Introduction to Alzheimer’s Disease: Understanding the Basics

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History of Alzheimer’s Disease Programs in Illinois

• September 1985 -- Alzheimer’s Disease Research Act: Created Alzheimer’s Disease Research Fund (Tax Check-Off)
  → http://www.idph.state.il.us/fundop.htm (last year due January 17, 2014)
• January 1986 -- Alzheimer’s Disease Assistance Act: Created Two Regional Alzheimer’s Disease Assistance Centers
  • Southern Illinois University School of Medicine, Center for Alzheimer’s Disease and Related Disorders
  • Rush Alzheimer’s Disease Center
    – Third Site Added in 1997
  • Northwestern University Medical School

Save the Dates: Our Upcoming Educational Events

Springfield, IL

• Saturday, November 22, 2014 – 19th Annual Memory Loss Conference for the Community
• Tuesday, May 19, 2015 – Risk and Protective Factors and Early Interventions Conference
• Wednesday, May 27, 2015 – Community Health Education: Healthy Brain Aging

Registration flyers will be posted at:
www.siumed.edu/alz
Cognitive Changes in Healthy Adults

- **Memory**
  - Modest decline in short-term memory
- **Verbal intelligence**
  - Stable at least until the seventh decade
- **Processing speed**
  - Declines throughout adult life

Frequency of Memory Problem Complaints in Healthy Older Adults

- Names 83%
- Where you put things such as keys, etc... 60%
- Telephone numbers you just checked 57%
- Words 53%
- Knowing whether you’ve already told someone something 49%
- Things people tell you 49%
- Faces 42%
- Directions to places 41%
- Begin to do something and forget what you’re doing 41%
- Losing the thread of the conversation 41%
- Remember things you’ve done such as lock door 38%
- Appointments 34%
- Telephone numbers used frequently 29%

“It takes a lot of patience on your part as well as on your supporters. Life is never going to be the same as the person becomes afflicted. I don’t think that as it passes that you and those around you will ever quite be the same. There are so many facets to this disease.”
“Sometimes it can be embarrassing. Sometimes people will treat you differently because they think you’re worse off than you are. They don’t understand what you’re dealing with. Difficult to express ourselves sometimes. They talk around you, not to you.”

“I feel okay because my husband loves to take care of me. He likes to help too much. I feel that he is doing too much. If he would let me do some of the cooking, that would be better. I feel good about myself!”

“If you haven’t been there, you don’t know what it’s like. It’s hard to stop trying to find the words or what you need to say. You have to stop and think about, stop and try to find out what to do. You just have to be patient. No point in getting upset. I can remember some things, can’t remember others.”
"I'll tell a friend about my disease and they say, “oh, you’re just busy or very active; that’s just normal.” But I know it’s not like when I used to forget something when I worked as a teacher. I can’t explain it. It’s like being in a cloud."

(Young onset, age 58)

"I get frustrated, because people are always saying “You’re too young.” Frustrating to have to talk to people who think I’m kidding or lying. It’s not a disease you can see, but it’s still there in the brain. I don’t want to rely on my husband."

Sometimes it’s pressure on other people who don’t understand you forget and get upset with you. Some people don’t have patience. They talk down to you. Others who want to do your things for you."
“I used to sew all the time. I started when I was three years old. I used to make my own clothes, but now I don’t do it and I don’t know if it’s that I can’t or I won’t.”

“If I ask my wife a question, and she says I’ve already asked it, it makes me frustrated, then it makes me mad. I’m not doing this to make you mad, why don’t you just answer my question?”

“Sometimes I won’t ask a question or start a conversation because I know it will start an argument.”
"I'm doing the best I can."

Alois Alzheimer (1864-1915)

On the occasion of the 37th Meeting of Southwest German Psychiatrists held in Tübingen in November 1906, Alois Alzheimer reported on a 51-year old female patient (Mrs. Auguste D.) who had been admitted to the Frankfurt hospital in November 1901 with signs of dementia. The title of his lecture was "Über eine eigenartige Erkrankung der Hirnrinde" (On a Peculiar Disorder of the Cerebral Cortex). In 1907 his presentation appeared in print. Later on, at the suggestion of Emil Kraepelin, presenile dementia was designated "Alzheimer's disease."

Percentage of U.S. Population 65 years of age and older

- 1 million in 1790
- 3 million in 1900
- 26 million in 1980
- 64 million in 2030

Graph showing the increase in percentage of U.S. population 65 years of age and older from 1790 to 2030.
Prevalence of Alzheimer's Disease
In a Community Population

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>65-74</td>
<td>3</td>
</tr>
<tr>
<td>75-84</td>
<td>18.7</td>
</tr>
<tr>
<td>85+</td>
<td>47.2</td>
</tr>
<tr>
<td>65+</td>
<td>10.3</td>
</tr>
</tbody>
</table>

Evans et al. JAMA 1989;262:2551-2556

What is Alzheimer’s Disease?

- Progressive, degenerative disease
- Affects brain
- Impairs memory, thinking, behavior
- Most common form of dementia

What is Dementia?

- Dementia is an umbrella term, a category, not a diagnosis
- Decrease in mental ability from a prior level of intellectual function
- Many causes
  - Metabolic imbalances
  - Head trauma
  - Cerebrovascular events
  - Depression (doesn’t cause, often associated)
  - Neurodegenerative diseases
Key differences between early signs of disease and normal aging include:

<table>
<thead>
<tr>
<th>Normal Aging</th>
<th>Potential Signs of AD</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Forgets part of an experience</td>
<td>• Forgets entire experiences</td>
</tr>
<tr>
<td>• Often remembers later</td>
<td>• Rarely remembers later</td>
</tr>
<tr>
<td>• Is usually able to follow written/spoken directions</td>
<td>• Is gradually unable to follow written/spoken directions</td>
</tr>
<tr>
<td>• Is usually able to use notes as reminders</td>
<td>• Is gradually unable to use notes as reminders</td>
</tr>
<tr>
<td>• Is usually able to care for self</td>
<td>• Is gradually unable to care for self</td>
</tr>
</tbody>
</table>

© 2008 Alzheimer’s Association

10 Warning Signs of Alzheimer’s Disease © Alzheimer’s Association

1. Memory loss
   - Forgetting recently learned information is one of the most common early signs of dementia. A person begins to forget more often and is unable to recall the information later.
   - What’s normal? Forgetting names or appointments occasionally.

2. Difficulty doing familiar tasks
   - People with dementia often find it hard to plan or complete everyday tasks. Individuals may lose track of the steps to prepare a meal, place a telephone call or play a game.
   - What’s normal? Occasionally forgetting why you came into a room or what you planned to say.
3. **Problems talking or writing**
   - People with AD often forget simple words or substitute unusual words, making their speech or writing hard to understand. For example, they may be unable to find their toothbrush and instead ask for “that thing for my mouth.”
   - *What’s normal?* Sometimes having trouble finding the right word.

4. **Confusion about time and place**
   - People with AD can become lost in their own neighborhoods, forget where they are and how they got there, and not know how to get back home.
   - *What’s normal?* Forgetting the day of the week or where you were going occasionally.

5. **Loss of judgment**
   - Those with AD may dress inappropriately, wearing several layers on a warm day or too little clothing in the cold. They may show poor judgment about money, like giving away large sums to a scam artist.
   - *What’s normal?* Making a questionable or debatable decision from time to time.
**6. Problems with abstract thinking**
- Someone with AD may have unusual difficulty performing complex mental tasks, like forgetting what numbers are and how they should be used.
- *What’s normal?* Finding it challenging to balance a checkbook.

**7. Misplacing things**
- A person with AD may put things in unusual places, such as an iron in the freezer or a wristwatch in the sugar bowl.
- *What’s normal?* Misplacing keys or a wallet temporarily.

**8. Changes in mood or behavior**
- Someone with AD may show rapid mood swings – from calm to tears to anger – for no apparent reason.
- *What’s normal?* Occasionally feeling sad or moody.
9. Changes in personality
   - The personalities of people with dementia can change dramatically. They may become extremely confused, suspicious, fearful or dependent on a family member.
   - What's normal? People's personalities do change somewhat with age.

10. Loss of motivation
    - A person with AD may become very passive, sitting in front of the TV for hours, sleeping more than usual or not wanting to do usual activities.
    - What's normal? Sometimes feeling weary of work or social obligations.

Alzheimer’s Disease Statistics
- Today, every 67 seconds someone in America develops AD; by 2050, every 33 seconds
- Approximately 5.2 million Americans with AD
- Expect 11-16 million in US by 2050
- One-third of all seniors who die in a given year have been diagnosed with Alzheimer's or another dementia
- Life expectancy may be 2-20 years or more
- Between 2000-2010, % of deaths from heart disease, stroke, and prostate cancer ↓ 16%, 23%, and 8%, respectively, while % from AD ↑ 68%

Alzheimer’s Disease Statistics

- Annual cost in this country today is over $200 billion; by 2050 it will be $1.1 TRILLION
- Over 70% of people live at home
- Almost 75% of home care provided by family and friends
- About 70% of all nursing home residents have cognitive impairment, 50% of assisted living residents have AD or another dementia, over 50% of adult day service participants have AD or another dementia, as well as about 25% of all elderly hospital patients
- Dementia is the most expensive malady in US ahead of heart disease & cancer!

The Four “A’s” of Alzheimer’s Disease

- Amnesia
  - Loss of memory initially for recent events and ultimately for remote events
- Agnosia
  - Total or partial loss of the perceptive faculty in any of 5 senses by which persons and things are recognized
- Apraxia
  - Inability to carry out a motor function in the absence of a motor weakness (ex. inability to dress oneself)
- Aphasia
  - Naming difficulties of familiar objects

Diagnosis of Alzheimer’s Disease

- No single clinical test to identify Alzheimer’s disease
- Confirmation requires examination of brain tissue
- Comprehensive evaluation includes:
  - Complete health history
  - Physical examination
  - Neurological and mental status assessments
  - Blood and urine analysis, EKG, chest x-rays, EEG, CT scan, PET scan
Why Diagnose?

- May be treatable or reversible cause (up to 10%)
  - Lesions (tumors)
  - Toxicities (medications)
  - Nutrition (B12, thiamine, niacin)
  - Infections (neurosyphilis, TB)
  - Metabolic disorders (electrolyte imbalance, thyroid dysfunction)
  - Organ dysfunction (liver, kidney)
- Helps patient and family members to anticipate changing needs and plan for the future
- With new investigational drugs, there is a need to know who would benefit from them

Causes of Alzheimer’s Disease

- Genetic predisposition
  - Young onset
  - Late onset
- Other factors
  - Head injury
  - Education
  - Estrogen
  - NonSteroidal anti-inflammatory drugs (NSAIDS)
  - Nicotine


More Risk Factors

- Traumatic Brain Injury
- Obesity
- Heavy Smoking
- Environmental Toxins
- Hypercholesterolemia
- Heart Failure
- Dietary Saturated Fats
- Atherosclerosis
- Genetics

Risk Factors

- Aging/Mutation
- Abnormal Aβ processing
- Stroke
- Diabetes
- Dietary deficiencies and/or
- Sensory Deprivation
- Lack of Education
- Lack of Mental Activity
- Lack of Exercise

Primary Response

- Decreased Brain Metabolic Activity
- Decreased Synaptic Activity

Secondary Response

- Increased Aβ Production and Deposition
- Mitochondrial Defects
- ROS

Cognitive Decline/Dementia

www.aboutalz.org
What Happens to the Brain? - Frontal

**Normal** – Personality; Reason; Movement; Speech; Attention Span; Alertness; Safety

**AD** – Change in Personality; Cannot Plan/Poor Judgment; Short Attention Span/Can’t Concentrate; Easily Distracted; Can’t Initiate Activity; Not Alert

**What to Do** – Give Step by Step Directions; Use Cues or Prompts to Start an Activity; Reduce Hazards in the Environments; Reduce Distractions

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What Happens to the Brain? - Parietal

**Normal** – Perceptions; Senses (Temperature, Touch, Pain, Space); Language

**AD** – Can’t Understand Input from Senses; Can’t Follow Auditory or Visual Cues; Can’t Recognize Familiar Objects by Touch; Doesn’t Understand Purpose of Objects

**What to Do** – Assist with Cueing; Use Gestures, Body Language, Demonstrate; Use “Hand-in-Hand” Technique; Use Prompt to Show Purpose of Object

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What Happens to the Brain? - Occipital

**Normal** – Vision; Interprets Information from the Eyes for Orientation, Position, Movement

**AD** – Loss of Depth Perception; Loss of Peripheral Vision; Difficulty Processing Rapid Movements

**What to Do** – Approach from the Front; Eye Contact; Use Slow Movements; Avoid Floor and Wall Designs that Could be Misinterpreted (A Black Floor Tile Could Appear to be a Hole)
What Happens to the Brain? - Temporal

Normal – Hearing; Memory; Language; Ability to Draw  
AD – Aphasic (Impaired Language) – Expressive (Inability to Speak); Receptive (Inability to Understand)  
**What to Do** – Early Stages: Fill in Missing Words  
Later Stages: Prompt with Gestures, Body Language, Physical Prompts, Hand-in-Hand

What Happens to the Brain? - Amygdala

Normal – Emotions; Anger, Sex, Fear  
AD – Angry Outbursts; Inappropriate Sexual Behaviors; Afraid  
**What to Do** – Distract; Reassure; Redirect with Activities, Music, etc.
Quotes from Art Express participants

- “I look forward to it every week. It’s like sunshine in here, no matter what it looks like outside.”
- “I really enjoy coming to this class. I think it’s my favorite part of the week.”
- “I love doing this. It just clears my mind of all the worries and the effort to remember everything. I can just paint for a while.”
- “I think I have come a long way because of this class. It helps me think outside the box.”

What Happens to the Brain? - Hippocampus

<table>
<thead>
<tr>
<th>Normal</th>
<th>AD</th>
<th>What to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory:</td>
<td>Loss of Short Term Memory; Asks Repetitive Questions; Gets Lost Easily; No Sense of Time; Easily Confused; Loses Things</td>
<td>Reassure; Validate; Answer Questions, Even if Repeated; Redirect; Move Slowly Between Tasks; Allow Time for Adjustment</td>
</tr>
<tr>
<td>Processes Short Term Memory, Stores New Memory, Learning</td>
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Alzheimer’s Disease -- Treatment Update

- tacrine (Cognex®) FDA approved - 1993
- donepezil (Aricept®) FDA approved - 1996
- rivastigmine or ENA 713 (Exelon®) FDA approved – 2000; patch came out two years ago
- galantamine (Razadyne®) FDA approved – 2001 (Trade name was Reminyl® prior to July 1, 2005)
- Boosts acetylcholine (brain neurotransmitter)
- memantine (Namenda®) FDA approved – October 2003
- Regulates glutamate, another brain neurotransmitter
Other Disorders - Lewy body dementia (LBD)

- Two distinct but related types of dementia
  - Dementia with Lewy bodies
  - Parkinson’s disease with dementia
- Second most common cause of dementia after AD
- Affects more than 1.5 million people and their families
- Accounts for 20-25% of all dementias

Other Disorders – Dementia with Lewy bodies

- Dementia before motor symptoms
- Impaired self care skills (bathe, toilet, stand and walk independently, eat, brush teeth)
- Rapid progression (? Literature conflicting)
- Attention and concentration fluctuates
- Recurrent visual hallucinations / delusions
- Repeated falls and syncope
- Transient loss of consciousness
- Depression
- Sensitive to neuroleptics
  (Haldol, Thorazine, Prolixin)

Other Disorders - Parkinson's disease with dementia

- Motor skill impaired before dementia
- Memory impaired / Language impaired
- Visuo-spatial function impaired
- Executive function impaired
- Reduced attention
- Hallucinations (often drug induced)/ Delusions
- Apathy
### Other Disorders - Vascular dementia

- Stroke with obvious impairment
  - Abrupt onset
  - Motor signs
  - Aphasia
- Multiple “mini strokes”
  - Gradual onset
  - Symptoms depend on infarct areas

### Other Disorders - Frontotemporal dementia

- Personality changes
- Executive dysfunction
- Hyperorality
- Visual-spatial preserved

### Treatment

- Planning
  - Medical and social management
  - Reevaluate and change as disease progresses
- Medication
  - Agitation
  - Anxiety
  - Unpredictable behavior
  - Improved sleeping patterns
  - Depression
Medications: “Start Low and Go Slow”

- Start with low doses
- Increase dosage slowly
- Always be wary of side effects

Medications Associated with Cognitive Dysfunction

- Benzodiazepines: valium, ativan
- NSAIDs: ASA, ibuprofen, indomethacin, naproxen, sulindac
- Antidepressants: TCAs, SSRIs
- Anticonvulsants: PHT, VPA, CBZ, PHB
- Antihypertensives: B-blockers, Ca-channel blockers
- H2 receptor antagonists: cimetidine, ranitidine
- Antibiotics: Cephalexin, metronidazole, fluoroquinolones
- Anticholinergics: Benztropine, trihexiphenidyl
- Antiarrhythmics: disopyramide, quinidine, tocanaide, amiodarone
- Antiparkinsonagents: L-DOPA, pergolide, bromocriptine
- Muscle relaxants: Baclofen, cyclobenzaprine, methocarbamol
- Others: antihistamines/decongestants, digoxin, steroids, narcotics


Medications Associated with Cognitive Dysfunction

- The American Geriatrics Society has an entire web page dedicated to the Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (2012), with tools and education resources located at:
  http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012
**General Differences Between Delirium & Dementia**

<table>
<thead>
<tr>
<th>Delirium</th>
<th>Dementia</th>
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<tbody>
<tr>
<td>Develops rapidly</td>
<td>Develops slowly</td>
</tr>
<tr>
<td>Fluctuating course</td>
<td>Slowly progressive course</td>
</tr>
<tr>
<td>Potentially reversible</td>
<td>Not reversible</td>
</tr>
<tr>
<td>Profoundly affects attention</td>
<td>Profoundly affects memory</td>
</tr>
<tr>
<td>Focal cognitive deficits</td>
<td>Global cognitive deficits</td>
</tr>
<tr>
<td>Usually caused by systemic medical disease or drugs</td>
<td>Usually caused by Alzheimer or cerebrovascular disease</td>
</tr>
<tr>
<td>Requires immediate medical evaluation and treatment</td>
<td>Requires nonemergency medical evaluation &amp; treatment</td>
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**Treatment**

- Physical exercise
  - Social activities
  - Nutrition
  - Health maintenance
- Calm and well-structured environment
  - Problem with adapting to change
- Positive attitude
  - Never argue
  - Sweet as pie, 24 hours per day, 7 days per week

**Staging Dementia – Three Stages**

**Mild or Early stage:**
- Memory loss, especially of recent events
  - Difficulty in recalling names and conversations; misplacing objects; repeating stories and conversations
- Orientation difficulties
  - Becoming lost in familiar neighborhoods; may not be aware of time
- Difficulty in handling problems
- More difficult chores and hobbies abandoned
- Needs prompting regarding personal care
- Personality changes
  - Decreased motivation and drive; can be easily upset or anxious
**Staging Dementia – Three Stages**

<table>
<thead>
<tr>
<th>• Moderate or Middle stage</th>
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<tbody>
<tr>
<td>– Worsening memory loss, only highly learned material retained; new material rapidly lost</td>
</tr>
<tr>
<td>– Severe difficulty with time relationships, often disoriented to place</td>
</tr>
<tr>
<td>– Increasing reliance on family for decision making and managing personal life; only simple chores preserved</td>
</tr>
<tr>
<td>– Requires assistance in dressing, hygiene, keeping of personal effects</td>
</tr>
<tr>
<td>– May see depression, withdrawal, agitation, confusion, disorientation, paranoia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>• Severe or Late stage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Severe memory loss, only fragments remain</td>
</tr>
<tr>
<td>– Unaware of time and place</td>
</tr>
<tr>
<td>– Inability to identify family members</td>
</tr>
<tr>
<td>– Unable to make judgments or solve problems</td>
</tr>
<tr>
<td>– No pretense of independent function outside home; appears too ill to be taken to functions outside home</td>
</tr>
<tr>
<td>– Requires much help with personal care; frequent incontinence</td>
</tr>
<tr>
<td>– Increasing insecurity, suspiciousness, agitation, paranoia</td>
</tr>
<tr>
<td>– Disturbed sleep, decreasing coordination</td>
</tr>
</tbody>
</table>

**Person-Centered Care (VIPS)**

- Valuing people with dementia and those who care for them
- Treating people as **individuals**
- Looking at the world from the **perspective** of the person with dementia
- Providing a positive **social** environment in which the person living with dementia can experience relative well-being

Analyze the symptom (behavior)?

- Description of incident
  - Was the environment too noisy or stimulating in another way?
  - Were too many people present?
  - Was the task too complicated?
  - Was communication effective?
- Date and time of incident
- What happened immediately before the incident?
- Who was there?
- What stopped the symptom?

Poor Environment

- Environment is too large
- Too much clutter or stimulation
- No signs, labels, or other cues
- Inadequate lighting, confusing sensory environment
- Changes in the environment
- New or unfamiliar environment

Difficult Tasks

- Task is too complicated
- Steps are combined
- Task is not modified for increasing impairments
- Task is new or unfamiliar
Poor Communication

- Caregiver is in a negative mood
- Too many distractions
- Asking complicated questions
- Speaking too fast, too high
- Using unfamiliar words, abstract concepts
- Caregiver not using active listening

Poor Physical and Emotional Health

- Medications
- Impaired vision or hearing
- Acute or Chronic illness
- Dehydration
- Constipation
- Depression
- Fatigue
- Physical discomfort
- Pain

Pain and AD

- People with AD experience pain and discomfort at the same level as people without dementia (Morrison et al, 1998)
- Think about pain before treating agitation with tranquilizers!
- Treat presumptively. Does the person have a painful condition or pace?
- Schedule pain medication, not on demand
Pain and AD

- If the pain is intermittent, the person may “deny” pain
- Watch for “guarding,” screaming, calling out, striking out when approaching the pain site
- Think about the person who is on their feet the whole day

Rules for Redirecting Challenging Behaviors

- STOP and THINK
- Look for the Reason; the Trigger
- Be Flexible
- Use Disease-Appropriate Communication
- Distract
- Use Flattery and Compliments
- Reassure; strive for feelings of security

Rules for Redirecting Challenging Behaviors

- Be Calm
- Be Pleasant
- Enter the Person’s World (validate the feelings, go along, etc.)
- Make Sure the Person Can See You Before You Touch Them
- Be Creative
Rules for Redirecting Challenging Behaviors

- Treat Person with Dignity (allow them to "save face")
- Be Aware of Body Language (yours and theirs)
- Use Positive Statements
- Sing Rather Than Talk
- Try New Approaches When Necessary
- Let Other Staff Members Know What Works

Why do they search?

- May need to use bathroom
- May be hungry
- May be thirsty
- May have physical discomfort
- May want exercise

Why do they search?

- May indicate worsening of confusion secondary to:
  - Dehydration
  - Infection
  - Congestive heart failure
  - Medication side effects
- May be in response to:
  - Uncomfortable temperature
  - Excess stimulation
  - Sensory deprivation
  - Uncomfortable clothing
Why do they search?

• May be:
  – Seeking fulfillment of unmet psychological needs
    • Need to relate to others
    • Need to feel safe
    • Need to feel useful
  – Acting out habitual routine
    • Daily walk
    • Shopping
    • Going to work
  – Type of person who handles stress by being physically active
  – Simply lost (can't find room or bathroom)

Communication Tips

1. Get the person's attention.
2. Maintain a calm tone and speak slowly.
3. Provide reminders and help with problems.
4. Give him or her more time to answer. It may take up to a minute for the person to form a response.
5. Ask simple questions that can be answered with a yes or no. Answer questions the same way.
6. Accept silence.

People with Severe Dementia Exhibit Episodes of Lucidity

• 57% of people with severe dementia with difficulties with communication
  – Person unexpectedly says or acts in a way that surprises caregiver and seems to be much more aware of their situation than usual
  – Had higher orientation scores and expressed more emotions than others
  – Took more outdoor walks with caregivers
  – Closer contact changed caregivers' expectations and enhanced communication

Communication Do's

- Reassure; strive for feelings of security
- Show Kindness, Love, Appreciation
- Use Simple, Single-Meaning Statements
- Be Calm
- Be Pleasant
- Enter the Person's Reality (go along, etc.)
- Smile
- Approach from the Front

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Communication Do's

- Consider Physical Needs, Comfort
- Be Conscious of Body Language (yours and theirs)
- Identify Yourself Often
- Make Eye Contact
- Show Respect
- Allow Person to Maintain Dignity
- Use touch
- Acknowledge the Person's Feelings (Validation)

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Communication Do's

- Make the Most of the Person's Abilities (usually social skills)
- Explain what you are doing or are going to do
- Expect repetitive behaviors & questions (repeat an answer that reassures)
- Redirect/Distract to end inappropriate behaviors
- Be Creative (try out your ideas)
- Talk about Familiar Things
- Cue the Person (provide clues & prompts)
Communication Do's

- Use Positive Language
- Allow the Person Time to Process Information
- Limit Noise
- Say "Thank You" for cooperation, attempts to help, etc.
- Sing -- especially when talking doesn’t get through
- Use Good Manners
- Compliment and Encourage Any Attempts to Communicate
- Use What You Know about the Person’s Past
- Dish Out “Good Vibes” (Lay the groundwork to make your next encounter - and your job! - a pleasant one.)

Communication Don’ts

- Don’t Talk or Take Action without THINKING first
- Don’t Try to Convince
- Don’t Try to Explain Reality
- Don’t Argue
- Don’t Try to Use Reason
- Don’t Raise your Voice
- Don’t Frown
- Don’t Scold

Communication Don’ts

- Don’t Tease
- Don’t Take Everything Literally “Where is my mother?” may mean “I need to feel safe and loved.”
- Don’t Ask a Lot of Questions.
- Don’t Use Complex Statements or Questions
- Don’t Approach from Behind
- Don’t Use “Don’t” (avoid negative statements to stop behaviors)
Communication Don’ts

- Don’t Use Language that Could Be Misinterpreted as Romantic or Sexual (*sweetie, honey, etc.*)
- Don’t Talk About the Person as if He or She Isn’t There
- Don’t Corner the Person
- Don’t Crowd the Person
- Don’t Call in Reinforcements
- Don’t Be Offended
- Don’t Ignore the Person’s Feelings
- Don’t Give Up! (*Keep trying to find the thing that works!*)

Online Communication Resource

- The Gerontological Society of America
  www.geron.org

*Communicating With Older Adults: An Evidence-Based Review of What Really Works; 2012.*

Some Possible Activities

- Walk around the yard or neighborhood
- Fold laundry
- Listen to music, dance or sing
- Look at old photographs
- Read a favorite book or the newspaper
- Watch movies or musicals
- Keep a journal together
Key points to remember
From Zoe Dearing, Alzheimer's Association

• When interacting with someone with a dementia, work heart-to-heart, not brain-to-brain.
• Whatever you are doing, it should be about how you make them feel while involved in a task, not about the task itself.
• When thinking about physical discomfort (including pain), consider other areas of the person’s life where they might be feeling pain, such as emotionally and spiritually.
• People need to feel loved, valued and acknowledged.

Alzheimer’s Caregivers Often Miss Messages

• Survey of 500 Geriatric specialists and 376 Alzheimer’s family caregivers reported at June 2001 American Medical Association meeting
  – 91% of doctors said they discussed Alzheimer’s meds w/family
  – 42% of family caregivers didn’t hear the information
  – 84% of doctors told family about disease progression
  – 37% of family caregivers heard the information

10 Symptoms of Caregiver Stress

1. Denial about the disease and its effects
2. Anger at the person with AD or others
3. Social withdrawal from friends and activities
4. Anxiety about facing another day
5. Depression begins to affect the ability to cope
6. Exhaustion makes it nearly impossible
7. Sleeplessness caused by a never-ending list
8. Irritability leads to moodiness
9. Lack of concentration
10. Health problems

Caregiver Treatment

- Respite
- Support
  - Groups
  - Friends and family
  - Networks

10 Ways to Help AD Families

- Keep in touch
- Do little things -- they mean a lot
- Give them a break
- Be specific when offering assistance
- Be alert
- Provide a change of scenery
- Learn to listen
- Care for the caregiver
- Remember all family members
- Get involved
Alzheimer's Disease Prevention?

- Education, mental exercise, physical exercise, stress reduction may protect against AD and other dementias
- Vegetables and fruits rich in antioxidants (Vitamins E & C) may help protect against AD and other dementias
- Eating fish once or more per week may reduce risk of AD by 60%
- High fat diet in early adulthood may be associated with an increased risk of AD, especially APOE4 carriers

Key points to remember

*From Zoe Dearing, Alzheimer's Association*

- When interacting with someone with a dementia, work heart-to-heart, not brain-to-brain.
- Whatever you are doing, it should be about how you make them feel while involved in a task, not about the task itself.
- When thinking about physical discomfort (including pain), consider other areas of the person’s life where they might be feeling pain, such as emotionally and spiritually.
- People need to feel loved, valued and acknowledged.

Web Sites For Information About Alzheimer’s Disease

SIU Center for Alzheimer’s Disease and Related Disorders
http://www.siumed.edu/alz

Rush Alzheimer’s Disease Center
http://www.rush.edu/radc

Northwestern University Cognitive Neurology and Alzheimer’s Disease Center
http://www.brain.northwestern.edu
Web Sites For Information About Alzheimer’s Disease

Alzheimer’s Association – National
http://www.alz.org
National 24 hour Helpline: (800) 272-3900
Alzheimer’s Association – Greater Illinois Chapter
http://www.alz.org/illinois
Alzheimer’s Association – Central Illinois Chapter
http://www.alzillinois.org
Alzheimer’s Association – St. Louis Chapter
http://www.alzstl.org
Alzheimer’s Association – Greater Iowa Chapter
http://www.alz.org/greateriowa

Web Sites For Information About Alzheimer’s Disease

Ageless Design – Alzheimer’s Daily News
Alzheimer's Disease Education and Referral (ADEAR)
http://www.alzheimers.org
ClinicalTrials
http://clinicaltrials.gov/ct/gui/c/a1b/screen/SimpleSearch
PubMed, a service of the National Library of Medicine
Alzheimer Research Forum
http://www.alzforum.org