

Geriatric Mental Health Training Series: Revised

When You Forget That You Forgot:  
Recognizing and Managing  
Alzheimer's Type Dementia, Part II

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## **When You Forget That You Forgot: Recognizing and Managing Alzheimer's Type Dementia: Part II**

### CONTENTS

The revised version of this training module includes the following components. To facilitate use, some components are combined in a file, others are located in independent files, and all are provided in at least two formats – the electronic processing format in which they were created and a PDF version. A brief description of each is provided to enhance overall use of these training materials.

- Statement of Intended Use: Contained in this file. Provides guidelines for use of the training materials.
- Statement of Purpose, Learning Objectives, Content Outline: Contained in this file. Provides guidance about both content discussed in the module and provides the basis for applying for continuing education credits for teaching the module to a group of people. The program is about an hour long.
- Notes for the Instructor: Contained in this file. Provides an overview of the goals of the module, along with suggestions to personalized the content and make the training more individualized to the audience.
- Handouts, Bibliography: Contained in this file. Handouts that address program content are provided. These may be used independently, or in conjunction with handouts made from PowerPoint. The bibliography is provided for your reference and consideration.
- PowerPoint Program: Separate file(s), provided in both PowerPoint format and in PDF (slides only). The module contains 48 slides. If opened using PowerPoint, they may be viewed and used in a variety of ways: 1) slides may be shown in Presentation View using a projector, 2) lecture content is provided in Notes View, and may printed for use to lecture, 3) slide content may be printed as handouts. Because some users may not have PowerPoint, the slides have also been converted into a PDF file which allows you to print a hard copy and make overheads or 35mm slides if desired to accompany the training program.
- Lecturer's Script: Separate file(s), provided in Microsoft Word and PDF format. This content provides the narrative to accompany and explain the slides and is also found in Notes View in the PowerPoint program.

## Supportive Materials: List

*The following materials are found in this file:*

- Statement of Intended Use (1 page)
- Purpose, Objectives, & Content Outline (2 pages)
- Notes for the Instructors (3 pages)
- Handouts
  - ✓ The New Culture of Dementia Care (1 page)
  - ✓ PLST Principles (1 page)
  - ✓ Interventions: Management & Care Planning (3 pages)
  - ✓ Interventions: Communication (2 pages)
  - ✓ Interventions: Reality vs. Validation (2 pages)
  - ✓ Interventions: Managing Delusions & Hallucinations (2 pages)
- Bibliography (6 pages)

## Statement of Intended Use

This training module is provided by the Hartford Center of Geriatric Nursing Excellence (HCGNE), College of Nursing, University of Iowa, as a free service. The training program, “When You Forget that You Forgot: Recognizing and Managing Alzheimer’s Type Dementia, Part I” is revised and updated from a module by the same title that was first published in *The Geriatric Mental Health Training Series (GMHTS)*. The GMHTS was developed and evaluated during a five year grant from The Division of Nursing, Bureau of Health Professions, Department of Health and Human Services, Grant # D10NU2711801, between 1989 and 1994. Other titles in the GMHTS include:

- Whose Problem Is It? An Introduction to Mental Health and Illness in Long-term Care Centers
- Getting the Facts: Effective Communication with the Elderly
- Help, Hope, and Power: Issues of Control and Power in Long-term Care
- When You Are More Than Just Down in the Dumps: Depression in the Elderly
- When You Forget that You Forgot: Recognizing and Managing Alzheimer’s Type Dementia, Part I (Overview)
- Acting Up and Acting Out: Assessment and Management of Aggressive and Acting Out Behaviors

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## **When You Forget That You Forgot: Recognizing and Managing Alzheimer's Type Dementia: Part II**

### **Purpose:**

Alzheimer's Disease and other dementias are commonly encountered in the long-term care setting. The second half of this two part program briefly uses the Progressively Lowered Stress Threshold (PLST) model as a basis for describing interventions. After briefly reviewing the PLST model (which was described in detail in Part I) common forms of stress for persons with dementia are reviewed. Nursing interventions to reduce stress and promote more functional behavior among those with dementia are described. An emphasis placed on managing the environment, adjusting routines, adjusting communication strategies and using validation methods.

### **Objectives:**

1. Discuss person-centered care and the importance of avoiding negative labels.
2. List 3 very common causes of stress for persons with dementia.
3. List 2 assumptions of the PLST model of care.
4. Describe 4 basic things that caregivers can do to keep stress at a manageable level for persons with dementia.
5. Describe communication methods that can promote comfort and function for persons with dementia.
6. Give an example of how to use Validation principles to reduce “You are wrong” messages.

### **Content Outline**

#### *Introduction and overview*

Dementia – Incurable, but not untreatable

Goals for today

New “culture” of dementia care

#### *Review of Part I*

PLST behaviors

Stress in dementia: fatigue, change, stimuli, demands, physical

Care planning goal

*Interventions*

Prevention is best intervention

Person-centered care

PLST Principles

*PLST Care Planning*

Reduce environmental stress

Compensate for lost abilities: Approaches

Compensate for lost abilities: Routines

Allow for lowered stress

Provide unconditional positive regard

Communication: An important form of regard and respect

Simplify the message

Simplify your style of speech

Use nonverbal communication effectively

Avoid “you are wrong” messages

Validation principle: Another method to show respect

Reality orientation: advantages, disadvantages in dementia care

Validation therapy: advantages, disadvantages in dementia care

Validation principles: examples to illustrate

Misbelief vs. delusions, hallucinations

Validation approaches: Do’s and Don’ts

Documentation of symptoms is key to problem-solving

Evaluate care: sleep, weight, incidents, medication use

*Summary*

Alzheimer's is incurable, not untreatable

## **Notes for the Instructor**

*In Part I of this program, we*

- Introduced the topic of dementia by providing a mix of conceptual and practical information, focusing on dementia of the Alzheimer's type
- Provided a brief overview of the various losses that occur in dementia, noting the stage-wise progression that is characteristic of Alzheimer's Disease
- Reviewed various other types of dementia, including some of the "reversible" dementias, and emphasized the point that *many factors can mimic dementia*
- Discussed the role of excess disability and the notion that any abrupt change in mental status should be thoroughly assessed
- Introduced the Progressively Lowered Stress Threshold (PLST) model of care, including
  - ✓ Common behavioral problems that tend to occur in the ambulatory stage of dementia
  - ✓ Reduced tolerance for stress in dementia
  - ✓ Forms of stress in dementia
  - ✓ Need to alter care routines and approaches to keep stress at a manageable level

This revised version of the dementia module divides the original content of the dementia program into two training modules. Evaluation feedback from the original evaluation of the training modules suggested that the program was difficult to teach in an hour, the length of time often provided for inservice education. To better address important points made throughout the module, the content has now been divided in two. Although trainers/users may elect to use only one of the two modules, they are designed to be used in conjunction with one another. The second module, which focuses on interventions to promote function among people with Alzheimer's disease and related disorders, builds on the content provided in this first module.

We recognize that there is a lot of VARIATION in terms of the amount of information needed to effectively assist persons with dementia. Differences between levels of care (e.g., home care, assisted living, residential facilities, nursing homes) and within type of care are common. *No matter what the care setting, however, successful training depends on the skills of the trainer and level of personalization of content to the real-life needs of staff.*

Even when taught in two segments, this program provides a substantial amount of information in a short period of time. This requires that you, as the trainer, are familiar and comfortable with the content. We urge you to be thoroughly familiar with the training materials so that you can offer personalized examples and illustrations to promote understanding (and retention!) of the information.

As in other modules, you will find instructions (e.g. //Trainer:) asking you to "personalize" the content. For example, in the section on Validation principles, "True Stories" are offered to illustrate key points. However, your OWN story – or one that related to care provided within the setting in which you are training staff – is a better alternative. To the extent possible, make the material "come alive" with examples that are familiar to staff!

When slides are self-explanatory, or the point is to review content, we place the content of the slides in a "box" in the Lecturer's Script. We have used this format because some slides have lists of information that don't necessarily need to be read verbatim. The handouts supplement the slides as well, and often provide more in-depth information than is found in the lecturer's script. This provides you with an opportunity to *focus on the aspects that are most relevant to your group*. Again, these decisions rely on the type of resident population that live in your facility and the expertise of the staff that you are training (e.g. nurses vs. nursing assistants vs. other ancillary personnel).

We urge you to go throughout the script and underline or "highlight" the points that you want to discuss, that you believe may not be easily understood by your staff. Examine the handouts for examples and illustrations. And then apply the concepts to any and all residents that are familiar to your staff!!

*As we noted in our "General Instructions," we do ask that you "try out" the concepts and interventions in advance of teaching the program so that you can relate, from your own personal experience, how they may work out in a real life setting with a real, live resident! After reviewing the program materials, think about the following questions and suggestions and make some notes to yourself in the margin of the lecturer's script or the handouts.*

1. What "labels" are typically applied to persons with dementia? How do these negative labels (e.g., disruptive, problematic, aggressive) influence the care that is provided?
2. What kind of real life examples can you give as you review the list of common behavioral problems? Who rocks, or paces? Wanders? Who calls out over and over again? (E.g. "Over here! Over here!" or "Help me! Help me!" or "Is it alright? Is it alright? or "Where am I? Where am I?") Who has claps, or taps, or stamps their feet repetitively? Who believes their parent are alive? Or that they're going to work? Or that you're their daughter? or mother? Who "sundowns?" Or gets up in the middle of the night? Examples of real residents are always useful.
3. Can you think of a person whose behavior had a clear "trigger" (e.g., hunger, pain, over-stimulation, caregiver approach, facility routine) that might be used to illustrate common sources of stress for persons with dementia?
4. Consider the content on "person-centered care." What policies and procedures FACILITATE day-to-day caregivers knowing the person's long-standing history? What impedes "hand on" caregivers knowing the person's long-standing social history? Ask yourself: How do caregivers "get to know the PERSON behind the disease"?
5. Throughout the section on Interventions, think of as many examples and illustrations as possible to tell "stories" that emphasize the points being made. For example, do you know of a time when a person with dementia was "caught off guard" and reacted with anger? Can you

think of an example of when a caregiver tried to “reason” with the person? Or used “reality orientation” that served as negative and restrictive feedback? Be sure to include success stories as well! What “worked” in the face of difficulties? Ask staff to share THEIR stories as well.

6. In the section on communication, think carefully about examples of what to DO, and not to do. Remember to infuse as much humor as possible!
7. Similarly, think carefully about possible examples to use in the section that differentiates “misbeliefs” and “illusions” from “delusions” and “hallucinations”. To the extent possible, illustrate how specific reassurance may calm and comfort the person with dementia.

As always, HUMOR is appreciated!! Can you think of a story, joke, or anecdotal story to tell about dementia?

One of my (MS) favorites is told by a colleague. The story relates to “John,” a man in later stages of dementia who was living in the community with his wife. For unclear reasons, John began to “tape up” everything in the house. He used duct tape on the refrigerator, doors through the house, cabinets, and all sorts of other odd places.

John’s wife, “Mary,” was both puzzled and frustrated by the behavior. Because John’s language was quite impaired, there was no way to talk with him about the taping, or understand the “point” of this behavior. To avoid problems, Mary hid the tape so John could not continue. However, he located the tape, and again, taped the refrigerator door closed. In her frustration, Mary exclaimed “I can’t stand this! What are you going to tape next?!?!?”

In response, John said, “Your MOUTH, if you don’t shut up!!”

\*\* The point is that we often do not understand the behavior, but should not assume that the person CANNOT understand and reply to the spoken word!

## The “New Culture” of Dementia Care

### Negative Labeling

- *Negative labels are commonly used to describe behaviors observed in people with dementia:*
  - ✓ Disruptive
  - ✓ Distressing
  - ✓ Difficult
  - ✓ Problematic
  - ✓ Aggressive
- Too often imply the **WHOLE PERSON** is a “problem.” That is, the person with dementia is labeled as “bad” because of his/her behaviors.
- Contributes to *lower quality care* as caregivers avoid, ignore, or retaliate against “bad” person.
- **REPLACE NEGATIVE LABELS** with alternatives that focus on *behavior as a SYMPTOM*:
  - *Behavioral and Psychological Symptoms of Dementia, or BPSD*
  - *Need-Driven, Dementia-Compromised Behavior, or NDB*: behaviors are the result of unmet needs
  - *PLST Behaviors*: behavioral symptoms are stress-related.
- **FOCUS** on remaining **ABILITIES** and resources – what he/she can still **DO!**

### Person-Centered Care

- Knowing **THIS** person and his/her life-long habits, routines, and preferences
- Thinking about long-standing personality traits, life experiences
- Focusing on strengths and abilities, what the person can continue to **DO** – not the just losses that are part of the dementia
- Promoting engagement in long life activities and interests using retained abilities

## **Progressively Lowered Stress Threshold (PLST) Principles**

### **Underlying Assumptions**

- All people need some kind of control over themselves and their environment.
- All behavior has meaning.
- Behavioral symptoms are a signal of discomfort.
- Persons with dementia live in a 24-hour continuum.

### **Six Basis Ways to Improve Care**

1. Maximize safe function by supporting losses in a prosthetic manner.
2. Provide unconditional positive regard
3. Use anxiety and avoidance to gauge activity
4. “Listen” to the person with dementia (what does the behavior “tell you”?)
5. Modify the environment to support losses and enhance safety
6. Encourage caregivers to participate in ongoing education, support, self-care, and problem-solving

## **Interventions: Management & Care Planning**

### **Eliminate or Reduce Environmental Stress**

*Caffeine*: promotes restlessness, agitation, sleeplessness

*Misleading stimuli*: TV, radio, PA system are not understood and can cause fear

*Unending spaces*: long corridors that seem to go on and on may cause fear; break up with color & texture

*Unneeded noise*: radio, TV, people talking outside their room

*Extra people*: limit visitors to one or two people at a time; avoid large groups that increase noise, confusion

*Large rooms*: dining room, dayroom, and/or activity rooms may be overstimulating to the person

### **Compensate for Loss of Ability to Think and Plan**

*Calm, consistent approach & routine*: provides security and allows person to use remaining memory abilities

*Do not try to reason with the person*: ability to think abstractly is lost so only creates stress and tension

*Do not ask to "try harder"*: lack of cooperation isn't intentional

*Do not try to teach them new routines*: loss of memory means they won't be able to remember changes in where they sit, which room is theirs, etc.

*Do not encourage them to recover lost skills*: lost ability (reading, knitting, etc.) will not be recovered

*Limit choices to those the person can make*: limit the alternatives; e.g., "Would you like to wear the blue dress or the pink dress?"

*Monitor changes in the environment*: holiday decorations, new furniture, unfamiliar people all create stress

*Eliminate changes of pace*: use a moderate, unhurried pace even when you feel like pushing along to get done

### **Allow for Lowered Stress Threshold**

*Maximize the routine and monitor the environment!*

*Plan rest periods* in morning and afternoon to reduce stress

*Maximize routine:* Rise, eat, rest at same time each day

*Alternate high and low stimulus activity:* quiet time following bathing, eating, visitor, doctor visits, etc.

*Reduce stimuli when reactions occur:* move into a quieter space without TV, noise, etc. Check for physical stressors like wetness, hunger, pain, etc.

*Keep records:* Be specific and descriptive in your charting!

-- Demanding? In what way?

-- Disoriented? In what sphere? Time, place, person, thing?

-- Delusional? What about? What did she say? Do?

-- Repeating herself? When? What does she say? What did you try?

### **Provide Unconditional Positive Regard**

*Remember: The person with dementia is an adult who deserves respect and consideration.*

*Address by last name:* formality sometimes increases cooperation; address by preferred name, first or last, if they can tell you

*Allow to use skills or abilities that are intact:* encourage to brush hair, eat, dress self, giving encouragement and simple instructions

*Communicate respect through care:* tone of voice, attitude, pace of care routines or activities

*Show respect through communication.* See "Interventions: Communication" for more information.

*One to one communication methods:* simple phrases, eye contact, exaggerated nonverbal gestures

*Use touch to reassure:* gentle, anticipated touch offers reassurance; don't take by surprise

*Eliminate "You're Wrongs" from the environment:* "No, this is your home now."

*Do not confront -- DISTRACT!*

Show respect through validation vs. orientation. See “Interventions: Reality vs. Validation” for more information.

*Avoid reality orientation:* loss of memory means they are unable to retain information on time, place, person and it becomes another "You're Wrong"

*Don't confront delusions or hallucinations:* belief or experience is very real to the person; attempt to distract or reassure that they are safe

*Use reminiscence & validation:* review of past experiences may promote feelings of security & happiness

*Listen carefully for meaning:* repetitive words, phrases sometimes have meaning that can be interpreted and responded to in a way that promotes comfort

*Provide reassurance of safety:* "You're safe here with me. I won't let anything happen."

### **Evaluation of Care**

Monitor progress in concrete terms.

Number of hours of sleep

Weight

Food intake

Incidents (falls)

Number of stress-related events (hitting, yelling)

Sedative and tranquilizer use

Family's expression of satisfaction with the care

## **Interventions: Communication**

### **Simplify the MESSAGE**

1. Short words.
2. Simple sentences ("Sit in the chair"); not compound or complex ("Sit in the chair and put on your socks").
3. No pronouns (it, that, they, them, she, he, here, there); only nouns (chair, dress, bathroom).
4. Begin each conversation (particularly at night) by identifying yourself and calling the person by name.

### **Simplify your Speech STYLE**

1. Speak slowly.
2. Say individual words clearly.
3. If you increase your speech volume, lower the tone; raise the volume only for deafness, not because you don't get a response you understand.
4. If you ask a question wait for a response.
5. Ask only one question at a time.
6. If you repeat a question, repeat it exactly.
7. Use self-included humor whenever possible.

### **Use NON-VERBAL Communication Effectively**

#### *General Principles*

1. Think carefully about your facial expression, body position, and hand gestures. What are YOU communicating?
2. Convince yourself that your nonverbal style can be felt all the way across the room and by several people, not just the patient or staff person you are addressing.
3. Deliver every verbal communication with proper non-verbal gestures.

#### *Specific Strategies::*

1. Stand in front of the person.

2. Maintain eye contact.
3. Move slowly.
4. If the person starts or continues to walk while you are talking to him, do not try to stop him as your first move. Instead keep moving along in front of him and keep trying.
5. Use overemphasis and exaggerated facial expression to emphasize your point, particularly if vision or hearing is impaired.

### **General Guidelines**

1. Listen actively. If you don't understand, say you don't understand and ask them to repeat the statement. If the person becomes more upset offer your best guess about what the problem is. If you receive a "no," try another guess but monitor their level of frustration.
2. If you have not really "gotten anywhere" in five minutes or less, you will probably do better to leave and either return in five minutes or have a colleague try. When possible have another staff member watch you interact with a resident, make suggestions, and perhaps trade off with you.
3. Assume they know what they need. If the resident refuses to participate in an activity assume that there is a reason (he has become sad, angry, frustrated, embarrassed, anxious about his condition). Your first job is to check it out -- not just ask something vague like, "Are you okay?" Get specific: "Are you uncomfortable? hurt? angry? sad?" (whatever).
4. Be sure to share all words, phrases, techniques that work for a particular person and a particular situation (write it in the care plan). Use each other's techniques. Compare notes on successes and failures.
5. When encouraging participation in activities, use the following guideline: If you push the person too hard, they may have a catastrophic reaction. Do you have the time to manage a problem if one occurs? How hard you push should be determined by how much time you can afford to spend resolving problems.
6. Finally, if you say you are going to do something, DO IT. If you forget, find the person and apologize. Assuming that the person has forgotten the episode insults both your intelligence and his/hers.
7. If you need to stop a patient-patient interchange, do it firmly and quickly, get them out of each others territory, wait five minutes then return and explain to each one why you acted as you did. Use factual explanations, not "guilt trips."

Source: Adapted from Mari Anne Bartol, RN, MA, and Michael C. Storrie, MD. Published in Bartol, M. A. (1979). Nonverbal communication in patients with Alzheimer's Disease. *Journal of Gerontological Nursing*, 5(4), 23.

## **Interventions: Reality vs. Validation**

**REALITY ORIENTATION (R.O.):** Stresses the importance of bringing the disoriented person back to the "here and now" by constantly emphasizing the four spheres of orientation (time, place, person, thing). R.O. is based on the belief that disoriented persons are able to return to the present, if given enough information to do so. Consequently, the method encourages us to correct persons who are disoriented or confused, and to provide accurate information that will help them stay in "the present."

**Advantages:** Is useful with persons who are, in fact, temporarily confused but not permanently impaired. A person who is acutely confused (delirious), because they have an infection or because they recently moved to the nursing home, needs to be provided accurate information to become reoriented (e.g. reminded of the correct time, place, person, and things that are happening).

**Disadvantages:** Is not useful with persons who have memory loss and are intellectually impaired, particularly those with dementia caused by any disease process. The progressive loss of memory means that the person lacks the ability to retain the information. Constant orientation, or contradiction of their stated beliefs (even when false) only functions as "negative feedback" -- the message that "you are wrong."

**Remember:** Negative feedback, those various messages that YOU ARE WRONG typically irritates, agitates, and embarrasses the resident. At some level they "know" and their self esteem is damaged by constant reminders that they are "wrong."

**VALIDATION THERAPY (V.T.):** Stresses the importance of "going with the person" to their reality to better understand what they are experiencing. V.T. suggests that some elderly may withdraw from the "here and now" because it is too painful and distressing. They return to their past, which is more pleasant and comforting, to avoid the present. V.T. suggests that we listen carefully to the words, phrases, and statements that the person uses to understand what they mean. Then we may be able to "bring the person to the present" by gently prompting their memories about both the past and the present.

**Advantages:** Validation of the person's reality avoids sending negative feedback to the demented resident who may believe that they are "going to work" or that they visited with "mother or father." Instead of contradicting the person, we can "go with them" and talk about what they are remembering at that moment. Through the reminiscence we may be able to help them feel more positive, instead of sending the message "you are wrong" that is likely to bring out sad/bad feelings.

**Disadvantages:** The person may respond to validation techniques "in the moment," but do not retain the ability to recall information. For example, validation may help the person realize that their daughter is their daughter (and not their mother) during the time she visits. However, that realization will be lost after the visit. In addition, validation techniques may be inconsistent in producing desired results, which can be frustrating.

Dementia

**Interventions Based on Principles of Validation Therapy**

1. Don't confront the person's delusional ideas. Instead distract and redirect the person whenever possible.

**Example:** "I'm going home!" Instead of pointing out that their home has been sold, and that this IS their home, suggest that "It's too cold (late, whatever) to go home right now, so why don't you stay here tonight? We've reserved this room just for you."

**Example:** "I've got to get to work." Try to redirect them to some activity that may parallel work. One aged nurse sat at the nurse's station in the middle of the night and wrote "nurses notes" dated 1932 until she became tired and returned to bed.

2. Validate the person's reality instead of confronting them with "you're wrong" messages.

**Example:** "Papa's coming to get me." Instead of saying, "No, Papa is dead," try something like, "And you love your Papa. Papa's a good man." Let the person respond to the idea of the lost person and go with the flow of their ideas. Direct them to think about the person, rather than the idea that he/she is alive or coming to take them away.

3. Listen carefully to content of what seems to be "nonsense." What is person doing? or saying? in their reality? By doing so you may be able to offer them some reassurance that is meaningful.

**Example:** A demented resident calls out the name "George" over and over again. By asking family who "George" is/was and what relationship the person had with George, staff may be able to ask questions to redirect the person or find out what they are thinking about that disturbs them.

## **Interventions: Managing Delusions & Hallucinations**

### **Definitions:**

*Misbelief:* a false belief that related to something real, like wanting to go home, see a parent, go to work

*Delusion:* a false, fixed belief that is maintained in spite of evidence to the contrary; in dementia, misbeliefs and delusions may overlap; delusions tend to be troubling to the person and others around him/her, bizarre (like thinking they are being poisoned or that someone is out to get them), and not based in reality

*Illusion:* a false belief based on misinterpretation of a real sensory experience, like hearing water dripping and thinking it is a voice, or seeing their own reflection in a dark window and thinking a person is spying on them

*Hallucinations:* false sensory experiences, such as hearing, seeing, smelling, feeling, or tasting something that is not real

### **General Principles:**

Keep in mind all of the factors that affect communication. Pay particular attention to your nonverbal messages: the look on your face, the tone of your voice, the way that you move, gesture, and touch.

Try to "put yourself in the resident's shoes." Think about the experiences from their perspective and appreciate how distressing these feelings or beliefs can be.

### **Specific Strategies:**

1. No matter how odd or absurd the delusions or hallucinations may seem to us, **ALWAYS** remember that the false beliefs or experiences are **quite real** to the person who is having them.
2. The experience may be upsetting or frightening to the person, and they may need our reassurance that they are safe. For example, that may mean assuring them that you will "make sure they are cared for," and that this is a safe or nice place even though it "isn't their house."

3. When the person is having paranoid delusions (e.g. believes that they are being poisoned by chemicals or fumes) we may need to recognize that they are afraid without agreeing that it's really happening. For example, "I don't smell the fumes but I can see that you are quite upset."
4. At times, we may need to offer information that contradicts the delusion by saying that you don't "share their reality." That is, that you don't see or hear the voices or people that they do. Again, offer reassurance that they are safe with you.
5. Listen carefully to the type and extent of the delusional content. The demented person may be responding to a real life event or stimulus in the environment. For example, after watching TV, a person might begin to have delusions that his/her room is filled with "little people."
6. Monitor whether the delusions are getting worse or more exaggerated, especially if they are paranoid in nature. The more fearful the person is, the higher the risk that they will strike out *to protect themselves*. Remember: most "aggression" is a reaction to the perception of THREAT.
7. Any action or movement that catches the person "off guard" may provoke a protective response, including hitting, pushing, or striking out. These behaviors are "defensive" response related to feeling threatened (even when that is NOT your intent!). Stay in their field of vision, make sure that they hear and understand you, use gentle touch to connect with them, and don't press them to continue something if they are trying to withdraw.

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<sup>1</sup> Note: Older references that provide the foundation on which additional research and clinical practice are based are purposefully retained here for easy reference to original sources.

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