

Module 1- Understanding Dementia

Site: [Caregiver Connection & Skills Training](#)
Course: Elderly Care and Caring for the Disabled
Book: Module 1- Understanding Dementia

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Description



Caregiver Connection — Skills Training —

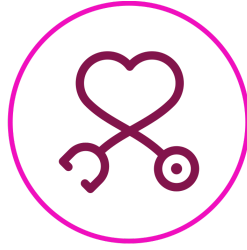
Learning Outcomes

- After completing this module you will be able to:
- Accurately define various forms of dementia, describe their symptoms and differentiate them.
- Determine the symptoms of the early, mild and late stages of Alzheimer's disease.
- Summarise a range of problem behaviours that are associated with Alzheimer's disease and describe how to treat them.
- Discuss the philosophy and values of dementia care.
- Develop skills to help families when a loved one has been diagnosed with dementia.

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1. Module 5- Understanding Dementia



Caregiver Connection

— Skills Training —

Module 5- Understanding Dementia

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2. Module 6: Understanding Dementia

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Discuss the philosophy and values of dementia care.

Develop skills to help families when a loved one has been diagnosed with dementia.

4. Introduction to Dementia

INTRODUCTION

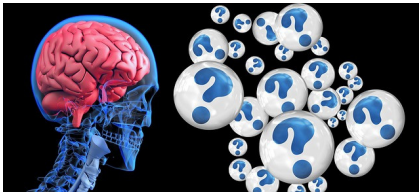


As a **care worker**, there is a good chance that the majority of your clients will be in the 70 or older age bracket. Because of this, it is important that you have an understanding of the most common conditions that clients of this age experience.

Research shows that when you reach 70 years or older, your chances of contracting *Dementia* increase significantly.

The purpose of this section is to introduce you to the person with dementia and to set a context for caring for those who display dementia symptoms - a condition of the brain that forever changes a person's memory, behaviour and ability to care for oneself.

DEFINITION



Dementia refers to a *spectrum of brain disorders*. These involve difficulty with memory and thinking, but they may vary in terms of cause, course and prognosis.

Dementia involves *impairment* in multiple facets of cognition. This can include visual/spatial skills, the ability to think, reason, talk and remember, and praxis functions. Personality and mood may also be affected.

Dementia is *not* a normal part of ageing. Although we hear people suffer from Dementia or are diagnosed as having dementia, dementia itself is not the diagnosis. We need to identify the type of dementia and the causes, some of which may be reversible, but most of which are incurable.

Alzheimer's disease is the most common cause of dementia. It is an irreversible, progressive disease. It causes gradual deterioration of mental functions and of the ability to take care of one's self.

5. Symptoms of Dementia

SYMPTOMS



It is important that care workers are familiar with the symptoms of dementia, as an early diagnosis of the condition may decrease its severity over the longer term.

The symptoms of dementia are outlined below:

- Decline in memory, thinking and reasoning.
- Changes in personality, mood and behaviour.
- Difficulties in the ability to communicate, to recognise people and places and to engage in activities.
- Forgetfulness - forgetting names and appointments.
- Difficulties with once-familiar activities.
- Impaired judgment.
- Problems with spatial and temporal orientation.

TREATABLE



Alzheimer's disease is the most common cause of dementia. It is progressive and irreversible. Early recognition of the symptoms and diagnosis is important for treatment.

Some symptoms are **reversible** when the causes are, for example:

- Inadequate fluid intake leading to dehydration or acute infections.
- Chronic conditions that have gotten out of control (hypothyroidism; diabetes; psychiatric conditions; reaction to medications).

6. Types of Dementia

ALZHEIMER'S DISEASE



Alzheimer's is by far the most common type of dementia, attributed to approximately 2/3 of cases. It was first identified 100 years ago.

The onset of Alzheimer's can be slow and subtle, followed by a gradual decline. Changes in short-term memory are noticeable, i.e. memory of recent events. This is typically the primary first complaint.

Those at greater risk of contracting Alzheimer's include:

The Elderly - there is an increased risk after the age of 65. By age 85 or more, there is an almost 50% risk of acquiring the disease.

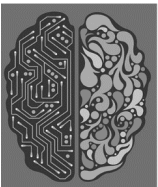
Females - females are at a greater risk of contracting the disease than males.

Genetics - if there is a genetic history of Alzheimer's in the family, there is a greater risk of developing the disease.

ALZHEIMER'S DISEASE



VASCULAR DEMENTIA



Vascular, or multi-infarct, dementia is the *second most common cause* of dementia, estimated to be 20% of cases. It is caused by reduced blood flow to parts of the brain, often as a consequence of tiny strokes (TIAs -transient ischaemic attacks) that block small arteries.

The onset of symptoms may seem more sudden and clear. The memory may or may not be as seriously affected as is the case with Alzheimer's. This can depend on whether blockage has occurred in the *memory* regions of the brain.

7. FRONTOTEMPORAL DEMENTIA (FTD)



FTD causes personality and behavioural changes and loss of language functions at an early stage. This is different from the memory complaints typical of Alzheimer's.

FTD represents approximately 10-15% of dementia cases, and nearly half of these cases occur in people under 65 years of age.

It is distinguished from Alzheimer's by some or all of the following:

- Inappropriate and anti-social behaviours.
- Apathy; compulsions (relative preservation of visual-spatial and cognitive skills).
- Language deficits progressing to mutism.
- Changes in the brain include shrinkage of the frontal and temporal lobes (which can be seen on PET scans).

8. Other Forms of Dementia

LEWY BODY



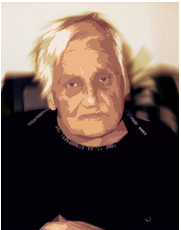
Lewy Body Dementia is caused when *abnormal protein deposits* called Lewy bodies are found in the brain. Symptoms include hallucinations and memory loss.

This is often mistaken with Alzheimer's disease but characterized more often by early changes in *movement* or the development of extra pyramidal symptoms. This includes: tremors; tics; rigidity; shuffling; gait, which can make individuals look like they have *Parkinson's disease*.

Alertness and severity of cognitive symptoms may fluctuate significantly on a day-to-day basis. There is often a poor tolerance to medications, as well as autonomic nervous system dysfunction. An example would be wild swings in blood pressure.

Lewy body dementia can be challenging to diagnose because of its similarities to Alzheimer's and Parkinson's disease.

OTHERS A.

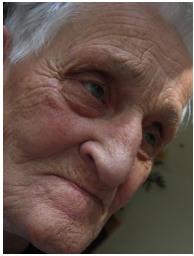


There are a range of less common forms of dementia, which are outlined here:

Parkinson's Disease is characterized by tremors, stiffness, speech difficulties and problems initiating movement. When muscle stiffness affects the face, the person may have a mask-like stare. Persons with Parkinson's may develop dementia late in the course of the disease. A clear sign of Parkinson's is the presence of Lewy bodies (abnormal proteins), specifically in the area of the brain that controls physical movement.

Huntington's Disease is an inherited degenerative and fatal brain disease caused by a faulty gene on chromosome 4, starting in mid-life. Characteristics include personality changes, depression and the development of involuntary movements.

OTHERS B.



Jakob's Disease is a rare and rapidly fatal brain disorder causing Dementia. It affects coordination and causes behavioural changes. It is caused by an abnormal protein (called a *prion*) that turns normal proteins into infectious ones. This disease is related to *Mad Cow Disease*.

HIV Dementia is a direct infection of the brain with *toxic viro-proteins*. It is believed to cause dementia in 20-30% of people with advanced HIV and 50% of those with fully developed AIDS. Initial signs are poor concentration, forgetfulness, depression, apathy, weakness and myoclonus (sudden, involuntary twitching of muscles).

9. The Stages of Alzheimer's Disease

STAGE ONE



The **early** stage of Alzheimer's Disease usually lasts two to four years. It is characterized by *forgetfulness, increasing difficulty with problem-solving and withdrawal from activities*. If these symptoms are recognised and diagnosed at an early stage, it can save both the individual and their families time and hardship.

During this stage, you can expect the person with Alzheimer's to *forget experiences* rather than details (like names). The person may need minor assistance or reminders but may be able to live alone competently. Efforts to *hide confusion* from others (the person usually knows something is not right) are sometimes successful at this early stage.

STAGE TWO



The **middle** stage of Alzheimer's Disease is characterized by an *increase in memory loss and confusion, shorter attention span, increase in language difficulties and repetitiveness*. The middle stage lasts for two to ten years.

In the middle stage, the confusion is apparent to caregivers. The person may be aware of his/her impairment but lacks the ability to hide it from others. *There is a full loss of executive function* (i.e. reasoning/problem-solving) and difficulty taking care of oneself. The person may need help with activities of daily living (ADLs), such as dressing and bathing.

As tasks become more challenging, both physically and cognitively, the person may become *delusional, paranoid and develop associated behavioural changes*. Optimizing physical, mental and social stimulation is key to slowing the rate of decline into the next stage. *Constant supervision is needed*. The person shows poor judgment and cannot live alone for safety reasons. At this time, patients are often placed in adult daycare programs and/or assisted living. Toward the end of the middle stage, the person loses the ability to control bladder and/or bowel function.

STAGE THREE



The **late** stage of Alzheimer's Disease is a time of *severe confusion and loss of all functional skills*. The person has no awareness of his/her condition.

During the late stage of Alzheimer's, the person has: *a loss of self-care ability; loss of language, is incontinent; is unable to recognize self or others; requires more sleep*. Other signs include: weight loss despite a good diet and difficulty swallowing.

The individual responds best to sensory activities and cannot tolerate crowded or noisy environments. Typical of this stage is care in dementia care units/nursing homes with *24-hour supervision and assistance*. The final stage lasts for one to three years and ultimately ends in death. Severe Alzheimer's can be quite distressing to witness.

10. The Condition of Alzheimer's Disease

BEHAVIOURS



When you work with a client who has been diagnosed with Alzheimer's Disease (at any stage), it is important to know that their behaviour can be unpredictable.

This is often a response to discomfort, an unmet need, and increasing confusion. Patients also develop an increase in difficulty communicating, progressive loss of independence and poor insight and judgment.

The key to reducing behavioural disturbances is to identify **triggers**. These include: *pain; fatigue; acute illness; sensory deficits; hallucinations, and/or delusions.*

Behaviours may be **psychomotor** (pacing, wandering, repeatedly crying out, etc.), **verbal** (belligerence, nastiness towards others, repetitiveness) and/or **physical** (combativeness, inappropriate touching). Careworkers need to be aware of these types of behaviours which can be expected from their clients.

EMOTIONS



Alzheimer's patients often experience a strong sense of **depression**. This may be reflected as *irritability, fearfulness, tearfulness, hopelessness, somatic complaints (i.e. feeling ill physically), lack of energy/interest, and changes in appetite.*

They also may experience feelings of anxiety. This includes feelings of nervousness, worry and apprehension. This is more common in *early-stage* dementia when the client is acutely aware of their deficits.

Alzheimer's patients also experience apathy, or flatness of mood, which manifests as an inability to interact appropriately with one's environment.

SLEEP/DELIRIUM



Sleep disturbance occurs in 50% of Alzheimer's patients living in a community setting. It is one of the most *disturbing* behaviours for caregivers and can cause exhaustion and despair in caregivers.

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Patients may have trouble falling or staying asleep or resuming sleep. They may wander, may reverse night and day, appear more confused and/or may have an exacerbation of anxiety or physical or verbal outbursts.

Alzheimer's patients can also experience **delirium** - a sudden increase in mental confusion accompanied by hallucinations. Alzheimer's patients often need *medication* to help them sleep.

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11. Treating Dementia Symptoms

TREATMENTS A.



This section focuses on **medications** that have been proven to be effective in the *treatment* of Alzheimer's.

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COGNITIVE

Aricept, Exelon, Razadyne: Indicated for mild dementia; used throughout the course of the disease. Side effects are mainly gastro-intestinal (GI) in nature, minimized by giving in the morning with food. There may also be vivid dreams or leg cramps.

Namenda: Indicated for moderate dementia, used either alone or together with one of three medications previously noted.

MOOD

Antidepressants of the class known as Selective Serotonin Reuptake Inhibitors (SSRIs) are generally used. They address depression and anxiety. Medications such as tricyclics (for example, Elavil) and benzodiazepines (such as Lorazepam or Valium) should not be used because of the potential for increased confusion and dizziness and the increased risk of falls with potential injury.

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TREATMENTS B.



BEHAVIOUR

Atypical antipsychotics (such as Seroquel, Zyprexa, Risperdal) can be helpful, but they carry a concern for side effects. These can include: movement disorders, increased confusion, and the potential for increased cardiac complications. Seizure medications (e.g., Depakote) may be given. However, blood serum levels need to be closely monitored.

PAIN

It is important to recognise and treat pain. This may require careful attention to body language and behaviour. Avoid medications such as Darvon, Percocet and Opioids. Tylenol, regularly dosed, is a very effective analgesic (pain medication). Consider **non-pharma options** such as: moist heat, massage, and re-positioning.

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Conclusion

GENERAL CONSIDERATIONS

When treating an Alzheimer's patient with medication, remember that it is administered for the benefit of the *patient* and not for staff convenience. The administration of medication should be tailored to the *individual*.

Carers should constantly be aiming to identify *links* between certain behaviours and medications. Carers should employ strategies that *do not require* medications. Medications can and should be considered when such strategies are ineffective or not effective enough.

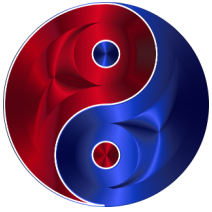
RISKS & BENEFITS

Carers need to remember the importance of *limiting the number of medications* administered to patients and monitor which medications patients react well to and which ones they react poorly to.

It is important to provide medication in a slow and infrequent manner because *elderly people do not tolerate medications as well as younger people*.

12. Introduction to The Philosophy of Dementia Care

INTRODUCTION



This unit is designed to provide an overview of the *philosophy and values* of **good dementia care** based on the following concepts:

A. People are unique and bring to the caregiving situation different perspectives and needs that shape the care environment.

B. The essence of good Dementia care is the maintenance and enhancement of *personhood* within this environment. This approach to caring involves having respect for the personhood of those who have dementia. This includes equal respect for the personhood of *those doing the work of caregiving*.

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Care workers need to recognise that clients who have dementia need to be treated the same as a client who has a broken hip. This unit will allow you to see clients who have dementia as the patients that they really are.

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RIGHTS



Every person diagnosed with Alzheimer's disease, or a related disorder, deserves the following **rights**:

- To be informed of one's diagnosis.

- To have appropriate, ongoing medical care.

- To be productive in work and play for as long as possible.

- To be treated like an adult, not like a child.

- To have expressed feelings taken seriously.

- To be free from psychotropic medications, if possible.

- To live in a safe and structured environment.

- To enjoy meaningful activities that fill each day.

- To be outdoors on a regular basis.

- To have physical contact.

- To be with individuals who know one's life story, including one's cultural and religious traditions.

- To be cared for by individuals who are well-trained.

Anybody providing care to an individual that has been diagnosed with Alzheimer's Disease, whether they are a professional caregiver, spouse, family member or friend, needs to ensure that the above rights are fulfilled.

13. Promoting a Caring Culture

CARE CULTURE 1



The **new culture** (N) of Dementia care outlined below describes how care workers should go about their work when working with clients who have Dementia. Note how it contrasts with the **old culture** (O).

O1: Dementias are diseases of the central nervous system. Personality and identity are destroyed.

N1: Dementing illness should be seen as a form of disability. How a person is affected depends on the care received.

O2: The people with the best knowledge are doctors and brain scientists.

N2: The people with the best knowledge are skilled and insightful caregivers.

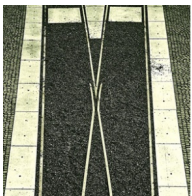
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O3: Research is focused on a medical breakthrough. Until that comes, there is not much we can do for the person with dementia.

N3: There is a great deal we can do through human caring, insight and skill. This is the most urgent matter for research.

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CARE CULTURE 2



O4: Caregiving is concerned with providing a safe environment, meeting basic needs, and giving competent physical care.

N4: Caregiving is concerned with the maintenance and enhancement of personhood. Providing a safe environment, meeting basic needs, and giving physical care is only part of the care of the whole person.

O5: It is important to understand the person's impairments, especially those of cognition. The course of a dementing illness can be charted in stages of decline.

N5: It is important to understand the person's abilities and tastes. There are as many manifestations of dementia as there are persons with dementia.

O6: Problem behaviours must be managed and changed skillfully and efficiently.

N6: So-called problem behaviours should be considered primarily as attempts to communicate. It is necessary to seek to understand the "message" and meet a comfort need.

O7: We should set aside our own concerns, feelings, and vulnerabilities and get on with the job of caregiving in a sensible, effective way.

N7: We should be in touch with our concerns, feelings and vulnerabilities and use them as positive resources for our caregiving.

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14. Dementia Care Rules

INSIDE DEMENTIA - EXERCISE



At times, it can be quite difficult for care workers to **empathize** with a patient with dementia. Let's take some time to complete this exercise that could help you see dementia from a different perspective.

Imagine a future in which you are in your seventies or eighties and suffering from dementia. None of your family is able to care for you at home, and you have moved into residential care. In the present, you know yourself and your personal history very well. Use your knowledge about yourself as you are now to pick out the information which would help the people who care for you in this imaginary future to maintain your well-being as far as possible. **What would you need to sustain your well-being?**

QUESTIONS TO ASK YOURSELF:

1. Everyday tastes and habits: How could it help you feel more settled if your caregivers knew about them?
2. Your body and your health: What should they know?
3. Fears and past events - If they understood these, could they respond more sympathetically?
4. Interests and activities - How can they help you sustain your sense of independence?
5. Still thinking of you as an older person with dementia: What do you most dread? What is your greatest hope?

RULES A.



When working with clients with dementia, it is easy to have preconceived notions about the type of client they will be. Try to follow the rules listed below. It will improve the standard of care you provide to your clients.

RULE 1: Be "present" in the moment. Be fully attentive. When you do these things, you satisfy the patient's need sooner and won't have to repeat the process as often. It also provides a personal touch to your care.

RULE 2: Recognise the uniqueness of each person. Know something about each patient that you treat. You need to remember that these are not just clients. They are individuals who have probably lived long and fulfilling lives. Ask them.

RULE 3: Draw out each person's remaining abilities. Help to encourage and maximise them. This will be rewarding for both the client and the carer. Try to find something they are good at and encourage it.

RULES B.



RULE 4: Communicate on a feeling level. Validate their feelings as you would like your own validated. Ask your clients how they are feeling. This will help develop a stronger bond between the carer and the client.

RULE 5: Assume words and actions have meaning. Try not to see them only as "problem behaviours". Try to find hidden meanings behind the client's actions. This can be difficult, but if you succeed in doing so, you can improve the client's quality of life.

RULE 6: Promote independence. Do for them only what they can't do for themselves. The decline of people with dementia is compared to the growth of children but in reverse. People at both stages need nurturing and encouragement.

15. Caring for the Carer

DIVERSITY



As a caregiver, you need to be aware of people's attitudes - personal biases, prejudices and stereotypes.

Understanding different values and being aware of cultural differences and where it's applicable will make you a better carer.

Where necessary, try to get information about the patient's culture/preferences. Make sure you adapt the care to fit their preferences and demands. **Diversity** includes race, ethnicity (culture), nationality, religion (or none) and sexual orientation.

CARER CARE A.



In addition to the client's rights, **the carer** has rights too! As a caregiver, take steps to safeguard your own health and well-being. This applies to the staff that provides care as well as to the family members.

It is important that you attend to your own health. Remember to be good to yourself. You're doing a very hard job, and you deserve some quality time just for you. Do not neglect your own health needs. Care for yourself as passionately as you nurture the people in your life.

Watch out for signs of depression, and don't delay in getting professional help. As a caregiver, you need to ensure that you have a routine that ensures your physical and mental health - not just for your own good but for the good of those you are working with.

CARER CARE B.



As a caregiver, you should make the following part of your routine:

- Go to your physician for regular health checks.

- Get flu shots; pneumonia vaccines where necessary.

- Take time for regular exercise to maintain your mental and physical health.

- Eat a sensible diet that includes plenty of fruit and vegetables.

- Consider taking classes and engaging in stress-reduction/coping techniques. Some people find yoga, meditation and other relaxation techniques helpful.

- Make sure you get enough rest and sleep.

- Continue to participate in your usual personal leisure/interest activities to ensure you maintain a healthy work-life balance.

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16. Working Effectively with Colleagues

If you are employed as a care worker in a formal setting, it is important to have a strong relationship with your supervisor. You need to see your supervisor as a resource and not simply your boss.

Follow the guidelines below to help create a positive relationship with your supervisor:

DO

Ask for the information you need.

Communicate information about changes in a client's condition.

Keep your sense of humour.

Accept constructive criticism.

Be flexible in accepting assignments.

Ask questions if you are unsure of what's expected of you.

DON'T

Be reluctant or shy in seeking important information.

Stop offering input, even if you feel you're being ignored.

React to others' anger or other stress-causing behaviours.

Take criticism of your work personally.

Insist on certain assignments.

Pretend to understand what you are unsure of.

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17. Introduction to Working With Patients' Families

INTRODUCTION

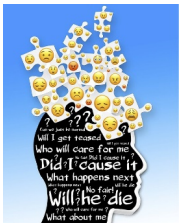


The purpose of this unit is to discuss the realities of working with the **families and friends** of the client with dementia and to determine methods for assisting families to cope.

Watching someone progress through the stages of Alzheimer's or other dementia is very *stressful*. Also, there may be *guilt* associated with the inability to "do more to help the person." When working with the families of a client, it is important to remember the following:

- Family members adjust to the client's condition in unique, individual ways.
- The process of adjustment involves grief and loss - anticipatory grief, i.e. grieving before death occurs.

ADJUSTING



Alzheimer's disease can be a long, lingering death, and the **stages of grief** are similar to the stages of adjustment to death described by Dr Elizabeth Kubler-Ross in her 1969 book *Death and Dying*.

This adjustment process does not always occur in clearly defined stages and is influenced by the following:

- Age and health of a person with memory loss.
- Length of illness.
- Family relationships.
- Roles of family members.
- How the family members impact care.

CAREGIVING



The **caregiving role** varies with different members of the family. The role of a spouse is different from that of a grandchild. The feelings experienced by a daughter or son are different from those of a spouse.

Caregivers should make a list of *relationships* and discuss how the person's role and relationship with the client with dementia may differ. For example:

Spouse | Adult Child - Long Distance Caregiver | Grandchild | Extended Family | Friends

Careworkers need to be aware of the family situation of their clients. Family can be a valuable resource for supporting the care worker.

18. Acknowledging the Experiences of Family Members

FAMILY EXPERIENCES A.



Family members can react in unique and individual ways when a loved one is diagnosed with dementia. The most common reactions are outlined below:

DENIAL: Reflects the initial response that nothing is wrong. Denial is a natural reaction; can prevent a family from seeking help; can create family conflict. Helpful Interventions: Provide accurate information on dementia when appropriate; Listen without judging; Do not assume the person is in denial. There may be a lack of information among family members.

OVER INVOLVEMENT: The primary caregiver may try to meet all the needs of the person with memory loss and refuse help from everyone; The caregiver believes they are helping, which can create a barrier to getting further help. Helpful Interventions: Involve family members in care and care planning; Encourage family members to express painful feelings such as guilt, loss and anger.

ANGER: Resulting from the physical, emotional, and financial burden of providing care. It can stem from feelings of loss and abandonment. Angry feelings can cause guilt. Helpful Interventions: Discuss anger at the disease rather than at people. Encourage interaction with other families going through the experience. Listen without judging or taking sides. Encourage the caregiver to take some time for his/herself.

FAMILY EXPERIENCES B.



GUILT: A feeling that comes from a sense of wrongdoing in words, actions or thoughts. Guilt can come from: Old conflicts, Placement and other tough decisions; Feeling like you “have not done enough”. Helpful Interventions: Learn about guilt and how it affects clients' families; Encourage the caregiver to talk about guilty feelings if appropriate.

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ACCEPTANCE: This is possible when the process of the disease and its effect on others is fully understood. Remember, families can still revert to earlier stages of adjustment. Helpful Interventions: Enable caregiver to see setbacks as temporary; Encourage caregiver to pursue personal interests and hobbies; Encourage involvement in care (if appropriate) and continue to ask for their help/support on issues of caregiving.

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19. Family Concerns

COPING STRATEGIES



It is important that both families and caregivers can develop **strategies** that help them to **cope** with caring for the client with dementia. Effective strategies are outlined below:

- Learn about Alzheimer's to understand what is happening to the client with dementia.
- Develop realistic expectations about the future.
- Accept past mistakes. Learn from them and go on.
- Become aware of your own mental and physical reactions to stress.
- Accept and enjoy your successes and breakthroughs, but accept that they are temporary.
- Accept your own feelings of frustration or anger at the person with Alzheimer's.
- Realise that taking out these feelings on the person with Alzheimer's is not appropriate.

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CONCERNS



Families feel particularly helpless and guilt-ridden when they turn over the care of a loved one to others in a **directed care setting**. Of course, part of them knows that this is best for the person with Alzheimer's, but another part believes that they could/should do more.

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When a client is placed in a directed care setting, both the resident and family struggle to develop new roles and adapt to new settings. Some concerns are outlined below:

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- Concern about someone else being a parent to their parent.
- Concerns about the community condemning their decision to place their family member in a directed care setting.
- Concerns about the care their loved ones will receive.
- Concerns about the loved one suffering/being distressed and not being able to report it.
- Grieving for the abilities that their loved one has lost.
- Concern about the future of their loved one.

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NOTE: Family members may be worried that they, too, will get Alzheimer's one day and witnessing the disease may exacerbate this concern. This is a legitimate concern as Alzheimer's does occur more often in members of the same family. Other risk factors are if the individual is over 60, female or has had a previous head injury.

Traits for Dealing with Families

Caregivers can be a valuable asset for families throughout the difficult process of a loved one being diagnosed with dementia. Follow the steps outlined below to ensure that you have the skills to help a family through such a difficult time:

BE YOURSELF

- Remember that you do this job to help people.
- Approach family members in a friendly and relaxed way.
- Don't tell them you are overworked or too busy.
- Share problems and successes you are having with their loved ones and ask for their advice.

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BE A GOOD LISTENER

- Pay attention to what they say and what they do.
- Repeat what they say back and ask them to clarify it.
- Ask questions and listen to answers.
- Don't take complaints personally.

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Understand the Family is Grieving

- Their anger, frustration, helplessness, complaints, suspiciousness, condescension and unrealistic expectations are part of the grieving process.
- Empathize - "It's very understandable to be upset in this situation."
 - Let them help with care and offer suggestions.
 - Encourage them to attend a support group.
 - Talk about their loved one as if you are a part of their family.

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Let the family know how special their loved one is to you

- Ask the family to tell you about the person before the illness.
- Talk with the family about the good times.
- Develop a committee to plan family/staff activities, such as dinners.
- Write notes to the family.
- Remember a spouse's birthday and anniversary with a card.
- When the resident passes on, send a sympathy card.

20. Module 6 Summary

Dementia refers to a spectrum of brain disorders. These involve difficulty with memory and thinking, but they may vary in terms of cause, course and prognosis.

Symptoms of dementia include: a decline in memory, thinking and reasoning; changes in personality, mood and behaviour; difficulties communicating, recognising people and places and engaging in activities.

Alzheimer's disease is the most common cause of dementia. It is progressive and not reversible. Early recognition of the symptoms and diagnosis is important.

When treating an Alzheimer's patient with medication, remember that it should be administered for the benefit of the patient and not for staff convenience.

Vascular or Multi-Infarct Dementia is the second most common cause of Dementia, estimated to account for 20% of cases. It is caused by reduced blood flow to parts of the brain, often due to tiny strokes which block small arteries.

Fronto-Temporal Dementia causes personality and behavioural changes and loss of language function.

Lewy Body Dementia is caused when abnormal protein deposits called Lewy bodies are left in the brain. Symptoms include hallucinations and memory loss. The early stage lasts for two to four years. It is characterized by forgetfulness, increasing difficulty with problem-solving and withdrawal from activities. The middle stage is characterized by an increase in memory loss, confusion, shorter attention span, increase in language difficulties and repetitiveness. The late stage is a time of severe confusion and loss of all functional skills. The person has no awareness of his/her condition. This lasts for 1-3 years and ends in death.

As a caregiver, take steps to safeguard your own health and well-being. This applies to the staff that provides care as well as to the family members.