Unit II
Communication and Assessment

(COMPETENCIES 2–6, 13, 15)

CHAPTER 5 TEACHING AND COMMUNICATION WITH OLDER ADULTS AND THEIR FAMILIES (COMPETENCIES 2, 5, 13, 15)

CHAPTER 6 COMPREHENSIVE ASSESSMENT OF THE OLDER ADULT (COMPETENCIES 3, 4, 6)

Teaching and Communication With Older Adults and Their Families

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(Competencies 2, 5, 13, 15)

LEARNING OBJECTIVES

At the end of this chapter, the reader will be able to:

> State the importance of communication with older adults.

> Identify effective and ineffective communication strategies.

> Understand how normal and pathological changes of aging effect communication.

> Discuss communication strategies for older adults with common normal and pathological changes of aging.

> Describe person-centered communication.

> Apply gerogogy strategies for enhancing teaching and learning of older adults.

> Explore changing demographics for older adults as it affects the teaching–learning process.

> Adjust teaching related to the diversity in learning styles of older adults.

> Draw correlations between effective communication and teaching strategies.

> Examine teaching variations needed for those with chronic illness.

> Identify assessments for the older adult in and out of healthcare settings.

KEY TERMS

Active memory	Broca's aphasia
Activities of daily living	Cataract
Alzheimer's disease	Cognition
Andragogy	Communication Enhancement Model
Anomia	Communication Predicament of Aging Model
Aphasia	Compensatory scaffolding
Apraxia	Compensatory strategies
Background noise	

Compliance scaffolding	Nondeclarative memory
Declarative memory	Nonverbal communication
Dementia	Parkinson's disease
Depression	Partnering communication model
Diabetic retinopathy	Patient-centered communication
Dual sensory impairment	Pay-for-performance
Dysarthria	Pedagogy
Eden Alternative	Person-first language
Elderspeak	Personal amplification devices
Episodic memory	Presbycusis
Frequencies	Presbyopia
Gerogogy	Relational teaching
Glaucoma	Restorative strategies
Global aphasia	Scaffolding Theory of Aging
HCHAPS surveys	and Cognition
Hearing aids	Semantic memory
Isolation	Short-term memory
Language	Social networks
Lexical memory	Successful aging
Long-term memory	Tinnitus
Macular degeneration	Wernicke's aphasia
Major neurocognitive disorder	Working memory

Communication links all of us to each other and to the environment and is a key factor in how we relate and coexist. People use communication to provide and receive information from others for a variety of reasons. For many decades, scientists have created communication models from the work of Satir (1967), in which she states, "Communication is a two-sided affair: senders are receivers, and receivers are also senders" (p. 88). Successful communication involves conveying a looping message between a sender and a receiver in which their roles continuously reverse and cycle back. However, many issues must be addressed for this communication to be effective. Effective communication is a dynamic process that includes an ongoing exchange of information with feedback, context, clarifications, language, definitions, and removal of barriers between the sender and receiver—it suggests a partnership that increases understanding going both directions. When considering how best to communicate with and to teach older adults, several key principles must be considered. Basic knowledge of communication with older adults is fundamental to effective teaching. These concepts are discussed in this chapter.

Communication Basics for Older Adults

Communication relies heavily on intact senses, such as hearing, vision, physical, and cognitive processes. Any level of distortion or failure of one or more senses can cause significant challenges for effective communication. The individual's cognitive abilities and a conducive environment must be present for effective message transmission because background noise and internal distortions can be serious barriers.

Communication is complex and encompasses verbal and nonverbal messaging that may have a cultural dynamic to its meaning. In some cases, communication is affected by the variances seen in different age groups and how these various age groups create meaning. A common example is how boomers and millennials define the word *sick*. The boomer generation thinks the word means *to be ill and not well*. Millennials define the word to mean *impressive and outstanding* (using boomer terms). We are seeing additional strategies affecting the way most people communicate with the use of symbols ($), emoji (☺), and various forms of short hand (lol).

In the past, communication tended to be more linear, with a feedback mechanism to help clarify what was being said. Today it may be dynamic and more of a constant building of beliefs and ideas that must be sorted and integrated by the reader to give it meaning. There are several methods for showing one's emotions when the individual cannot be seen in person, using emoji symbols, where in the past you would typically use bold or all capital letters. On Facebook® and Twitter®, you can see the building of what a person is thinking regarding an idea that also has pictures with multiple persons giving opinions and feelings to the threaded discussions. The language of symbols is updated regularly, and refinements are put into smartphones for current generational understanding. The following link is a place where these updates can be seen and then integrated: https://twitter .com/Emojipedia?ref_src=twsrc%5Egoogle%7Ctwcamp%5Eserp%7Ctwgr%5Eauthor (Emojipedia, n.d.). The Internet can quickly give you definitions, perspectives, and variations in meaning, but there is very little support for the older adult who has not learned this language or is having cognitive confusion.

Most new computers and electronic devices have voice-activated messaging, searching, and responses such as seen with *Siri* on an iPhone®. Television remotes allow you to speak into the remote and that channel will appear, or it will find all movies or shows on a given topic. However, many older adults have difficulty with fast-paced change and are not always willing to use all this valuable technology unless they have a chance to practice and become comfortable.

Building a Framework for Understanding Normal and Abnormal Aging

If you are the average adult and well under this age group, you probably have beliefs similar to those of other persons who might have participated in the exercise. Examine your own thinking right this minute regarding some beliefs you have regarding people ages 70 to 90. Write them on a piece of paper. Many of the stereotypes are negative and do not suggest favorable characteristics for the older adult. Having negative and significant cognitive decline of this group is a myth, and even clinicians get caught in this thinking. "Perhaps one of the most serious assumptions made by many psychologist is that of universal cognitive decline" (Shaie, 2016, p. 4). Shaie's (2013) longitudinal study of older adults suggest there is a decline in various domains (verbal, spatial, word fluency, and inductive reasoning), but it is so individualized that generalizations are not useful. It has been shown that a significant population of older adults do not show any decline until they are near death.

Normal Language and Speech

One area of *language* that has been shown to improve with age is vocabulary. The longer one lives, the more that person is exposed to a variety of words and meanings, and thus their vocabulary continues to expand. When verbal knowledge was compared between adults ages 20 and 80 years, the 80-year-old group had better scores than the 20-year-old group (Park et al., 2002). Syntax (the structure of sentences) remains intact throughout the process as well. How older adults use language to interact remains relatively strong, but people tend to be more verbose and/or drift off topic. The rate of speech slows, and word articulation becomes less clear because of the slowing rate of cognitive processing and declining strength and range of movement of the mouth, tongue, and jaw. Having missing teeth or dentures that do not fit properly are also factors that influence word articulation.

Complex and lengthy verbal and written information may be more difficult to understand (Lubinski, 2010) and often causes frustration on the part of listeners. It is easy to identify caregivers who think they cannot give any more time to a given conversation and may quit listening, be more directing, or even show frustration and anger to cut off the conversation. In addition, comprehension during conversation may be more challenging because of hearing, vision, or sensory loss, cognitive changes, or emotional factors.

A study by Haro and Isaki (2009) found that older adults had more cohesive and organized speech and used fewer fillers (e.g., like, um, uh) compared to younger adults. Older individuals continue to display abilities to learn and retain world knowledge as well. Appropriate content of sentences, vocabulary, and grammar remain strengths for normal-aging older adults. However, the length and complexity of sentences is reduced (Schreck, 2010). Nonspecific language (she, they, thing) becomes more prevalent, leaving the listener to guess or ask more questions to understand to whom they are referring. Although there are changes in being able to recall names of people, places, and objects, the ability to functionally communicate remains intact.

During the process of normal aging, some start to notice changes in strength, endurance, memory, vision, hearing, sensation, and taste. Body hormone levels shift, affecting libido and causing night sweats, sleep changes, energy reduction, and weight variances. Lifelong relationships are reinforced for different reasons, and staying active becomes a necessity if a person is attempting to counteract some of these normal aging changes. Changes in communication patterns and functional abilities are a part of this aging process, with some older adults becoming less interactive for various reasons. Some nonresponsive behaviors during conversations occur because the person is not sure what he or she heard or may not be clear on the topic being discussed. In some cases, the individual thinks what he or she has to say does not matter or there may be an opposite response, with the older adult thinking he or she must be heard and present *the truth* on a topic. There is a group of older adults who think that if they do not present *the truth* on a certain topic, no one will. A few older adults may invade the conversation with bold and unwavering absolutes that cannot be reasoned away or discounted through any rational reasoning. There is significant diversity in how older adults respond during conversations. This is something you may have already noticed in your own experience. The latter two responses presented are often a challenging issue for healthcare providers because there is a tendency to argue or present a *more rational way of thinking*. **Case study 5-1** is a real example of how different older adults think. Both of these older men are in total independent living situations and both are in this author's personal life.

Schaie (2008, 2016) suggests "there are four major patterns that will describe most of the observed aging trajectories" (p. 5). These are as follows:

> *Super-normal or successful aging*: This group is able to be very successful, engaged, and socially advantaged and hit a peak of their mental abilities in late midlife. They are usually doing what they enjoy right up to their death.
> *Normal aging*: This group does well and hits their social and cognitive peaks in early midlife, but can have a couple of divergent endings. One group stays very independent and the other needs significant support.

Case Study 5–1

I went to breakfast with my neighbor John, who is now 80. He was born in Poland with a German heritage and lived in Germany during World War II from ages 8 to 10. John's view of Hitler sounded like this: "Hitler was not all bad, and he did a lot of good for the German people. You know, the Jews brought much of their problems on themselves. Hitler wanted them to give more to the poor people of Germany, because most of the Jews in Germany had significant wealth, and they would not give it up." Other conversations centered around how his family hid a Jewish neighbor from the Gestapo who came looking for him, but the Jewish farmer was their friend and they risked everything to protect this man.

John does not listen to the news media in the United States and thinks everything in the U.S. news is filtered in an unacceptable way. He only listens to the foreign news media so he can, "hear the truth about what is happening in the world." John, when given the opportunity, wants to tell the "real story" about what is happening in the world, and there is no changing his opinion. It is a conspiracy story with a few unknown people running everything—elections, leader assassinations, policies, and all major money activities.

The medical system is just as corrupt, and he will see a physician for the specific purpose of getting a blood test and then uses the data to treat himself using natural vitamins and minerals. He takes more than 20 types of naturalist supplements and does not trust that any traditional medical clinicians could advise him accurately. He had self-overdosed on some of these vitamins, with significant muscle weakness, and then spent 10 months reassessing his regimen and finally recovered. There is not an invasive procedure he would undergo for any reason. After tearing one bicep tendon, he decided to let it heal on its own with more than 5 years of problems from his decision. However, after 5 years, his bicep appeared to become connected on its own.

Bert is 82 and has been involved in more than 100 men's personal growth retreats. He enjoys small groups who work closely together and worked most of his life in the railroad industry. He has pain in his hips and back, is hard of hearing, and is a man of faith and spirituality. He listens most of the time with an expressionless affect until he decides to engage and speak on a topic. He likes to tell jokes and laughs along with everyone else, or he will give a comment with some emotion. Sometimes Bert's wisdom moves others with words of encouragement, insight, or how he would address a particular issue in his own life. He cautions others not to think like him, but would like them to hear his wisdom and see if it is valuable for them. He is still being asked to give talks at various men's retreats—then he offers wisdom from all his years of living.

Bert receives traditional medical care for his back pain and functional limitations. There are times when he has difficulty maneuvering, but understands his limitations.

Both men struggle with remembering simple things: the name of a street, a place they want to have breakfast, the name of someone they met. They both drive, own a home, enjoy company, continue to engage the world in their own way, and remember historical information like it just happened.

> *Mild cognitive impairment (MCI) or unsuccessful aging*: This group has earlier than normal cognitive losses and struggles with normal functioning as they progress past their midlife years.
> *Dementia group*: This group is diagnosed with some form of dementia and is in need of constant attention. They are considered to age and progress very differently from those in the other three groups.

Developmental models provide reasons for such diverse responses to life, as seen in the vignette. Some aging deficits seem more universal, whereas other issues are very individual. As presented in Schaie's model and in

the two stories of John and Bert, there may be major differences on how older adults connect to others and how they see the world.

Categories of Normal and Abnormal Barriers to Communication

Communication failures occur when barriers to communication exist in any component of the older adult, regardless of what technology is being used to assist in the process. Normal and abnormal aging barriers might be:

> *Internal* (e.g., cognition and physical deficits)
> *External* (e.g., speaking too softly, noisy room, elderspeak)
> *Language* (e.g., misunderstanding of terms, the use of a word in a different generational context, idiom, and slang)

Internal Barriers and Interventions

The older adult has a natural progression of sensory and *cognition* reduction over time, but it is not uniform or consistent from person to person. Think about how someone at the age of 70 struggles to navigate through a room or drive a car. There are others, such as Paul Newman, who raced competitively to age 70, hitting speeds of 140 m.p.h. in his 1988 Nissan race car. Here is a video of Paul Newman in action: https://youtu.be/4Szj0gCkFuk. The variations in internal decline are present; however, eventually body and cognitive functioning lose the race against time. Schaie's model (2016, 2008) suggest the four types of identifiable groups, but some general statements can be addressed with this in mind.

Maturational Variations in Cognition

Part of a people's cognitive ability is related how they functioned throughout their life. Worldviews, educational level, conspiracy beliefs, religious beliefs, political views, and how the person has related to others continue into older age. Erik Erikson's stages of development can be misleading if the reader thinks all persons mature in the same way (Schaie, 2016) and each person makes it to the eighth stage (see Erikson's Eight Stages of Psychosocial Development: http://web.cortland.edu/andersmd/ERIK/sum.HTML). This site presents a summary chart of the eight stages presented by Erikson, but there are different thoughts today as to how these stages are really played out and at what age (Schaie). Regardless of the debate, we can examine an example of a person who keeps failing at each stage of development. It is possible for an older adult to mistrust, have shame and doubt, carry guilt, feel inferior, have role confusion, become isolated and stagnant, and then fall into despair. The cognitive coping abilities of such a person would be minimal, and care partners might see a person wishing to die, even when the person is not ill. This person would fall into the maturational group called unsuccessful aging, presented earlier.

An alternative view of older adults might have a very different perspective of development. They learned to trust in others, developed autonomy, and had initiatives with successes. They may have developed skills and an identity in how they worked and lived to include fostering intimacy in relationships. These older adults might go on to become generous and giving as they maintained a sense of healthy ego identity or a sense of purpose for their creator. This older adult moves into a world equipped to manage a host of issues that come as challenges, problems, or obstacles and falls into the Schaie model under the heading of super-normal and successful aging. Developmental maturational paths have a significant impact on the cognitive abilities in later years. Despite this variance, there are still issues that have an impact on many older adults, but it may happen at different ages or their response to these difficulties can be significantly varied.

Brain Function and Cognition

As people age, there is a gradual decrease in brain mass and neuronal function that results in cognitive changes. Long-term and short-term memory declines as people age. *Short-term memory* is limited in capacity, and information remains for only a few seconds. Older adults are thought to hold approximately five to nine pieces of information, such as a phone number, in short-term memory. Some information in the short-term memory is then encoded to be stored in *long-term memory*. Long-term memory is suggested to be more expansive than short-term memory, and there is no limit as to how long information can be stored (Lustig & Lin, 2016).

Bayles and Tomoeda (2007) describe two subgroups found in long-term memory: declarative and nondeclarative. The authors present *declarative memory* as factual information that can be presented objectively and has three subtypes:

> *Episodic* (events)
> *Semantic* (concepts)
> *Lexical* (word) memory

If you thought of a specific time you went to a park, you used *episodic memory* (event) memory. If you are asked to imagine a beautiful park, you might think of swing sets, flowers, grass, barbeques, or a sunny day, all of which requires *semantic memory* (concept). *Lexical memory* is the memory of words, including meanings, spellings, and pronunciations. If you decided to write about going to the park or tell a friend what you did, then you would be using lexical memory to select and communicate the words you think have universal meaning. *Nondeclarative memory* includes the following:

> Motor skills
> Cognitive skills
> Reflex responses
> Priming
> Conditioned responses

Repetition typically strengthens nondeclarative memory. Examples of nondeclarative memory are how you might solve a math problem, how you get angry when someone cuts in front of you on the highway, or a conditioned response to loud noises.

Bayles and Tomoeda (2007) also describe *working memory*, which includes executive functions such as:

> Planning
> Attention
> Inhibition
> Encoding
> Monitoring

They define *active memory* as an immediate brain function that can describe what you are thinking at any given moment. Phelps (2004) expanded the idea of memory as being more vivid and memorable if it is tied to an emotional state created by the amygdala charging the hippocampal memory system. Unfortunately, the amygdala is also involved in symptom severity of posttraumatic stress disorder (PTSD), bringing forth memories and symptoms associated with those memories, even when they are not wanted (Shin, Rauch, & Pitman, 2006). This allows the individual to integrate positively or negatively several memories. The individual may have a sematic memory that is a reflex memory that bypasses cognitive processing and goes directly to an emotional response that is expressed as PTSD or a positive emotional feeling of love and peace. Based on your history of listening to music, it is possible to experience this effect in this moment (active memory). To engage in this experience, complete the first critical thinking exercise at the end of this chapter.

Normal Aging Changes in Cognition with Compensatory Strategies

As people age, certain types of memory are more vulnerable to decline than others. Episodic memory and working memory are the most affected in the aging processes, whereas semantic, lexical, and nondeclarative memory are more likely to be preserved (Bayles & Tomoeda, 2007). It may be difficult for these persons to recall what they did the day before or what they ate for breakfast (episodic memory). There may be difficulty with multitasking (e.g., talking and writing a check) because of a decline in working memory in which the individual is attending to information, encoding, or planning. Studies show that memories that are especially difficult to recall are often the result of not having a connection with the hippocampus (Tulving & Markowitsch, 1998). It is much easier for an older adult to recall a story that happened decades earlier because the information has already been stored in areas of long-term memory not affected by the hippocampus. Repeating new names or developing an association with the name or face of a person can help older adults create instinctive remembering, but either way this memory loss may cause frustrations for the individual. Nondeclarative memory may be slower, yet still accurate, which is seen in some sports activities (Bayles & Tomoeda, 2007). For example, an older individual who has played golf for many years can still play at the same level as at a younger age, but it may take more time to complete one round.

With normal aging, cognitive processing slows and abstract reasoning becomes more difficult. Also, new information becomes harder to remember (Lubinski, 2010). Attending to daily tasks may be mildly impaired, especially when there are distracting factors such as the phone ringing or television noise (Schreck, 2010). On a day-to-day basis, older adults may show that they have challenges with following conversations, managing money, driving, safety, and complex tasks (Schreck, 2010). Because of brain changes, individuals over 65 "are slower in perceiving, processing, and reacting especially when the situation requires rapid processing of complex information" (Bayles & Tomoeda, 2007, p. 49). The overall knowledge does not diminish. However, the time necessary to process and retrieve that information does increase. This can appear as knowledge impairment to family members and care providers, so it is important to provide adequate time for older individuals to process and respond.

Aging causes changes in the physical brain (Park & Farrell, 2016), but it is important to remember that the maturational development of individuals varies in how they adjust and compensate for losses. For some older adults, cognitive integration is as strong as it has ever been and there may be greater coping strategies compared to their younger years as they have progressed positively during maturational development. One theory on how the compensation occurs is called *compensatory scaffolding* and has been recently described in the model by Reuter-Lorenz and Park (2014) as the *Scaffolding Theory of Aging and Cognition* (STAC) (p. 90). It is described as a process in which the individual's brain recruits additional neuron connections for maintaining memory and decoding what has been observed.

Pathological Changes that Affect Cognition and Communication

Dementia is defined as memory loss accompanied by speech and language impairments and/or decline in executive functioning (Bayles & Tomoeda, 2007). It been called a *major neurocognitive disorder* as a clinical diagnostic category (American Psychological Association, [APA] 2014). Because changes in memory occur with normal aging, the symptoms have to be significant enough to interfere with social, occupational, or daily activities before it is diagnosed medically. There are different types of dementia, including Alzheimer's disease (AD), vascular dementia, dementia with amyloid deposits, mixed dementia, and frontotemporal dementia (Park & Farrell, 2016). Dementia can be seen in numerous other conditions, such as Parkinson's disease (PD), Huntington's disease, Creutzfeldt–Jakob disease, Wernicke–Korsakoff syndrome, and normal pressure hydrocephalus (NPH). *Alzheimer's disease* is the most common form of dementia and accounts for 60–80% of dementia cases (Alzheimer's Association, n.d.). AD is a progressive degenerative brain disease that first affects memory (Bayles & Tomoeda, 2007; Park & Farrell, 2016). As it progresses, physical movement, communication, cognition, personality, and emotional and mental health are affected. In the United States, 1 in 8 people over the age of 65 has AD and individuals 85 and older have a 50% chance of having AD (Alzheimer's Association, 2012). With a growing population that is older than 65, we can expect a greater need for care partners to become more competent in memory care as they

work with dementia patients in need of special understanding. Strategies for caring for persons with dementia are discussed further in Chapter 10.

The Effect of Cognitive Issues on Communication

Effective communication relies heavily on an intact memory. When we are listening, we first have to attune to the speaker and then use our memory to recall what the person said in order to make an appropriate response. When speaking, we use our memory to recall stories and information as well as to select the right words to convey what we mean. As with the aging process, episodic memory is the first to be affected in individuals with AD (Bayles & Tomoeda, 2007). The difference between age-related changes and AD–related change in episodic memory is the rapidness with which one forgets the information. Individuals with AD, as well as individuals with PD plus dementia, forget within seconds. In addition to short-term memory issues, persons affected with AD experience long-term memory problems. Because of short-term memory impairments, people with dementia will repeat the same stories or repeatedly ask the same questions. If persons with a memory impairment are asked what they did yesterday, common responses include "I don't remember," "I don't know," or saying something vague such as "Oh, you know, the usual." Long-term memories from distant times, such as events that happened in childhood through young adulthood, are easier to recall and discuss with aging dementia. The aim in working with all types of dementia is to reduce the individual's frustration when communicating by minimizing the demands on memory and providing enjoyable communicative opportunities. This process can be facilitated by the use of pictures, objects, or music from the older adult's past, which allows individuals to practice communication without having to rely on memory.

CLINICAL TIP

For persons with dementia, reduce their frustration during communication by minimizing the demands on memory and focusing on enjoyable communication opportunities that do not rely on memory.

Dysarthria and *apraxia* are speech and motor impairments caused by neurological changes in the body. Speech apraxia is a speech impairment with an inability of the individual to send the correct messages to the mouth muscles for making motor planning. Dysarthria refers to muscle weakness difficulties of the mouth affecting speech movements. Some adults who have had a stroke will have brain damage that has an impact on what the person wants to say, causing the language impairment *aphasia*. These persons continue normal intellect but are unable to connect the brain to the speech motor receptors (Yorkston, Beukelman, Strand, & Hakel, 2010). Although other conditions and diseases can cause language impairments, the term *aphasia* is used if it is primarily a language deficit. If cognition, personality, or speech is impaired, it does not fit the diagnosis of aphasia. There are several types of aphasia that are categorized by fluency, comprehension, and repetition abilities. All types of aphasia share one common feature—*anomia*, which is a naming impairment (Bayles & Tomoeda, 2007).

When damage occurs to Broca's area of the brain, it is called *Broca's aphasia*. With this type of aphasia, comprehension remains intact, but spoken communication is not fluid. Speech is slow, effortful, choppy, and often lacks proper grammatical markers, such as "-ed" at the end of a verb to indicate past tense. Individuals have difficulty initiating speech, but they provide good content. Repetition is moderately to severely impaired, and most people with Broca's aphasia are aware of their impairments and try self-correcting (Bayles & Tomoeda, 2007).

Another nonfluent type of aphasia is *global aphasia*, with even greater damage to the left hemisphere than found with Broca's aphasia. The effects on communication are more devastating, causing the person to have very limited spoken language and individuals may use only single words that are not always understood. Unlike Broca's aphasia, comprehension of written and spoken information is significantly impaired. In addition, written

expression is equally as impaired as the spoken form (Bayles & Tomoeda, 2007). This form of aphasia has a poor prognosis for recovery of meaningful use of language.

A common fluent type of aphasia is *Wernicke's aphasia*, which is caused by damage to the Wernicke's area of the brain. People with this aphasia have fluent speech with unintelligible content. Individuals will use real or nonsense words, but the string of words has no clear meaning. Comprehension of spoken and written information is impaired, as is repetition. Unlike Broca's aphasia, those with Wernicke's are generally unaware of their communication deficits and seem to have a cognitive filter that makes sense in their own mind but not to others, (Bayles & Tomoeda, 2007).

Individuals with *Parkinson's disease* often experience dysarthria. PD is a progressive degenerative brain condition that includes symptoms such as resting tremors, slow movements, rigidity of limbs or trunk, and unstable balance (National Parkinson's Foundation, 2012a). Research estimates there are 50,000 to 60,000 Americans diagnosed with PD each year (National Parkinson's Foundation, 2012b) and there is a higher prevalence in individuals over the age of 60 (American Parkinson Disease Association, n.d.).

Approximately 15% of individuals with PD develop dementia as the condition progresses. Slow movements and rigidity have a negative impact on producing speech. Because of rigidity of the trunk, people with Parkinson's have a reduction of air pressure needed to adequately support speech, causing a weakened voice. Other common problems include hoarse voice, monotonous voice, difficulty initiating speech, and reduced word articulation. When reduction in the word articulation occurs, listeners find it more difficult to understand what is being said. Rigidity also prevents a full range of motion of the facial and jaw muscles, contributing to reduced intonation and soft speech tones. In addition, individuals often appear to have a flat affect with minimal facial expressions, leaving some to think the Parkinson's patient is disconnected from the conversation (Yorkston et al., 2010).

In the early stages of a progressive dementia such as AD, sentences are typically grammatically correct, but fragmented and repetitious. At this point, there are signs of declining vocabulary, and words may be substituted with similar words (e.g., "look" for "took"). In addition, the person may perseverate on an idea or a topic. In the middle stages, attention, memory, speech, and language skills continue to decline. Speech becomes slower and more repetitive, and the content becomes less cohesive. At this point, comprehension of written and spoken language is typically impaired.

Interventions for Those with Cognitive and Language Barriers

To effectively communicate with patients who have speech, language, and/or cognitive impairments, it is imperative to use a multitude of modalities to aid in communication. Although oral communication is what we generally think of most when we think of communication, written information, pictures, drawings, concrete symbols (such as letters and numbers), gestures, and facial expressions all aid in effectively communicating a message. Some approaches will help patients communicate better than others. It is important to collaborate with the patient, family members, care partners, and speech–language pathologists to determine approaches that work best for that specific person.

Questions that incorporate confrontation naming should be avoided. One common example of confrontation naming involves the care partners looking at family pictures in a patient's room and then asking, "Who is this?" or "What's her name?" In early stages of dementia progression, individuals are typically aware that they should know the information but simply cannot remember. This can lead to frustration, anger, guilt, and sadness. Caregivers and care partners need to switch from a confrontational naming question to a comment about a picture or ask multiple-choice and yes/no questions. Nurses can convert a "Who is this?" to "This is a beautiful picture. Is this your daughter?" In later stages of dementia, it may be simply, "I like this picture on your wall," eliminating any expected response.

Daily factual postings may be useful for some dementia patients to know the day, what is happening today, or what is on the menu for today. Care partners can use items such as whiteboards or large wall calendars to

TABLE 5-1 **Strategies for Communication with Persons with Dementia That Support Personhood**		
Strategy	**Definition**	**Example**
Recognition	Acknowledge the person, know the person's name, affirm uniqueness.	"Come along Mrs. Jones, your dinner is being served."
Negotiation	Consult the person regarding preferences, desires, needs.	"That was a nice bit of fresh air. I'm ready for my dinner now; would you like to join me?"
Validation	Acknowledge the person's emotions and feelings and respond.	"Mrs. Johnson, it sounds like you would like to wait for your bath."
Facilitation and collaboration	Work together, involve the person. Enable the person to do what he or she otherwise would not be able to do by providing the missing parts of the action.	"What is it you are looking for Mrs. Smith? Can I help? Tell me what it is and we can look for it together."

Modified from Ryan, E.B., Byrne, K., Spykerman, H., & Orange, J.B. (2005). Evidencing Kitwood's Personhood Strategies: Conversation as Care in Dementia in B. Davis's (Ed.) Alzheimer's Test, Talk, and Context: Enhancing CommunicationPalgrave, New York: McMillan.

post their names, the time for various activities, or other daily facts that the patient may ask about. Expect such care recipients to ask the same questions anyway. The ability of the care partner to respond in a calm and reassuring voice going back to the whiteboard and showing the information as if it were for the first time, is useful for reorientation to the reference board without sending a nonverbal message of frustration, guilt assigning, or contempt for the question being asked. **Table 5-1** provides guidance on how to communicate with persons who have cognitive deficits.

Normal and Abnormal Changes in Vision

Another internal barrier affected by normal and abnormal aging is vision. As people age, functioning of anatomical structures decreases, which is true in respect to vision. Age-related changes can start occurring in the 30s. Over time, the cornea becomes less sensitive and the pupils decrease to about one third of the size during young adulthood. It also takes longer for one's eyes to adjust from light to dark environments, such as walking out of a movie theater on a sunny day. The lenses become less flexible, slightly yellowed, and cloudy (Dugdale, 2011). Visual acuity also decreases with age. In the normal aging process, *presbyopia* (*aging eye*) occurs and causes difficulty seeing at close range, such as in reading (National Eye Institute, National Institutes of Health [NIH], n.d.). This change in vision can affect anyone over the age of 35. Although the age that presbyopia becomes apparent may vary from person to person, it is expected to affect everyone at some point. This type of vision impairment may be corrected by wearing glasses with bifocals or contact lenses or by various forms of surgery, such as Karma inlay, monovision Lasik, or refractive lens exchange (Boxer-Wachler, 2016). As presbyopia increases with age, care partners and family may need to set up regular annual vision assessments to determine any progressive changes affecting the older adult over time. If there is a reduction in reading, headaches, or eye fatigue, the older adult may need new glasses and lenses regardless of how they made these adjustments earlier in life.

It is common for older adults to experience an increase in sensitivity to light and glare. Too little or too much light may hinder vision. This will vary from person to person, but typically older individuals require more light to be able to see adequately. On the other hand, bright lights, such as headlights, may be temporarily blinding

Case Study 5–2

Mark is a 60-year-old active man who was driving his car down the interstate on a sunny Colorado day. He blinked his left eye and noticed the cars ahead of him shrink instantly from both sides. He then did it intentionally to see what his right eye was seeing. Everything pulled in and seemed to shrink. Not sure what was happening, he went home and looked at the TV in the same way—closing his left eye and then noticing the TV shrink in from its sides to be narrower than it was. Not only did it shrink, but there was a dark spot directly in his vision and faces on the screen disappeared. Mark moved his vision with his right eye to the left and right of faces on the television and they would reappear, and then disappear when he looked directly at the faces. Not sure of what was happening, he kept testing himself. Yes, he could make things disappear with just his right eye open. In the distance the blank spot was larger and could cover a car. As he looked at closer objects, a piece of the object would go dark and shrink at the same time. As he began to read an article in a magazine, the words would not become clear unless he looked to the right of the word, and then the letters became clear.

Mark went to see a retinal specialist and eventually was diagnosed with a macular hole. The treatment was to have a vitrectomy (removal of inner eye fluid), with argon gas put in the eye. Mark was to lie face down on his stomach or in a back massage chair for 2 weeks to aid in preventing the hole from enlarging. After the 2 weeks, it was 4 weeks of a water line slowly rising in the right eye as the fluid returned— like having a fish bowl in his right eye. The complications could be a *cataract* from the gas used. Yes, Mark had a cataract in less than 6 months and then went for cataract surgery. "OK, now I should be good to go" Mark thought. Fortunately, the left eye became increasingly more dominate and the blind spot was not as bothersome and the macular hole did stabilize. Unfortunately, there was significant loss of peripheral lower right side vision that was present after the second surgery. In addition, the right eye continued to become dominate after being in bright sunlight. As Mark goes from outside to inside a house, he has significant eye adjustment delays to see clearly indoors.

and impair the ability to drive at night (Ayalon, Feliciano, & Arean, 2006). Reading material with a glossy cover or on glossy paper may reflect light and make it more difficult to read. Changes also occur in the cones of the eyes, which affect how a person sees colors. For older adults, it is more difficult to differentiate between green and blue than between red and yellow.

There are many diseases of the eye (*diabetic retinopathy*, *macular degeneration*, retinal detachment, macular holes, vessel ruptures, *glaucoma*, herpes, and cancer) that will make seeing more difficult regardless of having just the right amount of light. All of these diseases and more affect the quality of life of older adults, with a constant reduction of activity and accurate vision. These changes in activities include the climbing of stairs, walking exercise, driving a car, and many other *activities of daily living* (ADLs). As various diseases progress, more *isolation* is likely, with activities needing guidance from family and friends. The vignette in **Case Study 5-2** describes how one older person noticed changes caused from a macular hole in one eye.

Case Study 5-2 demonstrates how a simple eye issue can have an impact on ADLs for older adults. Chronic vision changes, regardless of the cause, can affect driving, reading, watching television, working on a computer, and many sports activities.

Care Partner Strategies for Vision Barriers

Contrasting warm and cool colors should be used when creating visuals such as calendars, instructions, and signs with a contrasting dark print for reading messages. Overall eye movement and peripheral vision are reduced as well, and anything that can be a tripping point or low-level obstacle should be placed far from walking areas. The older adult may need larger print papers, books, or tablet screen print and icons. If vision is nearly gone, they may need auditory visual support, as seen in movies and books for the visually impaired, or talking computers. There is also value in being in direct line of sight while speaking, because they may be watching mouth movements and gestures to understand more clearly. Correct lighting for the task is important. Reading lamps are useful and special magnifying devices can be used to see something that has fine detail or smaller print.

Normal Aging Changes in Hearing

Hearing loss has a great impact on individuals' daily activities, relationships, socialization, psychological health, and quality of life. Work environments often rely on communication between people. Whether it is the employer and employees, therapist or doctor and patients, teacher and students, or clerk and customers, good communication is fundamental to working relationships. Some individuals who have difficulty hearing leave jobs because they feel they can no longer do their job or they become frustrated with the situation. People may feel embarrassed about having a hearing loss and do not want to address it with coworkers, family, or friends. Hearing loss also can put a strain on marital and familial relationships. If a spouse or family member continually repeats things, frustration and increased relational stress are likely to occur.

Certain levels of hearing loss are a safety risk, and attempting to guide the person by commands is significantly reduced. More visual communication with gestures and movements, and showing mouth movements, may be needed if vision is not impaired. If hearing loss is severe, there may be a need for warning lights or alarms. Some environmental noises are important for safety and need to be heard. For example, a tornado siren warning people to take cover may sound like a soft noise in the background or may not be heard and should trigger a light instead. Another example involves pedestrian safety in which the sound of an approaching car may not be heard when an individual is crossing the street. These sounds provide important information regarding the surrounding environment and influence choices people make.

Being able to understand conversation over the phone is one of the most difficult situations for individuals with hearing loss because it increases the barriers to those they had frequent contacts with in the past. When communicating over the phone, there are no visual cues to help the person fill in what he or she cannot hear as one could if the conversation took place face to face. Social situations also may be avoided. Restaurants, parties, meetings, and family celebrations are just a few social situations in which there are multiple competing sounds. If there is music or television playing in the background or multiple people talking, it makes it more difficult for the person to hear and understand conversations.

Persons with hearing loss may experience *depression*, loneliness, and decreased quality of life (Ayalon et al., 2006). In addition, hearing loss has been shown to have a negative impact on cognitive functioning and it increases the risk of dementia (Oyler, 2012).

Like vision, hearing declines as people age. Normal hearing loss in older adults begins with the inability to hear higher frequencies. Microscopic hair cells within the cochlea (inner ear) detect frequencies from sound waves and then send signals to the brain. The hair cells that detect high *frequencies* (6,000 and 8,000 hertz [Hz]) are the most vulnerable to damage. With age, these higher frequency hair cells deteriorate and lose their function. They cannot be repaired nor do new hair cells grow back; this is called *presbycusis* and is permanent (Lin, 2012). As hearing loss progresses and moves to speech frequencies from various forms of damage or very old age, the person ends up with much more serious health issues. The most common complaint from someone with progressive presbycusis is that the person can hear but does not understand what was said (Norrix & Harris, 2008). As damage begins to affect the speech frequencies of 500, 1,000, 2,000, 3,000, and 4,000 Hz,

several speech consonants are not heard (p, t, k, f, s, th, sh, ch) because they are produced at 4,000 to 6,000 Hz and are a low-intensity sound. The loss of these specific tones can greatly affect the meaning of words being heard. Older adults are affected by more than not hearing a word; they do not understand what you are trying to say. When all the frequencies of a word are not present, the word does not sound like a true word. People with progressive presbycusis affecting speech frequencies often claim that the speaker is mumbling. At some point, the ability to understand speech, listen to music, and hear environmental noises is seriously impaired (Norrix & Harris, 2008).

One in three adults ages 60 years and older and one in two adults over the age of 85 are reported to have some level of hearing loss. There are estimates of 26.7 to 35 million U.S. adults with hearing impairment, but less than 15% use hearing aids to assist in their hearing (Hear-it, n.d.; Lin, 2012). Fortunately, the speech frequencies (500–4,000 Hz) are not significantly lost in normal aging until much later in life. One can expect mild losses in 28% of older adults (Dalton et al., 2002). Dalton et al. also studied the impact on ADLs in older adults who had hearing loss and found 24% of the 2,688 subjects tested had moderate to severe hearing loss that also affected speech frequencies, and this group had significantly impaired ADLs. Assuming Dalton's research can be generalized even further, one should expect to see moderate to severe hearing loss in 24% of the older adult population that will worsen over time. Such losses will need care partners and family members to assist with ADLs.

Tinnitus is also fairly common in older individuals. This is a continual, abnormal sound in one or both ears and is similar to the internal noise one hears after being exposed to loud sounds, such as at a concert. Tinnitus is generally caused by some mild hearing loss and can be extremely annoying to the person. For some individuals, the symptoms are temporary, but others may experience this long-term (Vorvick & Schwarz, 2011). In some cases, it interferes with being able to adequately hear speech or go to sleep easily. It can appear louder if persons are in a quiet place or when they turns their head into the pillow and try to sleep. Early mornings may be very problematic, as the person is in a quiet time, but the sound seems extremely loud. Other sounds may override the tinnitus, or, during very busy activities, the brain will ignore the ringing, so it appears to come and go. There are medical specialties that state they can do something for tinnitus, and others state it is best just to learn to live with it.

Hearing loss can be more progressive and more serious as a result of various factors: excessive noise, diseases such as measles, trauma, medications that are ototoxic, and genetic predispositions. Obtaining a very complete health history is key to starting the assessment process for what is causing hearing loss. Was the loss caused by a conductive process, a sensorineural issue, or both?

Care Partner Interventions for Hearing Impairments

Most care partners think of *hearing aids* to amplify the speech frequencies when considering interventions. There are many devices with varying costs, and they are effective only if used. Older adults have a host of reasons why they may not be using the devices even if they have them. Some parts may be lost, the older adult does not like the negative side effects with certain devices, and the devices require management and cleaning. If hearing aids are not a viable option due to financial constraints or noncompliance from the patient, there are *personal amplification devices* that can aid in hearing and are less expensive. These not only amplify the speaker's message but also reduce *background noise* if they are the right type of device.

Ferguson (2012) found that persons who use clear vowel pronunciation, could be understood more easily by older adults with hearing loss. Unfortunately, it is challenging for those with moderate to severe hearing loss to understand foreign accents, strong English dialects, and those who speak rapidly. It would be important to use a second form of communication to augment the verbal speech, such as writing, using pictures, or speaking in a native language if possible. In addition, there is value in looking at these individuals directly so they can augment their hearing with some lip reading that may have been learned over time, even though these persons may not know this is a skill they were developing.

When using hearing devices, place them on correctly and make sure they are working properly before having a conversation that is important or you are expecting the patient to understand. You may need access to spare batteries, ensure proper prong insertion, and adjust to the right sound level.

As the aging process progresses, many elders move to what they know and trust the most—music from their past and common sounds from their generational life experience, such as religious music and old movies. Past familiar sounds become more important, and with headphones and music, they have the opportunity to go to something they can hear and remember well. One of our best gifts could be music from their past that has enough sound quality to make up for high frequency losses. Today, we have background noise–reducing headphones, which may be excellent for the older adult or those in their end-of-life, as presented in the next vignette. **Case Study 5-3** gives an example of how special noise-reducing headphones made a dying woman comfortable during a very painful night.

BOX 5-1   Research Highlight

Aim: *The researcher wished to examine the range of variability for vowel intelligibility among talkers during clear versus conversational speech for older adults with hearing loss.*

Ferguson sought to study the impact of speech perceptions, namely, those associated with vowel sounds, on the interpretation of speech by older adults with hearing loss. The researcher sought to discover whether the clarity of speech that benefits those with normal hearing would also be of benefit to those with auditory limitations. Sign into your database of nursing literature (CINAHL or PubMed, for example) and use the citation below to perform a search for this article. What were the results of this study? What did Ferguson conclude? How can these findings help caregivers and the older adults they care for?

Ferguson, S. H. (2012). Talker differences in clear and conversational speech: Vowel intelligibility for older adults with hearing loss. *Journal of Speech, Language, and Hearing Research, 55*(3), 779–790.

Case Study 5–3

I went to see my mother, who was 93 and in her last stage of life: cardiac ejection fracture less than 30%, legs completely edematous and oozing with open sores, and in severe pain with every movement. I assisted her throughout the night and called the hospice nurse for more medication so she could sleep. I had my noise blocking headphones from my flight to her care center and I had music that I knew she liked on my smart phone. I put the head phones on her and played Whispering Hope by Phil Coulter (https://youtu .be/3t3_yWQH1Go), which I knew she loved to sing. Her face relaxed, and her fidgeting stopped for several minutes as she listened. Julie was exhausted and tired and then would fall asleep for short periods. As she awoke, I played another song by Phil Coulter https://youtu.be/-8MmeVhkMv8 and she continued to rest for 10 more minutes—it seemed longer as she relaxed and had peace on her face.

Later that morning she was not able to do much except struggle for pain relief, which the nurse supported with oral medication. I read from her large print Bible, and sang softly in her ear as her breathing changed and finally stopped.

Physical Limitations

Physical abilities can decrease dramatically in a short period of time. The age when such physical limitations are noticed may be different for everyone. An older adult may say, "Oh, I have been doing this for years. I can garden and keep the house clean by myself. I don't need help." The following year this individual may want to move to a place without yard work, no stairs, no snow shoveling, and no gardening. Physical ability seems to have a mind of its own, and sometimes the denial of this change can result in an injury. Take time right now to view the personal stories of some older adults and how they stay fit. These YouTube video links are listed in the resources at the end of the chapter.

Dual Sensory Impairment

Dual sensory impairment is when one experiences a loss in two or more sensory functions. Research indicates that 21% of individuals over the age of 70 experience dual sensory impairment. As age increases, the prevalence increases. This has a significant effect on functioning and overall quality of life. One system is unable to compensate for the impaired system, because both are impaired. For example, if only a hearing loss is present, then information can be given in written form to help compensate for the hearing loss, or if vision is impaired, the individual relies on auditory input for communication. When both hearing and vision are impaired, it is more difficult for the message to be received. It has been predicted that this dual impact has a greater effect on quality of life and function compared to a single impairment (Saunders & Echt, 2011), which seem to make sense on a practical level with decreased ability to experience life or communicate.

Although it is difficult to find research on multiple sensory impairment, there is research on the *vascular-depression-dementia* connection. If there is a vascular blockage, especially in the frontostriatal brain, it can cause a dementia that also brings on depression symptoms (Barry & Byers, 2016). We still have much to learn regarding complex cases having multiple sensory and cognitive losses.

External Barriers and Interventions

Environmental Noise

The environment has been called a place of healing or a place that can increase disease. Florence Nightingale's nursing model centered around creating healthy environments so patients could heal (Nightingale, [1859], 1969). Nursing and hospital architects have been concerned about the patient's environment for some time, utilizing different construction strategies aimed at healing environments (Malkin, 1992).

Power of Choice

Balchik (2002) identified many environmental strategies that could be applied to hospitals to improve patient healing. A key component is the ability of the individual to control their lighting, room temperature, privacy, visitors and visitor exposure, type and volume of music played, and the timing and types of meals provided. She states, "It has been demonstrated that in all settings—not just hospitals—feeling as if we have control over our own environment reduces our stress. When we know we have options, even in the most minimal sense, we feel better" (p. 10). Power (2010) offers a way to give choice for those suffering from dementia, by creating options of choice versus commands to eat. He suggests "Pointing to the food on a plate and asking, 'What would you like to try first?'" (p. 93). This allows for a choice that everyone can find acceptable without a *telling* approach being used.

Physical Environment

Combining personal control with the physical environment makes the environment even better. Architects are putting in water fountains, fish aquariums, soft music, garden views, and interactive works of art as a part of healthcare environment construction (Malkin, 1992). Part of the Hospital Consumer Assessment of Healthcare

Providers and Systems (HCAHPS) quality strategy for patients in hospitals is to reduce noise for patients (Zusman, 2012), which is often a major complaint by those who are trying to sleep. Living environments for the elderly are discussed in detail by authors specializing in elder care. Power (2010) provides research and guidance on lighting (ambient, targeted, and natural), glare prevention, floor space, noise control, comfort of the chairs and bed, privacy areas, and asking care partners to experience the environment exactly as the residents do. Powers presents a story in which a resident was falling repeatedly every night for days. The nurse reviewed the medications and staff talked to the resident about her need for using the rest room and pain management or if she was hungry. They could not find anything that was causing this resident to leave her bed each night, and the resident was not sure why she felt the need to get out of the bed. One of the certified nursing assistants (CNAs) working on the unit decided to lie in the place in which the resident would be sleeping. A glare came through the door and hit her directly in the eyes. After removing this glaring light, the falls stopped. Sometimes there is value in putting ourselves in the place of the older adult to see if we are affected by something they find problematic.

Most older adults think normal room temperatures are too cold as their metabolism slows with age. This is a common concern for the elderly and should be monitored closely. If the environment is not easily adjusted, care partners may need to provide sweaters or more blankets when the resident is sleeping or resting.

Cultural Shifts in Living Environment

There are programs that have changed the entire culture of an elderly living residence. One such program is the *Eden Alternative*. These facilities use a different language, the naming of living areas having street names; words are selected with positive intent, with *behavior problems* becoming *behavior expressions*; and the idea of *care partners* versus *caregiver* is supported (Powers, 2010), which has been used throughout this chapter. In Eden facilities, "words make worlds" (p. 82). The Eden Alternative Golden Rule is, "as management does unto staff, so shall staff do unto the elders" (p. 52). There is little argument against the value of healing environments, but there certainly is a resistance to making such changes.

A person's home seems to be a key place for healing without the risk of hospital-acquired infections or excessive noise found in many hospitals today. There is an attempt to keep the elderly in their homes as long as possible and to offer necessary care in their familiar surroundings. Power (2010) describes this as the "death of the nursing home—aging in community" (p. 121). There are many levels of community involvement that might be used: family members, church family, helpful neighbors, healthcare aids, and assisted living facilities. The movement for Program[s] of All-Inclusive Care for the Elderly (PACE), or Naturally Occurring Retirement Communit[ies] (NORC) is driven by community standards and not insurance or regulatory requirements (Power). The home has advantages and disadvantages. The risks associated with staying home are being unsafe with the stove or electrical devices, falling, and various injuries from utensils or home equipment. Many older adults have neighbors who can check on them daily, have *Meals-on-Wheels* food delivery, or can wear an emergency alert button around their neck if they cannot reach a phone. These are useful services for those staying at home.

The home environment has some unique issues that are both positive and very dangerous. The positive comes from the older adult being familiar with how things operate, and they often have high levels of control on what the environment is like. However, there is a serious abuse of the older adult coming from scam letters, phone calls, and easy television purchasing, if they have a credit card. Alves and Wilson (2008), identify the older adult as being much more vulnerable to scam strategies by telemarketers or phone solicitors. A high level of loneliness may exist, and these phone and mail racketeers can remember names, wish them a personal good day, chat as if they are old friends, and then ask for various forms of money or sell a host of services or products the person does not need. Some are so convincing they are able to obtain checking account access or credit card numbers (**Case Study 5-4**).

Stories like Norma's are very common. There is an entire network of scam systems in place to take advantage of the older adult living alone, and making important changes are difficult for the family members to control.

Case Study 5-4

Norma, age 82, was living alone in her home, where she would receive two to four calls per day and 20 solicitation pieces of mail per week. She purchased special journals that were cheaply copied papers full of conspiracy theories, and would donate monthly for those publishing the journal in order to have her views go toward governmental change. The organizations were fake, and the addresses were post office box numbers.

Some of the money requests were tailored to her religious views that were obtained during phone calls. She would put cash in 4 or 5 envelops per week supporting different issues. Her son, who came to stay with her after a hip surgery, was concerned she was giving away hundreds of dollars every 2 weeks and wanted to stop mailing the envelops. After he left her house, the process continued, with Norma overdrawing her checking account twice by over $400 each time. In her mind, the bank had to be taking her money, but in reality she was giving it away. This process continued until she was 91 years old and was finally told she would need assistance with her checking account and finances. In addition, her phone was changed to an unlisted number. Yes, these changes created an angry Norma, who felt a lack of control as she was spiraling into deeper debt. When talking to her about these changes, Norma was told the person writing the checks would let her know how much money she had after she paid her bills first. Then some funds were put in a safe place and other money was given to Norma each month to spend on her choice of programs and vitamins she thought were helpful. She could choose to save it or spend it. Her vitamin orders were rationed with no more overstocked inventories. Her bills were then covered and eventually paid off. All her friends were notified of the phone number change, but she really missed the calls and complained of being more alone. The family was asked to call her more often and to let her talk even if they were listening to the same stories week after week. Giving some choice, but taking away risk, is a hard balancing act and was not easy to navigate.

Language for Improving Communication with Older Adults

The diversity of issues presented by older adults, and the demands on the time for the care partner, make effective communication very challenging. However, tools are available that can assist in most cases, starting with building trust.

Building Trust and Respect

Verbal strategies that support communication include addressing the older adult by name, listening and responding on topic or guiding the conversation back to a topic, reflecting on feelings, while holding space for delusions, paranoia, repeated stories, and attacking language. Buffering oneself and learning not to take attacks as something that has to be responded to is a critical behavioral outcome for those working with some older adults. Care partners are more likely to build trust in chaotic situations if they remain calm, do not have an emotional response to an attack, and are able to smoothly move the patient back to the topic at hand. Trust and respect continue to be built as the care partner continues to address and monitor communication tools and avoid elderspeak.

Avoiding elderspeak. Nurses are typically younger than older adult patients, creating an intergenerational relationship when it comes to communication. Society has adopted negative stereotypes of aging with beliefs that older adults are less competent at communication as well as in other functional areas. Because of this, younger persons often modify their speech when they talk to older adults. Modifications include simplification in which care partners reduce the complexity of a statement or use fragmented sentences. In some cases, these healthcare partners use clarification strategies, which include adding repetitions, stressing certain words, or altering the pitch of one's speech. The end result is speech that is overly caring or controlling and less respectful than normal adult-to-adult speech. This type of speech has been called *elderspeak* and is widespread in community and elder-care settings. Elderspeak is similar to *babytalk*, which has been documented to sound the same as that used by those who work in day care and are speaking to children (Caporael, 1981). Common features of elderspeak include terms of endearment (e.g., "honey," "dearie," and "sweetie") and tag questions that prompt the older adult to respond as the younger person wishes. Examples of elderspeak include:

"You're ready for lunch now, aren't you?" (controlling and not a real question)

"Honey, you can do this, and be a good girl." (terms of endearment)

"Let's go take our bath now." (inappropriate)

The *Communication Predicament of Aging Model* describes how speech modifications occur and lead to negative outcomes for older adults (Ryan, Hummert, & Boich, 1995). Aging individuals who receive elderspeak messages may recognize they are being talked down to and respond by withdrawing from engagement in such patronizing conversations, or they may suffer increased depression or decreased self-esteem. Older adults also may respond by enacting behaviors consistent with their own negative stereotypes of a frail elder and may avoid self-care activities.

Pay attention to the nonverbal. It is important to note that healthcare providers have had a long history with effective and ineffective communication patterns with patients and residents. *Nonverbal communication* is more powerful than verbal messages (Satir, 1967). Powers (2010), continues this theme and states,

> Only about 7% of the meaning we glean is communicated through the words themselves. Another 38% is paralinguistic, meaning that it is a function of how the words are spoken—the tone and inflection of the voice. The remaining 55% comes from facial expression and body language [non-verbal]. (p. 105)

Unfortunately, not all care partners are aware of the nonverbal messages they are sending.

Many messages and conversations are not really useful for the patient or resident, but are really a desire by the healthcare provider to get tasks completed and move on.

Partnering communication. Person-centered communication is an integral part of person-centered care and reflects a focus on the patients and their unique perceptions and experiences with health and illness. A key approach to this type of care is to partner with patients and meet them at eye level. Nursing interventions include providing information to promote health and healing and to engage patients in self-care or in more compliant behaviors. Person-centered care includes methods that build trust and respect. Various methods can be used; one example is the 5Ps *Partnering Communication Model* when establishing a relationship with the patient (Ondrejka, 2014). The 5Ps method provides a unique example of person-centered care that builds trust and respect in any setting, but has been built for in-patient care settings originally. Ondrejka presents this model as a partnering dialogue that states the following:

1. Tell the [patient] your name and your role as you sit at eye level.
2. Ask the patient his or her priorities for the day so you can assist him or her in meeting these goals.
3. Let the patient know what your practice needs are during your shift and look at integrating your needs and the patient's needs for the day.
4. Put your name, contact number [how to reach you], and partnered goals on the whiteboard [or other visible area].

5. Continue with the five Ps:
   a. You did **partnering** already
   b. Ask about the restroom needs—**potty**
   c. Obtain a **pain** assessment
   d. Make **positioning** adjustments.
   e. Check the **pump(s)** to reduce potential noise distractions.
6. Address pain or your first assessment of the day and do both soon.
7. Before leaving, ask if there is anything he or she needs before you leave to finish your regular rounds. (p. 42)

Partnering communication involves a person-centered approach such as the 5Ps, being respectful, and being flexible to accomplish all that is needed for the patient. It allows patients to participate in their own care as well as partnering with them for the care they must provide to the patient.

Use person-first language. When referring to the patient, regardless of whether the patient is present, use *person-first language.* This stresses the person as an individual who has some condition or disease instead the condition or disease as a defining factor of the individual. For example, say or write *person with dementia* instead of dementia or demented patient and a *person with hearing loss,* not a hearing-impaired person. This communicates respect for the individual.

Include the patient. In some situations, family members and caregivers speak as if the person being talked about is not in the room. Be sure to include the individual in the conversation. If conversations are taking place with the patient in the room, speak as though the person can understand you. Do not have conversations about the person in front the person and not include him or her, especially if you say something that might be hurtful or embarrassing to the person (e.g., *she does not remember anything anymore).*

Speak slower and pause between phrases. Slowing the rate at which you speak allows you to speak more clearly and provides distinct separation of words for better comprehension. Pause time between sentences allows for older adults whose retrieval and processing has decreased in speed to process and respond. This helps individuals with hearing loss as well.

Provide additional time for the person to respond. After asking a question or making a comment that you expect a response to, wait 5 to 10 seconds for a response. Processing time slows in adults with and without pathological conditions, so providing additional time allows the person to process what was said, plan what to say, and then provide an oral or written response.

Simplify vocabulary and avoid jargon. Try to use language that is easy to understand; refrain from using slang and medical jargon, especially. Watch to see if the person understands what you are saying. If you think the person did not understand or the person says that he or she does not understand, rephrase your sentence.

Use short, direct, clear phrases. Comprehension of complex sentences becomes more difficult as people age. Use short phrases, but remember to still use respectful language. Limit instructions to one or two steps at a time. Using short, clear phrases may help reduce the number of times you repeat the information. If the person forgets the topic being discussed, summarize what has been said to help guide the person back into the conversation

Use appropriate touch to communicate. Some individuals have difficulty with attention and alertness due to cognitive issues, medication side effects, and/or medical health problems. Gently touch the person on the hand, shoulder, arm, or leg to help gain his or her attention. If you start speaking when the person is not attending, you will likely have to repeat your message.

Speak in the direction of the person. Make sure you are in the same room and are looking at the individual. This will help the person prepare to listen. Being in the same room eliminates an environmental barrier, as talking to a person in another room or across the room leads to a reduced speech signal to the listener.

Speak into the ear with less or no hearing loss. For those who have hearing impairments, be sure look in their charts for information about their hearing. If one ear has better hearing, position yourself so that you are speaking in the direction of that ear.

Write out information. If the person does not understand you, write down key words, phrases, or sentences so the person can read the information. This will help ensure that the message is clearly communicated.

Provide written information in large, easy-to-read print. For individuals who have difficulty seeing written text, make sure that text is in an easy-to-read, large font. Stick to high-contrasting colors (e.g., black ink on white paper) and avoid using blue and green ink.

Request clarification. If you did not understand the intent of the person's message, ask questions that help to clarify. Another option is to say what you think was said and ask the person if you understood correctly.

Encourage use of clues. There are times when we all struggle with finding the word we want to say. Because this typically occurs more often in older adults, encourage them to provide clues so you can then guess the word. For example, you should suggest they describe appearance, function, and/or location.

Eliminate or minimize background noise. Additional sounds compete with the speech sounds, making it more difficult to determine what was said. Music, television, and other conversations all make it more difficult to attend to the conversation at hand.

Limit the number of speakers. Typically, group settings and social events have numerous people speaking at the same time or rapidly taking turns. This requires quick processing to be able to understand and keep up with the conversation. Because older adults are slower to process and respond to the information, it is best to limit the number of people speaking. This is less cognitively demanding for the individual.

Position yourself in the person's direct line of vision. This will let the person know that you are engaging in communication with him or her. Also, it provides visual information about what is being said. The person will be able to look at your lips and perhaps fill in what he or she does not understand simply by hearing. If understanding of nonverbal communication is still intact, positioning yourself in front of the person will allow for him or her to tune into nonverbal communication (posture, facial expressions, gestures). Another element to keep in the mind is lighting. Be sure there is adequate lighting so the person can see you. Individuals with vision impairments often require more lighting than those without vision issues.

Use gestures to aid in communication. Gestures help clarify the message when perhaps not all of it was understood. Pointing and demonstrating actions may aid understanding.

Say names. Say the person's name before providing instructions to get his or her attention. If memory is an issue, state your name as you enter the room so that the person does not have to guess who you are. When possible, use proper names instead of pronouns.

Make sure any assistive devices are on and working. This includes hearing aids and other assistive listening devices. If the person needs glasses to see, make sure the person has easy access to them. If the person has difficulty hearing, ask the person to wear his or her hearing aids or properly place hearing aids before speaking.

Using the Communication Enhancement Model

The *Communication Enhancement Model* (Ryan, Meredith, Maclean, & Orange, 1995) provides direction for effective healthcare–provider communication. This model directs the younger adult healthcare provider to make an individualized assessment of the communication abilities of each older adult and modify speech

only as needed to support effective communication with that individual. For example, many younger adults assume that all older adults have hearing loss and speak loudly and slowly to all elders. For older adults with intact hearing, excessively loud and high-pitched speech can be distorted and make it harder for them to understand.

There are two types of strategies to help with communication issues: compensatory and restorative. *Compensatory strategies* focus on providing mechanisms to assist the person with the physical or neurological impairment. Several types of compensatory strategies are used with older adults, such as adapting the environment, using relational communication, and adding technological devices or memory aids. *Restorative strategies* address rebuilding the patient's skills that are currently impaired. A man with nonfluent aphasia might start to focus on saying common single words to help communicate his wants and needs. As his ability to say these words increases, more words are taught. In most cases, a person needs to be assessed by a speech–language pathologist to determine appropriate evidence-based strategies to implement during this restorative phase.

Regulatory Communication Goals for Older Adults

Communication is an integral part of quality health care, as identified by the Institute of Medicine (2001) report. A key to quality includes *patient-centered communication* as a key characteristic of quality health care. Patient-centered communication is a very complex issue with many forces at play. Healthcare providers have struggled to show any improvements in their communication scores with patients until just recently. Dimensions of patient centeredness include respect for patient values, preferences, and expressed needs, along with a focus on information, communication, and education of patients using terms they would understand. Is it possible that improving communication with older adults is only being implemented part of the time or may be ignored by healthcare providers for various reasons? Consistent and effective communication between patient and clinician has been associated with improved patient satisfaction, safety, better health outcomes, and lower healthcare costs. In contrast, communication breakdown has been implicated in healthcare disparities and medical errors. Professional standards include respectful and effective communication as key factors in informed consent and a trusting relationship (Paget et al., 2011). We must ask ourselves if there are some barriers for healthcare providers, as the outcomes that were expected did not occur until just recently and after *HCHAPS surveys* and *Pay-for-Performance* were implemented under the Affordable Health Care for America Act of 2010 (Schimpff, 2012; Zusman, 2012).

Communication is essential for the giving and receiving of information and the exchange of ideas, thoughts, and feelings. We communicate to exchange information and meet our physical, social, and emotional needs, as well as to meet the needs of others. The Joint Commission on American Hospitals has recognized and mandated attention be placed on effective communication in healthcare settings to prevent errors and safety issues (Joint Commission, 2014). Research indicates that older adults who have a positive relationship to nurses state they are also highly satisfied with their care and the nurses who work with them. In addition, this positive relationship between the patient and nurse provides higher levels of job satisfaction for the nurses (Grau, Chandler, & Saunders, 1995; Parsons, Simmons, Penn, & Furlough, 2002). It is apparent that we need to have compassionate, patient-centered communication that builds trust and mutual respect. However, it is not always that easy to accomplish with communication being so complex.

Communicating with Families and Significant Others

Care partners can support family members caring for older adults by assisting them to overcome communication barriers as they occur. Healthcare providers must be aware of the need to include the older adult in communication regarding health matters as much as possible and then include family members as appropriate. Permission to communicate about the patient's health condition with family and significant others is a key privacy issue that

may be complicated. Ensure the patient is willing to have this information passed on, or encourage the patient to give this information to the family himself or herself.

Care partners also can help significant others to understand their role in caregiving as well as their need to recognize stress they may encounter. Be ready to explain what resources are available to aid the significant other in providing care. Nurses frequently counsel family caregivers, make referrals for resources such as respite care, and serve as role models for care partner communication practices. If this is not your skill set, have the name of someone who can offer such assistance.

Quick Intervention Table

The content in this chapter has focused on the importance of communication. Many older adults may have significant sensory or cognitive impairments that affect their ability to communicate, and care partners can use the techniques discussed in this chapter to facilitate appropriate communication. Health literacy should also be taken into account when planning teaching or providing educational materials. By choosing the most applicable strategies for information exchange, care partners can positively influence the communication process with older adults.

Table 5-2 is a quick tool describing what you can do to be an effective communicator with many older adults having significant communication barriers. Use it wisely and where it fits the patient's needs. Avoid the many traps and myths about working with older adults presented in this chapter. Greet and treat everyone like you would like them to connect to you.

TABLE 5-2 Strategies for Effective Communication with Persons with Vision, Hearing, Cognitive, and/or Speech–Language Impairments	
Impairment Type	**Communication Strategies**
Vision	• Use person-first language • Include the patient • Provide written information in large, easy to read print • Position yourself in the person's direct line of vision • Make sure glasses or contacts are worn • Use relational connections and partner with the patient
Hearing	• Use person-first language • Use slower speaking rate and pause between phrases • Include the patient and ask if you are speaking loud enough • Provide additional time for the person to respond • Summarize • Speak into the ear with less hearing loss • Write out information • Eliminate or minimize background noise • Limit the number of speakers in the room • Position yourself in the person's direct line of vision • Make sure the hearing aid(s) or assistive listening device is on and working • Say the person's name • Use touch to gain attention • Use relational connections and partner with the patient

(continues)

TABLE 5-2　Strategies for Effective Communication with Persons with Vision, Hearing, Cognitive, and/or Speech–Language Impairments (*continued*)	
Impairment Type	**Communication Strategies**
Cognition	• Use person-first language • Use slower speaking rate and pause between phrases • Include the patient • Provide additional time for the person to respond • Simplify vocabulary and avoid jargon • Summarize • Write out information • Eliminate or minimize background noise • Limit the number of speakers in the room • Say the person's name • Encourage use of clues for word-finding difficulty • Use touch to communicate or to gain attention • Request clarification • Use relational connections and be calm and nonreactive, partner with the patient
Speech and language	• Use person-first language • Use slower speaking rate and pause between phrases • Include the patient • Provide additional time for the person to respond • Simplify vocabulary and avoid jargon • Summarize • Write out information • Eliminate or minimize background noise • Limit the number of speakers in the room • Position yourself in the person's direct line of vision • Make sure the assistive devices are on and working • Say the person's name • Encourage use of clues for word-finding • Request clarification • Use relational connections and partner with the patient

Teaching Older Adults and Their Families

Older adults may have unique physical, psychological, or cognitive limitations that affect learning ability similar to how these same limitations affect speech and communication. The American Nurses Association (ANA) in collaboration with the National Gerontological Nursing Association developed the document *Gerontological Nursing: Scope and Standards of Practice* (ANA, 2010), which identifies a standard requiring nurses working with older adults to include health education of patients and their families. This is not always an easy task as the nurses may be confronted with a host of barriers on the part of the patient, their partners, or family members.

As a quick reminder, **Box 5-2** lists some of the areas that will challenge the older adult in the effort to become educated or to learn some type of health advice from their care partners.

Care partners would need specialized training to teach older adults having many of the barriers presented. However, there is knowledge that can support best teaching strategies for various educational and health needs. These same methods also can be used for the patient's partners or family members when needed.

> **BOX 5-2   Physical, Psychological, and Cognition Changes Impacting Learning**
>
> - Impaired vision, hearing, and speech
> - Literacy level
> - Multidimensional motor sequence impairment
> - Decreased reflexes, tremor, muscle weakness
> - Chronic illness or pain
> - Cognitive and memory changes and losses
> - Fear, anxiety, and confusion
> - Reality disturbances and hallucinations
> - Depression
> - Culture and habitual patterns of living

Theory of Adult Learning

Knowles (1973) provided well-known principles for addressing the way adults are motivated and prefer to learn. He is attributed with coining the term *andragogy* in the early 1970s and provided six principles that distinguish it from *pedagogy* used for younger learners with these principles being refined over time. More recently they have been described as:

> Adults need to know why they need to learn something before learning it.

> The self-concept of adults is heavily dependent on a move toward self-direction.

> Prior experience of the learner provides a rich resource for learning.

> Adults typically become ready to learn when they experience a need to cope with a life situation or perform a task.

> Adults' orientation to learning is life-centered; education is a process of developing increased competency levels to achieve their full potential.

> The motivation for adult learners is internal rather than external. (Knowles, Holton, & Swanson, 2005, p. 159)

The idea that andragogy principles need to be flexible has been emphasized in more recent years, as there are many factors affecting the various learners that change the teaching methods. "It seems clear that Knowles always knew, and then confirmed through use, that andragogy could be utilized in many different ways and would have to be adapted to fit individual situations" (Knowles et al., p. 147). The patient variances could be situational or individual, and each person has different strengths and weaknesses for learning new things. Older adults are just like any other adults in that they have situational and personal attributes for learning that vary in many ways to include specific barriers to learning presented in Box 5-2.

CLINICAL TIP

The good teacher tailors each teaching session to the learner's internal abilities to learn and then integrates this with the teaching method being used.

Gerogogy in Transition

John (1988) presented some of the first ideas on what it takes to have a teaching method for the older adult. He defined *gerogogy* as "the process involved in stimulating and helping older persons to learn" (p. 12). It has more recently been described as an art and a science of using teaching strategies that lead older adults to higher levels of empowerment and emancipation (Formosa, 2002; Thomas, 2007).

CLINICAL TIP

Gerogogy is the process of stimulating and helping older persons to learn (John, 1988, p. 12).

Categorizing Diverse Learners

Hunt (2013) suggests using Felder's historical categories for teaching to the type of learner the person is: visual, sensing, inductive/deductive, active, and sequential, which may be useful for those without impairments. In reality, the care partner may need to switch the typical learner preference with an alternative when there is a specific barrier. Visual learners who cannot see well may be able to complement their learning by active learning and touching things that would be looked at only in the past. Capitalizing on the patients' most functional senses is a great resource for teaching older adults. There may be more difficulty in assessing other forms of learning styles, and it is easier to connect to broader generalizations identified by surveys of older adults (American Association for Retired Persons [AARP], 2000) and exploring more universal highly effective teaching methods. Strategies for teaching older adults appear in **Boxes 5-3** and **5-4**.

Use a Relational Approach to Teaching

Many assume that humans are persuaded by rational approaches to decision making. This assumption has been challenged for years (Pilkington, 1997). Our real challenge is to see what others think they are seeing.

Building a *relational communication* approach to patients in clinical or teaching settings means connecting to the patients and integrating their perspective in a life-giving and caring way. This approach also has been called *biogenic* (Watson, 2008) and described as a connection that is life giving and life receiving. Ondrejka (2014) describes *relational teaching* as having many levels, from a toxic to a powerfully life-sustaining relationship; the

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BOX 5-3   Preparing a Short Educational Program for Older Adults and Families

1. Assure that the goal of the presentation is to provide information that the group is interested in. Work with the facility to be certain that the date and time of the presentation does not interfere with other regularly planned activities.
2. If the program being presented is for a regularly scheduled support group for elders with chronic disease and their families, make sure that the information is specific to the needs of the group. For example, if the session is about coping with COPD, assure that the content is specific to the needs of the elder (medications, activity, oxygen use) as well as the family in assisting them to cope with the challenges that the disease presents.
3. The information presented should be relevant to the group both in content and format. Ask older adults who may attend what topics they are interested in and want to know more about.
4. The more current research done on the subject, the more comfortable the presenter will be. If a health-related topic, assure application of the principles of health literacy.
5. For the program itself, employ strategies appropriate to teaching older adults (Box 5-4).
6. Plan at least one interactive activity to increase group participation; this can aid in overall understanding of the presented material.
7. Intersperse questions throughout the class to:
   a. Evaluate understanding by learners and allow changes in presentation.
   b. Allow learners to feel connected to the presentation by answering questions and making them feel that each question is important and will add to the material already presented.
   c. Encourage participants to share their personal stories, as this will make the presentation more realistic to those participants.
8. Be flexible. Allow extra break time if needed and plan to stay after the program to answer individual questions as necessary.

BOX 5-4 Strategies for Teaching Older Adults

Use the principles of adult learning theory.
- Assess readiness to learn
- Involve the audience in the presentation
- Draw the learners into the discussion
- Provide reasons for them to learn by pointing out the significance of the topic

Use multiple teaching modalities to keep the material interesting and maintain attention.
- PowerPoint slides
- DVDs
- Handouts, brochures, or pamphlets
- Posters
- Demonstration/samples
- Quizzes/games
- Social media, e.g., YouTube
- Internet Websites

Remember to accommodate any unusual physical needs.
- Avoid glare; control environmental temperature and noise level
- Use a microphone and speak slowly
- Face the audience as many elders lip read to fill in what they cannot hear

- Limit content to 30–40 minutes so questions can be answered
- Handouts should be in large font
- Make sure the room is large enough for the number of learners and their adaptive equipment
- If possible, have a helper to assist learners who need to leave for any reason or who come late

Make presentations elder-friendly
- Choose content that elders are interested in, such as advance directives, nutrition, heart health, medication safety, etc.
- Create a catchy title that will pique interest
- Use the principles of literacy and avoid "jargon" that may confuse the learner, but don't talk down to them. If you ask a few questions you should be able to judge the literacy level and speak at that level.
- Invite special speakers who are well known in the area to promote attendance.
- Provide a take-home item for all participants (e.g., handouts, pill organizers, etc.)

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latter takes a deep understanding of self on the part of the instructor. Freire (1998) was one of the great Brazilian education reformers, and states, "In short it is impossible to teach without a forged invented, and well-though-out capacity to *love*" (in Darder, 2002, p. 91). A similar view is also expressed by two great American educators, Nodding (2005) and Palmer (2007). Nodding even warns teachers that having knowledge of having a caring relationship is not enough,

> Knowledge alone is unlikely to establish a caring relationship. In fact a number of studies have shown that qualities such as 'counselor relationship' or 'teacher relationship' are only slightly correlated with multi-cultural knowledge. Knowing something about the other cultures is important and useful, but it is not sufficient to produce positive relationships. (p. 113)

Palmer continues to support a deeper inner awareness as a necessary component for the teacher and states,

> Good teachers possess a capacity for *connectedness*. They are able to weave a complex web of connections among themselves, their subjects, and their students so that students can learn to weave a world for themselves. . . . . The connections made by good teachers are held not in their methods but in their hearts—meaning heart in the ancient sense, as the place where intellect and emotion and spirit will converge in the human self. (p. 11)

A *relational teaching* approach has been described in detail by Ondrejka (2014) and expanded here for older adults who need to have *choice* (Balchik, 2002). In addition, older adults are more likely to comply when they have

compliance scaffolding (James, 2010) or there is connection from the request to something that is important for them or has personal meaning. The final step is show *care* and *acceptance* (Watson, 2008) from a *deep connectedness* of knowledge, feelings, passion, and spirit (Freire, 1998, cited in Darder, 2002; Nodding, 2005; Palmer 2007). The relational approach to teaching provides content, compassion, empathy, caring acceptance, and expresses this with a spirit of love for the older adult.

An example of a relational approach can be seen in a situation in which patients may think their medicine is poison and the care partners have been told they have no right to make the patient take this poison. The request to take medication becomes a teaching, effective communication and a challenging request for this person. A care partner who is avoiding a rationalizing approach might use this *relational* approach: "Mr. Hide *(dignity)*, I do care about you and what you think *(acceptance)*, and I know this medicine will help your heart be stronger *(teaching)* so you have energy to talk to your family when they come *(compliance scaffolding)*. That is why I think you should take the medicine *(request)*. Would you like to take it with water or juice *(choice)*?" [while holding his hand, or having a soft touch on the shoulder, *caring presence*]. Connection of these approaches can build trust and a positive relationship with patients so they are more likely to agree with you and there is a better clinical outcome.

Many care partners continue to use the rational approach. The rational approach might sound like this, "Mr. Hide, this medicine is not poison. The doctor wants you to take it so you will feel better, so please take the medicine." In this response, there is no caring acceptance, no scaffolding, and no choice imbedded in the message. It has a message that is factual but lacks a deeper connection that is needed to build to trust. It is important to remember that during times of patient frustration, delusion, or paranoia, rational conversations have very little value for compliance or teaching and in many cases can escalate to aggressive responses. James (2010) suggest, "part of our role is to try to get staff to empathize with the person's [patients] situation, to think what she might be thinking in that situation and to try to understand the reasons behind the challenging behavior" (p. 183). James thinks the deeper need for patients showing challenging behaviors is their need for respect, acceptance of feelings, and a way to sustain their dignity. Relational communication shows respect, does not argue, does not discount the patient's beliefs, builds on the relationship, and offers acceptable choices that still allow for compliance where needed. This same approach can be used for various types of teaching for the patient—especially those struggling with cognitive impairments.

Older Adults' Preferences on Teaching

The AARP Survey on Lifelong Learning (2000) provides teaching preferences desired by most older adults. They include the following:

> Methods that are easy to access, require small investments of time and money to get started, and allow learning to begin immediately
> Methods that are direct, hands-on experiences—putting hands on something, playing with it, listening to it, watching it, and thinking about it
> Newspapers, magazines, books, and journals are the most frequently used tools for gathering information (nontechnology driven).
> Methods that enable them to keep up with what's going on in the world, for their own spiritual or personal growth and/or for the simple joy of learning something new
> Subjects that will improve the quality of their lives, build on a current skill, or enable them to take better care of their health
> Ability to use what they have learned right away or in the near future

We can also examine the adult learning principles and adjust them to meet gerogogy methods as seen in building effective communication. A modified version to meet this need is as follows:

> Older adults need to know the teacher is providing information because they really care about them as a care partner.

> The self-concept of older adults is heavily dependent on a relationship that shows a partnership between them and the teacher.
> Prior experience of the learner provides a rich resource for learning.
> Older adults typically become ready to learn when they experience a need to cope with a life situation or if it supports more independence.
> Older adults' orientation to learning is life-sustaining, independence-promoting, and personal goal–oriented using resources, including technology, when needed.
> Older adults benefit by presentations that engage their functional senses using diverse and experiential learning methods in which there is engagement with objects and each other.
> Older adults need a simple reminder tool(s) for the critical content presented that does not require complex access. This is moving increasingly more to technology methods.

Technology for Older Adults' Lifelong Learning

Many think the older adult is more likely to reject technology, and this has been shown to be a myth. According to a 2008 Pew Internet Survey on older adults and use of the Internet, 70% of those ages 50–64 and 38% of adults 65 or older reported using the Internet. The fastest growing age group learning to use the Internet is those 55 and older. Madden (2010) found that social networking among Internet users 50 years of age and older nearly doubled between 2009 and 2010, so that now half of Internet users between the ages 50 and 64 and 26% of users age 65 and older use social networking sites. Older adults are more likely to use email than social networking, with 89% of adults 65 and over who use the Internet sending or receiving an email on a typical day. Additionally, "among Internet users ages 65 and older, 62% look for news online" (Madden, p. 4), with 34% doing so on a typical day. Older adults who were living with chronic disease used the Internet for blogging and participating in online health discussions. The process of aging may present challenges to older adults who wish to use computers to enhance learning, but it is clear that many older adults are embracing the use of computers and the Internet in some aspect of their lives. Advances in voice activation have led to computers that can send or receive messages verbally. Barriers to the use of computers and the Internet for older adults include the cost of computers and access to the Internet, concerns about being able to learn how to use a computer, and fears about privacy and security of computers and the Internet. Some of the challenges associated with the use of computer technology can be overcome (see **Table 5-3**). Chapter 21 provides a thorough discussion on technology and older adults.

Teaching Older Adults Using Technology

Wolfson, Cavanagh, and Kraiger (2013) offer specific strategies for older adults to promote higher levels of success with technology, as follows:

> Develop a structured and simple interface process
> Maintain feedback processes offering ways to make adjustments
> Be ready to assist the user in how he or she thinks through an issue and give guidance for decision making
> Integrate learning principles allowing for diverse ways of gaining information

The day has come when senior centers either have or will teach classes with titles such as *Getting Comfortable with Technology* as older adults are constantly being exposed to new technology. Older adults are seeing how some of their peers are staying connected to family members from a distance through technology and may want to connect in the same way. It is useful for older adults to have computer tablets with the following:

> Simple and consistent access keys
> Uncluttered screens without multiple apps
> A talking interface or problem-solving ques for a single social media platform

TABLE 5-3	Aging Alterations That Can Be Overcome Using Computer Technology	
Alteration	**Effect on Computer Use**	**Possible Solutions**
Decreased hearing	Sound from computer may not be heard	Use of external speakers and headphones to enhance sound
Decreased visual acuity	Need for bifocals or trifocals, viewing monitor size may be too small, alteration in light/color distinction due to glaucoma or cataracts	Adjust monitor tilt to decrease glare Get larger monitor Change size of font to 14 to 16 Adjust contrast to ensure clarity Adjust screen resolution to promote color contrast
Motor control or tremors Arthritis	May affect use of keyboard or control of mouse	Use "larger" mouse Use control arrows to move through text Purchase "touch screen" or voice-activated computer
Attention span	Inability to focus for extended periods and comprehend new informational subjects	Programs contain small modules of information Repetition of last concept in each new module Utilization of multimedia presentations (PowerPoint, streaming video, summary sheets)

Figure 5-1 Nurse teaching older patient to program his smart phone with a medication reminder.
Courtesy of Sergio Medina.

Figure 5-2 Nurse teaching older patient and her daughter about her chronic illness.
Courtesy of K. Steele.

These simple approaches could be just the right strategy, as suggested by the theories in the work of Wolfson et al. (2013). Keeping older adults from technology just because they appear confused at first may be short-sighted for care partners, family members, and the future of advancing older adult technology access (see **Figures 5-1** and **5-2**).

Additional Internet Resources for Teaching Older Adults

There are a variety of Internet resources for older adults who want to learn and stay connected (**Case Study 5-5**). **Box 5-5** provides a variety of choices.

Case Study 5–5

Marjorie Hanes is 70 years old. She always wanted to learn how to speak Spanish and enrolled in the local college, despite having a hearing impairment. She was enjoying her classes as she continued her responsibilities in her home, including caring for her husband who had hypertension. Unfortunately, her husband suffered a stroke and Ms. Hanes had to assume the responsibility of primary care partner, resulting in her withdrawing from college. She purchased some audiovisuals to help her practice Spanish. When her husband recovered from his stroke, Ms. Hanes was able to reenroll at the college; however, her hearing loss had become worse over time, which made it difficult to continue learning a language in class. Ms. Hanes decided to continue using books and audiotapes to learn Spanish, but she also had a new interest in plants and used educational programs on television to learn more about horticulture and working in her garden. These activities provided Ms. Hanes with educational activities in the home while she continued to care for her husband, who died 3 years later. After her husband's death, Ms. Hanes was feeling isolated and decided to go back to the college and continue her learning. She found a cohort of older adults who were also interested in continuing their education in a variety of ways. At this time, Ms. Hanes was enjoying art and took a class in art history—something she had always wanted to learn more about. Taking this class was not hindered by her hearing loss. She visited art galleries and was involved in group discussions that were led by class participants under supervision of the instructor. As an older adult, Ms. Hanes was engaged in a variety of learning experiences that changed over time because of circumstances in her life.

Consider the following regarding Ms. Hanes:

1. How has Ms. Hanes incorporated lifelong learning into her older years?
2. How has Ms. Hanes adapted to the challenges she has faced to overcome barriers and continue her lifelong learning?
3. How might technology have been used to help Ms. Hanes continue her learning when her husband became ill?
4. In your role as a nurse educator, what would you recommend to Ms. Hanes to enhance her education or to meet her lifelong learning needs?

BOX 5-5   Recommended Internet Resources for Teaching Older Adults

- Administration on Aging (AoA): http://www.AoA.gov
- American Association for Retired Persons (AARP): http://www.aarp.org
- American Society on Aging (ASA): http://www.asaging.org
- Association for Continuing Higher Education: http://www.acheinc.org
- Association for Gerontology in Higher Education (AGHE): http://www.aghe.org
- Gerontological Society of America (GSA): http://www.geron.org
- The John A. Hartford Foundation Institute for Geriatric Nursing: http://www.hartfordign.org
- National Council on Aging (NCOA): http://www.ncoa.org
- National Gerontological Nurses Association (NGNA): http://www.ngna.org
- National Institute on Aging (NIA): http://www.nia.nih.gov
- Osher Lifelong Learning Institute: http://www.olli.gmu.edu

Additional Web resources for health education are available for specific disease processes from focused organizations, including the American Heart Association, American Diabetes Association, and Alzheimer's Association.

BOX 5-6 Evidence-Based Practice Highlight

The authors examined learning theories and programs for older adults with chronic kidney disease. They concluded that "there is evidence that programs exist to address effective self-management of chronic illnesses and health literacy of the older adult. However, there are no programs in place to address health literacy specifically for the older adult with chronic kidney disease. The best way to address this issue is to have large, well-designed studies that will explore the most effective way to educate older adults with kidney disease. There is a definite need to conduct more research studies in this area of practice so the evidence can be translated to this growing population of individuals". p. 525

Elliott, R. W. (2014). Educating older adults with chronic kidney disease. *Nephrology Nursing Journal, 41*(5), 522–528.

Summary

What has become valuable for geriatric care partners is the significant amount of support for individually working with older adults in any setting. Assessment tools that were created for one setting work just as well in a host of other settings, including the home. The critical issue is to see the patient as a person—not just an older person. This video at the following Website allows the reader to note a potential flaw in what you are seeing: https://youtu.be/LOtNdn_GsMc. This video reflects what might be in the mind of the older adult as the care partner is focused on something different. Take a moment to *see them*, do not just do to them—this is a constant concern for older adults.

You have been asked to accept the assumption that **older adults are not the same, nor do they all have the same issues related to normal aging**. Some aging deficits seem more universal, whereas other issues are very individual. As presented in the two stories of John and Bert, **there may be major differences in how older adults connect to others and how they see the world**. However, most want to really be seen. Diversity is not just a cultural issue. It is a human phenomenon. Be ready to see all people in their diverse and unique selves.

A second assumption presented asked the readers to remember—**even when there is evidence of universal aging barriers to effective communication, continue to be open to the idea that effective communication strategies may not be age specific, but human specific**. Is it possible that everyone needs what has been offered in this chapter as valuable support for effective communication, teaching methods, and specialty assessments? Keep in mind that children, young adults, and older adults all may enjoy having care partners who are aware of what might be affecting effective communication and what they can do to address these deficits.

Care partners need to be prepared to meet the unique educational needs of the growing population of older adults who increasingly reflect a diversity of ethnicity, race, religion, gender, sexual orientation, and socioeconomic status. In addition to these factors, the older adult population also represents a wide diversity in age, ranging from 65 to 100 or more years of age. The increased longevity and diversity indicates that there will be greater needs for health teaching related to health promotion, illness and injury prevention, and chronic disease management. Older adults need to have a reason to engage in learning activities that is relevant to their lives and situation. Older adults are becoming more comfortable with technology and are accessing health information from the Internet. Care partners will need to be flexible and adaptable to meet the needs of older adults and use flexible gerogogy to make learning appealing and interesting.

By combining knowledge of appropriate communication techniques with older adults and the principles of gerogogy, nurses can be become more effective teachers with older adults and their families.

Clinical Reasoning Exercises

1. Realizing not everyone has the same past experience, but in an effort to connect the dots to what was presented in this chapter, you are being provided two music videos and are encouraged to listen to them. Play them both, and close your eyes. See where they take you in your memory. See if you touch old memory. Is it automatic? Does it bring an immediate emotional feeling and memory? Take the time now.
   - https://youtu.be/7E88RUqyjts?list=RD1SC0imBo5tg
   - https://youtu.be/7VBex8zbDRs

2. Choose one of these videos or music below from YouTube referred to in this chapter. Listen and review. What does this teach you about communication, individuality, and diversity that occurs with age?
   - https://youtu.be/4Szj0gCkFuk Paul Newman racing at 70 years of age.
   - http://web.cortland.edu/andersmd/ERIK/sum.HTML Summary of Erikson's stages of development.
   - https://youtu.be/7E88RUqyjts?list=RD1SCOimBo5tg Tell me 'bout the good-ole days.

   - https://youtu.be/7VBex8zbDRs   Gravity
   - https://youtu.be/3t3_yWQH1Go   Phil Coulter
   - https://youtu.be/-8MmeVhkMv8   Phil Coulter
   - https://youtu.be/H6cl_RJUMqM   Dave's Story on aging
   - https://youtu.be/iVEiAU_F2qw How we age
   - https://youtu.be/vPawWPXp5eg   SPICES assessment model
   - https://youtu.be/aPLt9OjwFTk   KATZ assessment model
   - https://youtu.be/_hRBPrfDQVI   Cognition and Memory Assessment Model
   - https://youtu.be/LOtNdn_GsMc   Just being human

3. What older persons in your own life demonstrate diversity in the way they communicate with others?

4. Do you agree with the chapter author's assumption that older adults are not the same, nor do they have all the same issues related to normal aging? Why or why not?

Personal Reflections

1. Think about one of your older relatives. How did this person's maturational state contribute to his or her ability to learn or see the viewpoints of others?

2. What has been your experience with older adults and their use of technology? Do you think older adults are using more technology to communicate (i.e., cellphones, email, tablets, Twitter, Facebook)? What teaching strategies have you found to be most effective when teaching older adults? Does this change if teaching in a one-on-one situation versus a large group?

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