Effective Communication and Behavior Management Strategies in the Care and Treatment of Alzheimer’s Disease

Part 2 of a 3-Part Continuing Education Series
Counseling Points™
Effective Communication and Behavior Management Strategies in the Care and Treatment of Alzheimer’s Disease

Continuing Education Information

Target Audience
This educational activity is designed to meet the needs of gerontological nurses and advanced practice nurses who are on the front lines of treating and managing Alzheimer’s disease and related dementias.

Learning Objectives
Upon completion of this educational activity, the participant should be able to:

• Implement effective communication strategies according to disease stage for the patient with Alzheimer’s disease (AD)
• Develop behavior management strategies according to disease stage of AD
• Describe effective ways to assist the patient with AD with activities of daily living and maintenance of independence
• Develop personalized treatment care plans to maximize the care of patients with AD across the disease spectrum

Continuing Education Credit
This continuing nursing education activity was approved by the National Conference of Gerontological Nurse Practitioners. Successful completion of this activity awards 1.2 contact hours.

The National Conference of Gerontological Nurse Practitioners is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

This program expires March 31, 2010.

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Disclaimer
Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any medications, diagnostic procedures, or treatments discussed in this publication should not be used by clinicians or other healthcare professionals without first evaluating the patient’s condition, considering possible contraindications or risks, reviewing any applicable manufacturer’s product information, and comparing any therapeutic approach with the recommendations of other authorities.
Dear Colleague,

In this, the second issue of *Counseling Points™* on Alzheimer’s disease and related dementias, we focus on the topic of strategies for communicating with patients with Alzheimer’s disease and dementia. Communication can be difficult given a patient’s declining cognitive abilities and requires that gerontological nurses and advanced practice nurses employ special strategies according to the patient’s stage of disease to maximize function and reduce behavioral issues. As in all areas of nursing, the best practice scenario relies on developing a personalized treatment care plan for each individual patient. Our faculty suggest a variety of communication and behavior management techniques to assist you in this task.

*Counseling Points™* is an official publication of the National Conference of Gerontological Nurse Practitioners (NCGNP) and the National Gerontological Nursing Association (NGNA). We would like to thank Eisai Inc. for sponsoring this publication under an educational grant.

We encourage you to send us your comments about the content of this and other issues of *Counseling Points™*, and we welcome your suggestions for topics you would like to see covered in future issues. A space is provided for your input on the evaluation form on page 15. We also hope you’ll consider becoming involved with the NCGNP and NGNA, if you’re not already; please visit our websites at www.ncgnp.org and www.ngna.org for information on membership.

Sincerely,

Debra Bakerjian, PhD, MSN, RN, FNP
President, NCGNP

Judith E. Hertz, PhD, RN
President, NGNA
Introduction

Once considered a rare disorder, an estimated 5 million Americans have Alzheimer’s disease (AD), the most common form of irreversible dementia in the elderly.1

Unfortunately, practice constraints often mean that dementia care falls short of the ideal. A study of primary care physicians published in the Journal of General Internal Medicine found that insufficient time to spend with patients, difficulty in accessing and communicating with specialists, low reimbursement, poor connections with community social service agencies, and lack of interdisciplinary teams contribute to delayed detection of behavior problems, reactive as opposed to proactive care, and increased reliance on pharmacologic rather than psychosocial approaches.2

Nurses and advanced practice nurses interface with patients with AD across the health care continuum, ranging from the primary care office to acute care, home care, and long-term care settings. Moreover, their role is pivotal to the improvement of AD care. One study found that collaborative care, in which dementia patients received 1 year of care management by an interdisciplinary team led by an advanced practice nurse working with the patient’s family caregiver and integrated with primary care, resulted in significant improvement in the quality of care and in behavioral and psychological symptoms.3 It was also reported that these results were achieved without significantly increasing the use of antipsychotics or sedative-hypnotics.

Given the complexities of AD management, coupled with often limited health care resources, utilization of evidence-based interventions and disease-management models in the treatment of persons with AD is essential to promote quality care and positive patient outcomes. However, one study of 480 elderly, community hospital discharges with dementia found that most nursing interventions emphasized safety precautions, often to the exclusion of psychosocial interventions to maximize and support the patient’s level of cognitive functioning.4

Clearly, a critical need exists for nurses and advanced practice nurses to be knowledgeable and skilled in the implementation of stage-appropriate, evidenced-based interventions at critical points across the disease trajectory to ensure maximal patient outcomes, regardless of treatment or residential setting. Finally, interventions must take into consideration the interaction between the patient, the environment, the caregiver, and the system of care.

Stages of Alzheimer’s Disease

In 1984, Reisberg identified stages of cognitive decline related to AD.5 Based on the findings of a longitudinal study of cognitive decline and clinical measures related to AD progression, he published the Functional Assessment Staging of Alzheimer’s Disease and proposed an AD management model based on knowledge of retrogenesis.6-8

Retrogenesis demonstrates that degenerative processes in AD reverse the course of normal human development: As the disease progresses, the patient’s knowledge and skills regress in reverse developmental order, and responses may be influenced by memories of the corresponding developmental stage of childhood.8

Retrogenesis is supported by evidence related to neuropathologic and biomolecular mechanisms, including patterns of myelin development and loss, physiologic measures of brain chemistry and activity, and neurologic reflex changes.6-10 Delineation of developmental ages is confirmed by positive relationships among symptoms of AD, cognitive performance, intellectual development, language skills, and functional ability.8,11

Although Reisberg identified seven stages of AD, the first three ranged from normal cognitive functioning to mild impairment. The Alzheimer’s Association focuses on the last four as the stages of AD: Mild or early stage, moderate or mid stage, moderately severe or mid stage, and severe or late stage (Table 1).12
Medication Types
Pharmacologic agents such as cholinesterase inhibitors and NMDA antagonists are utilized to temporarily improve or stabilize cognitive, functional, and behavioral symptoms of individuals with AD. AD has been associated with synaptic loss, and the mechanism of action of these medications involves preservation and stabilization of synaptic neurotransmitters such as acetylcholine and glutamate.

Cholinesterase Inhibitors
Cholinesterase inhibitors do not directly increase production of the neurotransmitter acetylcholine, but rather
increase its available level through inhibition of the enzyme acetylcholinesterase, which is responsible for the breakdown of acetylcholine within neuronal tissue. The cholinesterase inhibitors donepezil (Aricept®), galantamine (Razadyne®), and rivastigmine (Exelon®) are all approved by the Food and Drug Administration (FDA) for the treatment of mild to moderate AD, and all are similar in terms of treatment efficacy. Tacrine (Cognex®) is also FDA-approved for mild to moderate AD, but is infrequently used due to side effects and the need for QID dosing. Donepezil recently obtained an indication from the FDA for the treatment of severe AD as well.

The choice of agent depends on the side effect profile, dosing frequency, and titration recommendations. The most common side effects of the cholinesterase inhibitors are gastrointestinal, and include nausea, diarrhea, vomiting, anorexia, and/or weight loss. Rarely, cholinesterase inhibitors can cause irregularities in the heart rate, bradycardia, and syncope. Patients with mild to moderate AD who do not suffer from comorbid medical disorders have approximately a 50% chance of modest short-term improvement or stabilization in cognition, function, and/or behavior on these medications. For those patients who demonstrate modest improvements or stabilization of symptoms, the effects typically last 6 months to 24 months. Some patients with severe AD appear to benefit from treatment with cholinesterase inhibitors; however, further study of their longer-term use is needed.

Memantine

Memantine (Namenda®) is an NMDA receptor antagonist that is approved by the FDA for the treatment of moderate to severe AD. It can be used as monotherapy or in combination with cholinesterase inhibitors. The mechanism of action of memantine is based on the theory of neurodegeneration caused by glutamatergic neurotoxicity. Glutamate is an excitatory neurotransmitter prevalent in the regions of the brain associated with cognition and memory. In AD, abnormal amounts of glutamate are released, causing neuronal damage. Memantine blocks the activity caused by abnormally high or low levels of glutamate in the brain.

Like the cholinesterase inhibitors, improvements and/or stabilization of cognition, function, and behavior are modest at best with memantine, and patients typically continue to experience symptomatic decline after about 6 months; however, this decline may be less significant than in those individuals who do not receive treatment. Possible side effects include dizziness, constipation, and confusion. Memantine is contraindicated in patients with severe renal disease and should not be given to patients who are concurrently taking amantadine.

Effective Communication Strategies

For interaction with a person who has AD to be effective, communication strategies must change as the disease progresses. Particularly during the later stages of the disease, it is important to use both nonverbal techniques and verbal responses. Communication should include the person with AD and family members or significant others. Building or maintaining trust, communicating caring, and establishing a relationship remain constant goals.

Table 2 suggests communications strategies to use and those to avoid; these strategies can be used by nurses and advanced practice nurses and shared with caregivers.

Mild or Early-stage AD

During the mild or early stage of AD, the person has difficulty with word finding and will make the same statements repeatedly. For word-finding problems, it is helpful to supply the word after a brief time and then allow the person to finish the statement. When statements are repeated, respond appropriately and briefly. It may be most effective to make the same response each time. If the repetition relates to a social conversation topic, it is okay to change the subject after your initial response. If the repeated statement seems distressing to the person, attempt to understand the meaning and perceived circumstance. Assist in problem-solving to an acceptable solution. The person can still read words, thermometers, and time pieces, but the meaning of each may be diminished or forgotten. Effective approaches focus on retained skills, while helping the person to compensate for deficits. Frequently used items can be left in view in the location where they are used. Inconsistencies in ordinary tasks of daily living can be ignored.

Even though the ability for abstract thought decreases during this stage, the person can learn and participate in decision-making. Learning focuses on the illness, treatment options, and information necessary for making decisions related to all aspects of life. Topics that need to be discussed for decision-making include advance directives about health care or services desired or not desired, health care power of attorney, financial planning including durable power of attorney, options for living arrange-
When providing assistance with activities of daily living (ADLs), saying ‘here is your toothbrush’ may be more acceptable than asking ‘can you brush your teeth?’. Proceeding to do what the patient cannot while allowing the person to do what he/she can and while talking about an unrelated subject often allows tasks to be accomplished smoothly, and provides an enjoyable experience for both the care recipient and the caregiver. If instructions are needed, give one at a time and use simple, direct statements or yes/no questions. Keep the tone of voice neutral or positive. Touch should be gentle, convey caring, and result in guidance.\textsuperscript{13,14}

Attempts to orient the patient to reality are effective during the early stage of the disease, but reminiscence and validation are the responses of choice during mid to later stages. Reminiscence may be used in semi-structured group settings, but also is effective in individual communications during required tasks.\textsuperscript{13,14}

**Moderately Severe or Mid-stage AD**

As backward regression continues, the person with AD loses awareness of recent events and present surroundings, instead perceiving persons from his/her past and the home of early life. A frequent statement is ‘I want to go home.’ Effective responses include saying ‘okay,’ and allowing the person to continue to walk or to go outside into a fenced or enclosed area or asking ‘may I walk with you?’ and using distraction or redirection to refocus attention. Arguing or being authoritarian is not helpful.\textsuperscript{13,14}

Words may not be logically organized at this stage and may not make sense or fit the situation. If you know the situation or can discern the perception, you may be able to figure out what the patient is saying and respond accordingly. If not, respond as though the words are organized and do make sense. Smile and say “please” and “thank you” when making requests or offering guidance. If the person does not respond verbally, continue to address him/her in conversations, engage in eye contact, and use touch appropriately.\textsuperscript{13,14}

Cueing, modeling, or mirroring expected behavior may prevent resistance. If there is resistance to care, immediately back off (withdraw without abandoning the person). In 1-5 minutes, using a different technique (social conversation including listening, gentle touch, and

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<tr>
<th>Table 2. Communication Strategies to Use and to Avoid\textsuperscript{13,14,29,30}</th>
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<td><strong>Do...</strong></td>
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<td>- provide an enjoyable now (enjoyment of the moment)</td>
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<tr>
<td>- call by preferred name</td>
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<tr>
<td>- greet</td>
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<tr>
<td>- make eye contact</td>
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<td>- make hand contact</td>
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<tr>
<td>- laugh with</td>
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<tr>
<td>- use distraction</td>
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<tr>
<td>- redirect</td>
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<tr>
<td>- avoid power battles</td>
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<tr>
<td>- use reminiscence/validation</td>
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<tr>
<td>- be non-threatening</td>
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<tr>
<td>- decrease expectations</td>
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<td>- reassure</td>
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<tr>
<td>- use yes/no questions</td>
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<tr>
<td>- use simple, direct, present tense</td>
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<td>- use one-concept sentences</td>
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positive expression), re-approach and resume the task without focusing on it.

Hallucinations may occur during this stage. If they are not distressing to the person, you may ignore the hallucination or use validation or reminiscence to talk about the content of the hallucination. If the hallucination is distressing to the patient, use validation or problem-solving to work toward a solution that is satisfactory. The goal is to do what is in the person’s best interest.13,14

**Very Severe or Late-stage AD**

At this stage of the disease, the person will be nonverbal most of the time, although he/she may experience lucid moments until near death. There may be episodes of constant nonlanguage vocalization. Effective verbal strategies during this stage include using soft words during tasks, singing favorite songs from the past, or reading familiar passages. Equally effective are the gift of presence (being with, connecting without words, and affirming support) and offering a peaceful yet interesting environment.13,14

**Behavioral Symptoms Associated with AD**

The vast majority of patients with AD experience behavioral symptoms. Patients may develop a host of problems if their needs for pain control, nutrition, or social interaction are not adequately met. Depression is a common disorder occurring in patients with AD, especially in the mild or early stage of the disease. Psychotic symptoms such as delusions, paranoia, and hallucinations may also be experienced.

Table 3 provides an overview of stage-related behavioral symptoms and evidenced-based interventions. Agitation, sundowning, wandering, and sleep pattern disturbances are the symptoms that most greatly impact on quality of life, present a major threat to the safety of the patient and others, are more likely to result in caregiver burden or distress, and influence placement decisions.

**Managing Behavioral Symptoms**

Clinicians should be cognizant that behavioral symptoms are often multidimensional and can result from more than one cause. A thorough evaluation is always warranted when the patient has a change from his or her usual behavior or exhibits an abrupt increase in severity of symptoms. The aim of this evaluation is to rule out potential physical, environmental, or pharmacologic triggers.
A variety of nonpharmacologic strategies have been shown to be effective for managing behavioral symptoms associated with AD (Tables 3 and 4). Successful management of behavioral symptoms also often entails utilization of pharmacological approaches, such as atypical antipsychotics, antidepressants, and anti-anxiety agents.\textsuperscript{50-54}

Behavioral interventions that maximize involvement in functional activities and concurrently decrease symptoms of depression and agitation in older adults with dementia include the use of 1) modified communication strategies; 2) enhanced sensory stimulation; 3) motivation through humor and play; and 4) teamwork.\textsuperscript{56}

**Modified Communication Strategies that Promote Physical Function**

Communication strategies meant to effectively motivate cognitively impaired older adults to participate in functional activities should include short, simple, verbal cues given after gaining the individual’s attention. Short-term memory deficits will require the repetition of directions, as well as frequent encouragement and praise from caregivers. Using physical gesturing and role modeling can also be helpful for individuals with receptive aphasia.\textsuperscript{56}

**Enhanced Sensory Stimulation**

It is important to regulate environmental stimulation so that the older adult with AD does not become overwhelmed with too much noise, temperature variations, excessive tactile stimulation, or visual imagery. However, when attempting to overcome apathy and passive behaviors that are seen in a majority of older adults with dementia, it is imperative to selectively enhance sensory experiences that motivate them to actively participate in their own ADLs. For example, the use of familiar “big band” music can motivate movement and dancing, while petting or stroking a dog or cat can encourage active range of motion of the arms and hands. Finally, serving meals on dishes that provide visual and color contrast with the food may help to focus the patient’s attention on the task of eating.\textsuperscript{56}

**Motivation Through Humor and Play**

Older adults with moderate to severe AD are often described as “living in the moment.” Situations or interactions that are distressing are quickly forgotten when the individual is distracted with an alternative pleasant activity. The use of humor and play are important strategies that can be utilized to motivate older adults with dementia to be actively involved in their own ADLs. One strategy is to use a playful competition. For example, when a caregiver is assisting a patient with bathing, teach the

<table>
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<tr>
<th>Environmental Modifications</th>
<th>Interventions</th>
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<tr>
<td>Minimize noise</td>
<td>Encourage movement and exercise, balanced with periods of rest</td>
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<td>Place mirrors near doors/exits (the reflection of the person’s own face will serve as a distracter, often deterring the person from exiting)</td>
<td>Provide for walks in secure outdoor wandering areas</td>
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<td>Disguise or camouflage doors with cloth panels or murals</td>
<td>Ensure all basic needs are met (toileting, nutrition, thirst)</td>
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<td>Place activity boxes near doorways</td>
<td>Involve the person in daily activities, such as folding laundry</td>
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<td>Use electronic devices such as door sensors and bed-exit monitoring systems</td>
<td>Redirect pacing or restless behavior</td>
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<td></td>
<td>Reassure the person if he or she feels lost, abandoned, or disoriented</td>
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<td></td>
<td>Utilize calming music, massage, aroma therapy</td>
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<td></td>
<td>Enroll wanderer in MedicAlert\textsuperscript{®} and Safe Return\textsuperscript{®} programs</td>
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**Maximizing Function and Performance of Activities of Daily Living**

Compared to cognitively intact older adults, individuals with AD experience significantly more functional limitations in their ADLs. In addition, caregivers are frequently challenged by the agitated behavioral symptoms of individuals with AD. These factors may inadvertently contribute to a custodial model of care where caregivers perform necessary functional tasks for these individuals rather than eliciting their active participation in ADLs. A custodial model of care contributes to unintended levels of functional dependence, development of contractures, and pain due to immobility that will outpace the slow functional decline typically seen in individuals with AD.\textsuperscript{55,56} While we wait for the development of effective treatments to manage, prevent, or cure AD, we must not overlook the efficacy of nonpharmacologic, restorative interventions that have already demonstrated positive results in temporarily improving or maintaining physical function for individuals with AD.\textsuperscript{55,57-60}
Mrs. G is a 70-year-old woman who was diagnosed with Alzheimer’s disease (AD) by her primary care provider 1 year ago. She lives with her husband in their home of 40 years. Mr. and Mrs. G own a gasoline and automobile service station. Mr. G still enjoys working long hours at the station, but recently started leaving his wife at home because “it’s about time that she retired.” Mrs. G was a homemaker, but also did bookkeeping for the family business. In addition to dementia, her medical history is notable for osteoarthritis of the knees, well-controlled hypertension, and hypothyroidism. Her medications include acetaminophen 1,000 mg PO BID, hydrochlorothiazide 25 mg PO QD, and levothyroxine 88 mcg PO QD.

Over the past month, Mr. G has observed that Mrs. G frequently paces in the house. In addition, while her husband has been at work, Mrs. G has been found by neighbors wandering in the neighborhood and unable to find her way home. Her appearance has become more disheveled, her speech patterns have become more simplistic, and she is frequently verbally irritable with her husband. On one occasion, she attempted to strike him when he was helping her to clean up the kitchen after dinner. Her son and daughter, who live nearby, are concerned about their mother’s decline and convince Mr. G to have her evaluated at a dementia clinic.

Questions to Consider
- What communication and behavioral interventions could you advise caregivers to use to prevent or de-escalate Mrs. G’s agitation?
- How would you suggest that Mrs. G be allowed to pace but prevented from wandering?

On examination, Mrs. G is alert, pleasant, and cooperative with the interviewer. She is appropriately dressed and groomed because her daughter assisted her with dressing. Her husband states that at home her clothing is frequently stained or inappropriate and her hair is unkempt. Her mood is euthymic and she is not suicidal. There are no delusions or hallucinations. Her Mini–Mental State Examination (MMSE) score is 19, and she has little insight into her cognitive deficits. Her neurological exam is non-focal, and laboratory studies and brain imaging are normal. Mrs. G is started on galantamine and the family is educated about dementia care, especially regarding strategies for effective communication and cueing with activities of daily living. Mrs. G wears a Safe Return® bracelet for identification, attends a medical adult day program, and spends time with her children when her husband is at work.

Months pass and Mrs. G’s cognitive and functional deficits stabilize and her husband feels more confident in his caregiving skills. However, while in the airport during a return trip home from Florida, Mr. G has a massive heart attack and dies. Mrs. G is admitted to an Assisted Living (AL) facility and her children remain actively involved in her care.

Mrs. G does not consistently remember that her husband has died and spends much of her time in the afternoon walking around the AL facility looking for him. When staff use “reality orientation” with her and remind her that her husband has died and she lives at the AL residence now, she becomes either tearful or angry and verbally abusive. Even though the AL facility has secured doors to prevent elopement, Mrs. G is found outside near the street trying to get home to “fix dinner” for Mr. G. The staff of the AL residence involves Mrs. G in more activities in the afternoon and early evening; however, she often wanders away and says, “I don’t do crafts. I have to get home to my husband.”

After discussions about Mrs. G’s past interests with Mrs. G and her children, the AL residence staff tries a different approach. They provide her with an adding machine and ledger to help “keep the books” for the AL facility. She enjoys making her bed, and “works” doing bookkeeping in the early afternoon. When Mrs. G becomes anxious and begins looking for her husband, the staff reminds Mrs. G that her husband is busy at the gas station, and then redirects her to the dining room where she helps to get ready for his return by setting the table. Mrs. G is also outfitted with an electronic monitoring bracelet (e.g., the WanderGuard®), which alerts the staff when she is in close proximity to doors and might possibly exit if the doors are open.

Questions to Consider
- Are there other interventions that could facilitate redirection?
- Why is reality reorientation not appropriate at this stage?
- What can be anticipated as the illness progresses?
Web-based Resource for Nurses www.ConsultGeriRN.org

- Geriatric clinical nursing website from the Hartford Institute for Geriatric Nursing
- Evidenced-based resource center
- Geriatric Topics: Select from menu of topics such as dementia, delirium, and depression
- Need Help Stat—My patient is/has: Information on conditions such as agitation, restlessness, and confusion
- How To Try This Series of Assessment Tools: Best Practices in Care of Older Adult series focuses on topics specific to older adult population, including dementia (www.nursingcenter.com/library/static.asp?pageid=730390)

caregiver to playfully challenge the patient to do better than the caregiver. While the patient washes her arm, the caregiver washes the other, and when they are finished, the caregiver congratulates the patient on doing the best job. A playful and humorous interaction can make functional tasks fun and will thereby motivate individuals to actively participate in their personal care.56

Teamwork

The spirit of teamwork is especially important when promoting restorative care approaches for individuals with AD. Everyone involved in the patient’s care can be involved in some way in promoting physical function and physical activity. A woman who was once a fastidious housekeeper can partner with her husband or daughter to help clean the table and load the dishwasher after meals.

While repairing the air conditioning unit in a nursing home resident’s room, a maintenance technician may notice that the resident’s gait is unsteady and report this to the nursing staff so that it can be investigated before the resident experiences further functional changes. The administration and dining services department in an assisted living facility can collaborate with the resident’s family and nursing staff to be supportive of flexible meal times for a resident who is a “night owl” and is better able to feed himself breakfast after sleeping later in the morning.56 Clinicians can take the extra time to evaluate a patient whose family is concerned because “She has not been acting like herself for the past few days, and is no longer able to feed herself.” The prompt recognition of functional change by family caregivers and the careful evaluation of such a patient by the medical provider may reveal an underlying delirium that can be effectively treated and the patient’s functional performance can return to her previous baseline. When working with older adults with AD, it is important to motivate family and professional caregivers to use innovative strategies to optimize their functional performance, which ultimately will improve their quality of life.56

Summary

A variety of communication and behavioral intervention strategies as well as medications can be utilized by clinicians when dealing with patients with mild to severe AD. As the disease progresses, it is important to use both non-verbal strategies and verbal responses. At all stages of the disease, it is important to facilitate the person’s enjoyment of the moment, to honor and recognize the individual, and to validate his/her reality and experiences.

References


An estimated 5 million Americans have Alzheimer’s disease (AD), the most common form of irreversible dementia in the elderly.

Four stages of AD are generally recognized: mild or early stage, moderate or mid stage, moderately severe or mid stage, and severe or late stage.

The theory of retrogenesis, which is supported by neuropathologic and biomolecular research, demonstrates that degenerative processes in AD reverse the process of normal human development. As the disease progresses, the patient’s knowledge and skills regress in reverse developmental order.

Pharmacologic agents such as cholinesterase inhibitors and the NMDA antagonist memantine are utilized to temporarily improve or stabilize cognitive, functional, and behavioral symptoms of individuals with AD.

For interaction with a person who has AD to be effective, communication strategies must change as the disease progresses.

Particularly during the later stages of the disease, it is important to use nonverbal techniques as well as verbal responses.

Among other things, it is important for clinicians and caregivers not to argue, use logic, explain or defend, laugh at, show disapproval, or be authoritarian or confrontational with patients with AD. At all stages of the disease, it is important to facilitate the person’s enjoyment of the moment.

The vast majority of patients with AD experience behavioral symptoms, which are often multidimensional and can result from more than one cause.

Light therapy, exposure to preferred music or white noise, simulated presence therapy, Snoezelen®, aromatherapy, pet therapy, and administration of antidepressants, anti-anxiety agents, and/or antipsychotics are therapeutic approaches employed to manage behavioral symptoms in patients with AD.

Behavioral interventions that maximize involvement in functional activities and concurrently decrease symptoms of depression and agitation in older adults with dementia include the use of 1) modified communication strategies; 2) enhanced sensory stimulation; 3) motivation through humor and play; and 4) teamwork.
1. A study by Callahan et al of collaborative care in which dementia patients received 1 year of care management by an interdisciplinary team led by an advanced practice nurse found:
   A) significant improvements in cognitive function
   B) significant improvements in behavioral symptoms
   C) significant improvements in psychological symptoms
   D) both B and C

2. The Alzheimer's Association includes all BUT which of the following in the stages of Alzheimer's disease (AD)?
   A) mild cognitive impairment
   B) moderate or mid stage AD
   C) moderately severe or mid stage AD
   D) severe or late stage AD

3. Death in patients with AD may result from complications of pneumonia, urinary tract infection, or septicemia.
   A) True
   B) False

4. Research suggests that the effects of cholinesterase inhibitors last ___ months among patients with mild to moderate AD who respond with modest improvements or stabilization of symptoms.
   A) 3–9 months
   B) 8–12 months
   C) 6–24 months
   D) 12–36 months

5. Particularly during the later stages of AD, what techniques are as important as verbal responses?
   A) Authoritarian techniques
   B) Nonverbal techniques
   C) Sensory techniques
   D) Reality orientation techniques

6. Effective communication strategies to employ with patients with AD include all BUT which of the following?
   A) Call by preferred name
   B) Focus on task
   C) Use distraction
   D) Use reminiscence/validation

7. The behavioral symptoms that most greatly impact quality of life, present a major threat to the safety of the patient and others, are more likely to result in caregiver burden and distress, and influence placement decisions are:
   A) Agitation, sundowning, wandering, and sleep pattern disturbances
   B) Agitation, anxiety, sundowning, and wandering
   C) Anxiety, sundowning, restlessness/pacing, and agitation
   D) Forgetfulness, agitation, restlessness/pacing, and anxiety

8. Which of the following evidence-based behavioral interventions is NOT appropriate for use in patients with moderate stage AD?
   A) aromatherapy
   B) preferred, calming music
   C) reality orientation
   D) pet therapy

9. Pharmacologic agents employed to manage behavioral symptoms in patients with AD include:
   A) atypical antipsychotics
   B) antidepressants
   C) anti-anxiety agents
   D) all of the above

10. A custodial model of care in which caregivers perform necessary functional tasks for individuals:
    A) is a reasonable alternative to eliciting active participation in activities of daily living
    B) contributes to unintended levels of functional dependence
    C) contributes to the development of contractures and pain
    D) both B and C
**EVALUATION FORM**

**Counseling Points™: Effective Communication and Behavior Management Strategies in the Care and Treatment of Alzheimer’s Disease**

To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few minutes to complete this evaluation form. **You must complete this evaluation form to receive acknowledgment for completing this activity.**

Please answer the following questions by circling the appropriate rating:

1 = Strongly Disagree  
2 = Disagree  
3 = Neutral  
4 = Agree  
5 = Strongly Agree

### Extent to Which Program Activities Met the Identified Objectives (After completing this activity, I am now better able to):

1. Implement effective communication strategies according to disease stage for the patient with Alzheimer’s disease (AD) ........................................... 1 2 3 4 5
2. Develop behavior management strategies according to disease stage of AD ........................................................................................................ 1 2 3 4 5
3. Describe effective ways to assist the patient with AD with activities of daily living and maintenance of independence ........................................ 1 2 3 4 5
4. Develop personalized treatment care plans to maximize the care of patients with AD across the disease spectrum .................................. 1 2 3 4 5

### Overall Effectiveness of the Activity (The content presented):

5. Was timely and will influence how I practice ............................................................................................................................................... 1 2 3 4 5
6. Enhanced my current knowledge base ..................................................................................................................................................... 1 2 3 4 5
7. Addressed my most pressing questions ..................................................................................................................................................... 1 2 3 4 5
8. Provided new ideas or information I expect to use ................................................................................................................................ 1 2 3 4 5
9. Addressed competencies identified by my specialty .................................................................................................................................. 1 2 3 4 5
10. Avoided commercial bias or influence .................................................................................................................................................. 1 2 3 4 5

### Impact of the Activity

Name one thing you intend to change in your practice as a result of completing this activity:

______________________________________________________________________________________________________________________________________________________

Please list any topics you would like to see addressed in future educational activities:

______________________________________________________________________________________________________________________________________________________

Additional comments about this activity:

______________________________________________________________________________________________________________________________________________________

### Follow-up

As part of our continuous quality improvement effort, we conduct postactivity follow-up surveys to assess the impact of our educational interventions on professional practice. Please indicate if you would be willing to participate in such a survey:

☐ Yes, I would be interested in participating in a follow-up survey.        ☐ No, I’m not interested in participating in a follow-up survey.

*If you wish to receive acknowledgment for completing this activity, please complete the posttest by selecting the best answer to each question, complete this evaluation verification of participation, and fax to (201) 612-8282.*

### Posttest Answer Key

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### Request for Credit

Name _________________________________________________________________ Degree _________________________________

Organization __________________________________________________________ Specialty _________________________________

Address _________________________________________________________________________________________________________________

City _____________________________________________________________________________ State __________ ZIP ________________

Phone _____________________________ Fax _____________________________ E-mail __________________________________________

Signature _________________________________________________________________ Date ______________

Fax form to (201) 612-8282