reminiscence, life review, remotivation, diversion and behavior modification. Most of these techniques rely on functional memory, which are impaired in persons with AD. A more useful strategy involves using validation to affirm the patient's feelings and thoughts. Validation is a method of communicating with empathy to help the elderly persons, such as those with dementia, to regain dignity, reduce anxiety and prevent withdrawal.

The physical and developmental aspects of aging cannot be separated and many disruptive behaviors can be related to failed resolution of past conflicts. Care givers must assess and be knowledgeable of the patient's past history and know their patient's likes and dislikes for validation to be totally effective. These strategies are most effective when used by one person over a period of time to establish a relationship with a patient with dementia.

Naomi Feil's (the developer of using validation techniques with disoriented elders) techniques of validation therapy are used successfully to facilitate meaningful communication including the following:

Centering is a technique that involves the care giver's willingness to lay aside negative emotions in order to listen emphatically and to be receptive to the feelings of the patient. The care giver stops all inner dialogue and focuses on breathing deeply and exhaling completely after each breath. The centering process takes about three minutes. This exercise frees the mind and allows the care giver to focus on the patient. This technique is especially useful with patients who are time-confused or repetitive movers.

Using non-threatening words to build trust is an effective strategy because the focus is on the events rather than on the patient. Patients have little desire or capacity to understand why they behave the way they do and will usually retreat when confronted with emotion-laden content. Some personal knowledge helps the care-giver understand what is triggering the behavior. ***Example***: If a female patient complains about someone assaulting her, try asking such questions as "What does this person look like? Is it all the time?" The approach eventually allows the care giver to discover a way to exchange meaningful information with the patient.

Rephrasing allows the care giver to restate the meaning of whatever question or statement the patient has made in such a way as to validate the patient rather than argue with or demean him. ***Example***: The patient says "I am so angry today." The care giver responds in a reassuring tone "you're so angry today?" this allows the patient to express anger and or dismay while on a deeper level, recognizes his failing abilities and that someone heard what he said.

Using polarity the care giver asks the patient to express the worst instance that she can imagine about his complaint. ***Example***; In validating a patient who complains about the food being inedible, the care giver asks "Is it the worst food you have ever tasted?" This statement allows the patient to freely express emotion, thereby relieving some anxiety.

Imaging the opposite, the care giver asks the patient to express instances of when an event does or does not occur. ***Example***; When a patient states "That witch came by last night," the care giver can respond asking if there are nights when he has not seen the witch. A response from the patient like "Only when you are here," should prompt the care giver to explore further. The care giver might ask, "you mean if I was here all the time, the witch would not come?" The patient might respond, "I don't know. The only time I was alone was after my wife died," to which the care giver could respond, "What did you do after your wife died?" From that point the care giver has helped the patient move beyond the fear to another time that can be further explored.

Reminiscing can be used with the words "always" and "never" to bring to mind similar events from the past. This helps to capture retained memories. ***Example***; If a patient is having trouble eating or sleeping, the care giver might ask, "have you always had trouble sleeping?" This may trigger episodes in the patient's memory when similar problems occurred. Such triggers can help the patient recall what might have worked in the past as care giver explores the patient's feelings.

Maintaining genuine close eye contact and **using a clear, low, loving tone of voice** helps the patient feel safe, recognized, loved and cared about. A clear, low, soft nurturing tone of voice can often trigger memories of loved ones and earlier happy experiences, thereby reducing stress.

Touching is another technique used to establish communication and to problem solve. Touch is most effective when used with a time confused person. It is an effective way to establish emotional contact. However, "touch" should be used with caution, and only with those persons who are comfortable with gentle touch. Touch is often necessary while performing physical or personal care procedures; however "touch" outside of "procedural touch" can enhance meaningful communication.

Using music can be an effective communication link. Often when speech is impoverished, the ability to sing familiar songs remains intact. Using this as a means to communicate can help reduce anxiety, divert attention, and preserve some quality of life for the patient.

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