Communication with Cognitively Impaired Clients 2.0 CE Hours

Objectives:

1. Define communication.
2. Describe three kinds of communication.
3. Recognize how to communicate with people who have cognitive impairments.

What Causes Cognitive Impairment?

There are different types of Illnesses that cause impairment, such as Alzheimer's disease, Huntington's chorea, cerebrovascular disease, psychiatric disorders, chronic alcoholism, and AIDS dementia complex (Oruche, 2009).

Alzheimer's disease (AD) is the most common cause of irreversible dementia. It is typically characterized by a gradual onset of cognitive deficits that worsen over a certain period of time. Memory loss is a primary symptom of Alzheimer's disease. Individuals with AD experience functional deficits in communication, activities of daily living, and quality of life that result directly from memory impairment. The two main memory impairment categories in dementia are explicit (declarative) and implicit (non-declarative) memory. Explicit memory systems rely on conscious or intentional recall of past information or experiences. An individual's ability to remember specific events or facts, such as days of the week (e.g., birthdays, anniversaries), is an example of explicit memory. Explicit memory is most affected in individuals with AD. Implicit memory is mediated by unconscious retrieval of past experiences through habit or

procedure (e.g., walking, talking, and reading) and is preserved for longer periods of time in persons with AD.

Improving Communication in Persons with Dementia

There are several rules for improving communicative function in persons with dementia.

1.   Demands on explicit memory systems should be reduced.

2.   Reliance on implicit memory systems should be increased.

3.   Activities that strengthen lexical and conceptual associations should be provided.

4.   Therapeutic activities should be previously well-known and significant to the person with dementia.

There are several different behavioral approaches available for the treatment of memory-related communication impairments in persons with AD. These treatments can be used separately or in combination depending on the severity of the client and his or her personal needs. Memory aids such as picture notebooks and wallets can help the client function more independently and increase communication.

Reality orientation therapy also know as (ROT) is a psychosocial approach that employs formal or informal classes that reorient the client by means of continuous stimulation with repetitive orientation to the environment, e.g., location, date, names, and personal information. Activities such as category sorting and games are used to stimulate language, increase active engagement in the environment, and decrease purposeless behaviors.

Spaced Retrieval Training

Spaced Retrieval Training also known as (SRT) is an intervention that gives individuals practice at successfully

recalling information over progressively longer intervals of time. SRT is a method of learning and retaining information by recalling that information over increasingly longer periods of time. When retrieval is successful, the interval preceding the next recall test is increased. If recall failure occurs, the participant is told the correct response and asked to repeat it. Intervals are manipulated to facilitate production of a high number of correct responses. Strength of association between concepts in semantic memory depends on how often they are activated. Repetition bringing into consciousness these associations will result in their increased accessibility. This is how SRT involves strengthening of associations, increasing reliance on implicit memory expression, and reducing demands on episodic and working memory (explicit memory).

SRT requires little cognitive effort and requires no explicit recall of a training situation; SRT is increasingly being used to teach new and forgotten information and behaviors to persons with dementia. SRT can be used to improve attainment of a variety of communication goals. For example, SRT can be used to train persons with dementia to improve orientation to place or to look at activity calendars and daily schedules to determine what they will be doing that day and to decrease repetitive questions regarding daily activities, such as "What do I do?" or "Where do I go?" It has been shown to be effective for a variety of memory tasks, such as naming common objects, remembering to perform a future action, making face-name associations and object-location associations, and remembering to use external memory aids.

SRT can also be used to co-treat with other rehabilitation disciplines to improve attainment of their goals. For example, SRT can be used in collaboration with physical therapy to train a person with a hip fracture and dementia to remember to lock her wheelchair brakes before standing or transferring, or to use the support of arm rests on the chair rather than the

walker to stand.

Because implicit or "habit" memories are preserved for longer periods of time, SRT is implemented in order to transfer explicit memory tasks to habitual or implicit memory tasks. The individual's ability to perform tasks, e.g., take medicine at a certain time, safely use wheelchair, or recall specific information, e.g., address, wife's name, and room number, without conscious effort should improve his or her communication abilities and independence. SRT is based on the concept of "errorless learning". Only the target response with no deviations should be accepted, no incorrect responses. Errors that are close approximations to the target should be corrected immediately. If they aren't, then over time the error itself can be permanently learned.

Using SRT, specific goals are identified and those goals are repeatedly reviewed during a session with increasing time intervals. For example, a goal might be for a client to remember his room number. The client would be given the prompt, "What is your room number?" and asked to give the target response, "My room number is 145." Typical SRT sessions last about 30-60 minutes depending on the client. When retrieval is successful, the interval preceding the next recall test is increased.

Time intervals are doubled as the client progresses through training. Doubling of time is appropriate for most individuals. Time intervals typically are 30 seconds, 1 minute, 2 minutes, 4 minutes, and so on. If failure of recall occurs, the participant is told the correct response immediately and asked to repeat it. The following interval length returns to the previous successful recall interval. Intervals are manipulated to facilitate production of a high number of correct responses (or correct utilization of procedures) to the stimulus question and retention of information over increasingly longer periods of time.

Strength of association between concepts in semantic memory depends on how often they are activated. This is why repeatedly bringing into consciousness these associations will result in their increased accessibility. Once the client responds correctly at the beginning of three consecutive treatment sessions, training of new information can begin. Between interval recalls, conversation or various therapeutic activities can occur. SRT is not commonly used by speech language pathologists (SLPs).

Best Practices for SLPs

Typically, SLPs rely on a "Best Practices" (BP) approach to treatment. Best practice consists of the traditional cuing hierarchy, prompting, and rehearsal of target information techniques. The traditional cueing hierarchy involves using semantic, phonemic, visual, tactile, or imitative cues to prompt a client during a task. For example, during a task in which the client needs to remember to use their calendar, the SLP might say, "You need to use the thing that's on your nightstand (semantic)," or "Where is your ca (phonemic)," or "Let's look around the room (visual)."

When using SRT, a goal is considered mastered when the client is able to demonstrate initial recall for three consecutive sessions. Initial recall means that when the client is asked the treatment question/goal (e.g., "What is your room number?") they are able to immediately recall the correct answer with no prompting. Possible causes of failure of goal mastery during the treatment phase could be attributed to lack of perceived importance to the participant for goal.

Communication Barriers

Communication barriers of the mentally and cognitively impaired clients seem to erode the quality of care. Lack of caregiver-client interaction due to patient's cognitive impairment affects caregiver assessment of the client and the

medication adherence. The reliability of the client's communication and sensory ability are affected by cognitive status. The major factor contributing to the communication barrier between the cognitively impaired and the caregiver has been the inadequacy in training of caregivers in associated communication skills. Other factors include the client's concealing their disability, work pressure, and poor communication of the caregivers.

Communication with the cognitively impaired is complex. Studies show that caregivers tend to spend more time with normal clients than with the cognitively impaired. Non-speaking clients are the worst affected and it is important to improve their communication to allow them to receive care and comfort.

Non-Verbal Communication

Use of non-verbal communication skills also known as (NVC) to improve care, especially with mentally ill and cognitively impaired people seems to be the key to providing care. Care of cognitively impaired clients requires clear communication during care procedures. But, the client's inability to provide an accurate history of his problem and to participate in self-care blocks the usual process of care and often results in medical uncertainty, inadequacy, and frustration for the caregiver. Other emotions such as sadness, fear and empathy, has been shown among caregivers.

Typically, most of the health care professionals are more directed in the physical care of the patients than the psychological interaction. Studies have shown the lack of knowledge and skills in health care professionals to deal with these clients. These studies have also recommended the introduction of communication and interpersonal skills in the care and management of these patients. Cognitive impairments pose a serious barrier on the reliability of caregiver's assessments of such patients.

Use of non-verbal communication skills (NVC) is to improve care has been recommended for cognitively impaired patients. A study outlining a health care professionals' diagnosis of altered non-verbal communication and a new wellness diagnoses for enhanced non-verbal communication with detailed discussion on use of NVC with people with comprehension difficulties stresses on the fact that caregivers play an important role in enhancing the non-verbal skills of the patient to help them communicate.

Resident Assessment Instrument/Minimum Data Set

An assessment instrument called the Resident Assessment Instrument/Minimum Data Set (RAI/MDS), with a self-incorporated MDS Cognitive Performance Scale (CPS), has been recently evaluated and has been found to contribute to the improvement of quality of care of the cognitively impaired. Another instrument has been developed, consisting of a single sheet of paper with the human body pictured from the front and from the back for the observation of touch and nurse-patient interactions. The non-verbal communication in such settings includes patient-directed eye gaze, affirmative head nod, smiling, learning forward, expressive touch, and instrumental touch. These non-verbal communications have had tremendous impact on the patient's well-being and comfort. The caregivers use eye gazing, head nodding, and smiling to establish a good relationship.

The Importance Of Touching

Touching is a form of communication used in providing care. The importance of improving communication by touch is an integral aspect of care. The language of touch includes tactile symbols of duration, location, action, intensity, frequency, and sensation. Clients experience touch by caregivers as gentle, comforting and important. Touching induces a good relationship between caregivers and their patients. Such a caring touch has been classified as

affectionate, functional and protective.

An examination of touch between health care professionals and patients showed most touch interactions in the care of the elderly are instrumental in nature. Expressive touches are usually given to body extremities like the forehead, arms, and legs. There cannot be an universal approach to employ non-verbal communication such as touch, because of the fact that while some clients enjoy contact, some avoid contact, some are aggressive, some show only slight reaction, and some patients do not react at all.

The caregiver should be able to perceive the expressions of the client and also the client's perceptions of caregiver's interactions to provide maximum comfort. The distance between the client and the caregiver, posture and position, utterance time, the direction of a caregiver's face to the client, facial expression, head nodding, gestures, and the self-contact behavior of a caregiver during interaction with a client are important in the non-verbal communication process.

Therapeutic Communication

With caring comes the trained ability of the caregiver to facilitate therapeutic communication. One might ask, what is therapeutic communication? To better answer this question, the term communication should first be defined.

Communication can be defined as, "the process of transmitting messages and interpreting meaning." (www.nurseslearningcenter.com, 2012) With therapeutic communication, the sender, in this case the caregiver, seeks to illicit a response from the receiver, the client that is beneficial to the client's mental and physical health. Just as stress has been proven to adversely affect the health of individuals, the therapeutic approach to communication can actually help.

In any given situation everyone uses communication. Everyone

has seen the individual that looks like they are either angry, stressed, feeling ill, or maybe sad. These emotions are communicated to others not always by words, but by gestures and facial expressions. A nurse must always be aware of these expressions in clients, for these expressions may be the only way that the caregiver can tell if there is something else going on that needs their attention.

Meta-Communication

The term given to this type of non-verbal communication is called "meta-communication". In meta-communication, the client may look at their amputated stump and say that it doesn't really look that bad, while at the same time tears are rolling down from their eyes. In a case such as this the caregiver should stay and further explore how the person actually feels. There are many factors associated with the healing and comforting aspects of therapeutic communication. Circumstances, surroundings, and timing all play a role in the effect of therapeutic communication. If a client is being rushed for an emergency surgery there might not be time for a bedside conversation, but the holding of a hand could convey much more than words to the client at such a moment.

Ideally, for therapeutic communication to be effective the caregiver must be aware of how he or she appears to the client. If caregivers appear rushed, for example, they are speaking quickly, their countenance looks harried, and they are breathing heavily, their eyes not on the client but perhaps on an intravenous bag on the client in the next bed. In a case like this, there is nothing that a caregiver could say to the client in a therapeutic manner that the client would believe.

The helping relationship has not been established and therefore therapeutic communication cannot be facilitated. Some of the emotions associated with therapeutic communication include but are not limited to the following: Professionalism,

Confidentiality, Courtesy, Trust, Availability, Empathy, and Sympathy. All of these emotions go into the client-caregiver relationship, which must be established by the caregiver as soon as possible upon first meeting the client. To begin to establish this caregiver-client relationship, the caregiver must assess the overall message that the client is communicating to the caregiver, such as fear, pain, sadness, anxiety, or apathy. The caregiver should be trained in keying into the message that the client is sending. Only then can the caregiver determine the best therapeutic approach. For example, the caregiver should be attuned to the fact that anyone that has to be thrust in to a hospital or emergency room environment experiences some level of anxiety.

This level can go up considerably when the client feels that they have been abandoned or that there is no one there that really cares about how they feel. On the other hand, when a client is the recipient of therapeutic communication from a caring individual a certain level of trust is achieved and the client's entire countenance can change for the better. The client's blood pressure, respirations, and levels of stress can simultaneously decrease. When this takes place, the management of pain, if any is involved, can be resolved more quickly.

One of the most frustrating aspects of caring for a client with stroke or dementia is the difficulty in achieving effective two-way communication. (Opus Communications, Inc., a division of HCPro, retrieved January 10, 2014 from http://www.fairfaxcounty.gov/dfs/olderadultservices/pdf/ltcombudsman/commcogimp.pdf).

Communication Tips

Some practical tips for communicating with someone with speech or cognitive disorders include the following:

- Use concrete, short sentences.

- Ask only one question at a time.
- Choose conversation topics the client was interested in prior to his or her admission.
- Use body language and facial gestures to augment the verbal message.
- Use a "yes" or "no" format whenever possible, so it will be easier for the client to answer.
- Never speak for the person with a communication disorder unless requested.
- If verbal/auditory messages are not effective, use other options, such as writing, gestures, or pictures, to communicate. (Opus Communications, Inc., a division of HCPro. Retrieved January 10, 2014 from http://www.fairfaxcounty.gov/dfs/olderadultservices/pdf/ltcombudsman/commcogimp.pdf)
- Trying to discern the meaning behind a client's repeated questions or statements can be more fruitful than responding literally. For instance, if a client keeps asking, "Where is my mother?" It might be because she is feeling lonely or frightened. Content of the sentence is not as important as the emotion being expressed. Other tips include:
- Do not ever resort to arguing. Rather, try distractions instead of confrontation if the client becomes increasingly anxious.
- Use direct and literal speech, and enunciate clearly.
- Use positive body language-smile, hug, and hold hands.
- Bring favorite foods or old photographs to evoke memories and elicit positive responses. (Opus Communications, Inc., a division of HCPro. Retrieved March 15, 2011 from http://www.fairfaxcounty.gov/aaa/pdf/ombudsman/commcogimp.pdf)
- Make good eye contact with the person with dementia.
- Good eye contact lets the person know that you're listening and that you do care.
- Simplify the environment. At meals, keep the table

settings very basic and serve one or two foods at a time.

- Maintain a calm environment
- A loud television, for instance, can trigger anxiety in a person with dementia.
- Call the person by name and, when interacting, approach the person from the front.
- Provide choices whenever possible.
- Use verbal cues in conjunction with tangible objects. For example, when helping to dress a person, the staff member could hold up two pairs of pants and say: "Do you want to wear these pants or these pants?"
- Don't interrupt when the person with dementia is talking.
- If the person is getting anxious due to having trouble finding the right word, try guessing the word for the person.
- Talk slowly and clearly and, if necessary, repeat slowly and clearly what already has been said once.
- Ask the person with dementia to point or gesture if that helps in communicating needs or concerns.
- Medical concerns should immediately be brought to the attention of the medical staff and the person's doctor.

References

Smith, E. R., Broughton, M., Baker, R., Pachana, N. A., Angwin, A. J., Humphreys, M. S., … & Chenery, H. J. (2011). Memory and communication support in dementia: research-based strategies for caregivers. *International Psychogeriatrics*, *23*(2), 256.

Nurse Care for the Cognitively Impaired-The Role of NVC. Journal of Nursing. American Society of Registered Nurses. Retrieved January 10, 2014 from http://www.asrn.org/journal-nursing/287-nurse-care-for-the-cognitively-impaired-the-role-of-nvc.html

Lin, F., Vance, D. E., Gleason, C. E., & Heidrich, S. M. (2012). Taking Care of Older Adults with Mild Cognitive Impairment: An Update for Nurses Journal of Gerontological Nursing (in press). *Journal of gerontological nursing*, *38*(12), 22.

Christenson, A. M., Buchanan, J. A., Houlihan, D., & Wanzek, M. (2011). Command use and compliance in staff communication with elderly residents of long-term care facilities. *Behavior therapy*, *42*(1), 47-58.

Williams, C. L. (2011). What spouse caregivers know about communication in Alzheimer's disease: Development of the AD Communication Knowledge Test. *Issues in Mental Health Nursing*, *32*(1), 28-34.

Earley, Robin, Doyle, Sharon, Chodos-Beth-all, Eileen. Communicate More Effectively with the Cognitively Impaired. Opus Communications, Inc., a division of HCPro. Last updated September 27, 2013 from http://www.fairfaxcounty.gov/dfs/olderadultservices/pdf/ltcombudsman/commcogimp.pdf

Lozito, Jeffrey P., and Neil W. Mulligan. "Exploring the role of attention during implicit memory retrieval." *Journal of Memory and Language* 63.3 (2010): 387-399.

St-Laurent, M., Abdi, H., Burianová, H., & Grady, C. L. (2011). Influence of aging on the neural correlates of autobiographical, episodic, and semantic memory retrieval. *Journal of Cognitive Neuroscience*, *23*(12), 4150-4163.

[Quiz Button](#)