

Geriatric Mental Health Training Series: Revised

Getting the Facts:  
Effective Communication with Elders

Lecturer's Script

Revised by Marianne Smith, A.R.N.P, B.C., Ph.D.(c)

*From original content by*

Marianne Smith, R.N., M.S.

Kathleen Buckwalter, R.N., Ph.D., F.A.A.N.

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## **Getting the Facts: Effective Communication With Elders**

### INTRODUCTION AND OVERVIEW

#### **>>Title slide**

Today we are going to think some more about the CHAIN OF EVENTS that may lead to behavioral symptoms in older adults. As we discussed in the program “Whose Problem Is It,” that means looking at behavior as a SYMPTOM of some other, underlying problem that is causing the person discomfort or distress. By looking for the underlying cause, caregivers are in a better position to treat the *real problem* instead of just the *symptoms*.

#### **>>Getting the facts: Understanding the person & the situation**

In order to identify and treat the real problem, caregivers often need to assess the person and the situation, taking time to collect additional information to be able to really *understand what is actually going on*, which we can think of as “getting the facts.” By getting the facts, caregivers are better able to develop interventions to reduce the person’s discomfort and increase more adaptive and functional behaviors. Reducing or eliminating behavioral symptoms is good for everyone – the person who experiences the behavior AND others around him or her! *Even when we can't change the person, caregivers are often better able to manage their own feelings about the behavior because they understand it!*

Today we will focus on GETTING THE FACTS and more specifically about the COMMUNICATION PROCESS that is essential to collecting information needed to see the "chain of events" that may lead to behavioral symptoms. The goal today is to "tune in" to *all the things that can enhance, or interfere with having a clear understanding of what is going on with the older person.*

#### **>>Getting the facts: Observing, reading, listening, asking**

The FOUR main ways that caregivers often "get the facts" are by

- 1) OBSERVING the older person’s behavior;
- 2) READING the information that is in the chart;
- 3) LISTENING carefully to what the older person and the family have to say; and
- 4) ASKING questions to get the additional information that will help us understand what is going on with the person.

Getting the facts – by observing, reading, listening, and asking – sounds simple enough. However, there are lots of *BARRIERS that can get in the way!!*

## >>Common barriers to understanding

Let's stop and think about some of the things that might interfere with what is seen, heard, or read. Try to think about what interferes with

- *caregivers* understanding the older person, and ALSO, what interferes with
- the *older person* understanding the caregiver!!

**//Trainer: Ask participants what they think might interfere with understanding one another. Take a few minutes to discuss ideas. If the following points aren't mentioned, bring them up.**

1. Attitudes, beliefs, assumptions of the *person who is asking or observing*. E.g., jumping to conclusions because of past experiences with the person.
2. Attitudes, beliefs, assumptions of the person who is *being asked questions*. E.g., not answering the question because you think it's "none of their business" or because you feel they are "talking down" to you.
3. Sensory impairment or interference. E.g., not hearing what is said correctly because it was said too softly, too fast, or because there were too many other distracting noises; misunderstanding the message because of hearing impairment.
4. Unclear use of language. E.g., using jargon, medical terminology, or words that are unfamiliar may interfere with understanding.
5. Having different "agendas" or goals. E.g., being "task-oriented" and in a hurry may interfere with "hearing" what the person is trying to communicate.
6. Effects of disease or illness that affects the person's on ability to *speak or form words, remember information and/or think clearly*. E.g. strokes causing aphasia, dementia causing loss of memory, schizophrenia or other mental illness that causes misinterpretation of reality and disordered thinking.

In order to GET THE FACTS caregivers need to be able to COMMUNICATE EFFECTIVELY with the older person. Anything that interferes with that process is going to affect *the quality of the information that is gained – and in turn, decisions about how to respond and care for the person.*

## >>Key ingredients to Getting the Facts

Although many different things can influence effective communication, we are going to focus on the following factors.

- 1) *The purpose of communication*, and its role in both human relationships and high quality care;
- 2) *Basic components of the communication process* and how we can use these to our best advantage;

- 3) *Attitudes, beliefs and assumptions* that we make about elders that can affect our understanding of the situation; and
- 4) *Age-related changes* that could affect the person's ability to understand us and respond appropriately;
- 5) *Diseases and disabilities* that may interfere with an elder's ability to communicate their feelings, needs and thoughts using language; and
- 6) *Environmental factors* that influence the elder's ability or willingness to interact with caregivers or others.

Let's look at each topic separately, and then think about interventions that caregivers can use to improve communication.

### PURPOSE OF COMMUNICATION

#### >>Virginia Satir quote

#### **\*\*Refer to handout: Overview of Communication**

Let's start by thinking carefully about the purpose of communication. Virginia Satir, a famous family therapist, said that *communication is more important than anything else in terms of what kind of relationships we have and what happens to us in this old world!*

#### >>Purpose of communication

That's an important perspective to keep clearly in mind. Communication is *more than the exchange of information*. It's more than the charge nurse telling you that you're working with Mrs. Jones and that she needs procedures "X, Y, and Z" done today.

*Communication is fundamental aspect of all human relationships*. It's the way that we *connect* with other people, the way that we *maintain our relationships*. Older adults who have difficulty expressing themselves, or understanding what is being said or done, are also being deprived of the main way that they "connect" with people in their lives. Caregivers need to be sensitive to the idea that every time they "communicate" they are also making a "human connection!"

#### >>Task-oriented care

So much of health care is "task-oriented" – meaning that caregivers interact with the older person around an activity of daily living, like getting dressed or bathed, eating, walking, taking medications, or some other "chore." Caregiver's may lapse into thinking about communication as just a way to "get the job done."

Communication too often becomes “instrumental”, meaning that we focus on

- problem-solving,
- information-giving,
- clarification,
- direction, or guidance *as it related to physical care!*

In our hurry to “get things done,” we may be tempted to do things “TO” frail older people, instead of doing things “WITH” them – *and that shows up in our communication methods and style!*

### >>Person-centered care

It becomes easy to forget that communication serves many SOCIAL and EMOTIONAL NEEDS as well – and that THOSE may be MORE important to the older person than the task at hand!! Older people in your care also need

- reassurance,
- encouragement,
- concern and understanding, and
- *interest in them as human beings* who have many interests and concerns OTHER THAN their health conditions!!

### >>Psychosocial needs: Low priority

Unfortunately, considerable research supports the fact that nurses and other caregivers often SAY that *it is their job to promote dignity, self-respect, autonomy, and independence among their elderly patients.*

However, in practice, these care providers place higher priority on providing PHYSICAL cares than on meeting the PSYCHOSOCIAL needs of older patients – like promoting dignity and independence! Caregivers tend to spend little time INTERACTING with care recipients, particularly older people who are confused and dependent. The small amount of interaction that does occur revolves directly around physical cares (e.g., is instrumental communication related to “getting things done”).

Unfortunately, *even the instrumental communication used is often ineffective!* In one study, 60% of the nurse-patient interactions observed during morning cares were inappropriate, including

- the complete lack of communication – which indirectly says “you are not important enough for me to even speak to you” and

- interactions that were dependency-creating – which increases disability for the older person and often arouses anger and resentment.

Another common communication problem with older people is “baby talk” or other patronizing language. In short, there are considerable differences between what caregivers SAY is important and what they are observed to DO in practice!

### >>Morrison & Bernard quote

However, as Morrison and Bernard note, “caring and communicating are inseparably linked. *You cannot hope to communicate effectively if you do not care about the person on the receiving end.*” (1997, p. 177)

Thus, one of the most important first steps in promoting good quality care is to remember that we establish and maintain human relationships through communication. Taking time to “connect” with the person – by making eye contact, listening carefully to their views, and thinking about the individual as a PERSON first – is as important as the physical care they receive!

## BASIC COMPONENTS OF COMMUNICATION

### >>Communication as a process

In addition to thinking about communication as a way to maintain relationships, it also helps to stop and think more about the actual “process” that is involved. As most people know, *communication involves a lot more than just the words that are spoken!*

### >>Components of communication

#### **\*\*Refer to handout: Components of the Communication Process**

Although the “words used” or “messages” we use are an important part of communication, there is a lot more to it than just that!! As this diagram shows, communication is a dynamic process that involves verbal and nonverbal messages, and internal and external feedback that occurs in a specific “context” or situation.

### >>Verbal vs. Nonverbal messages

We communicate VERBALLY, through the words that we actually say, and NONVERBALLY by how we say those words!

**//Trainer: In the next sequence illustrate each of the following with the appropriate nonverbal.**

Our nonverbal messages include

-- the *look* on our face (frown),

-- the *tone* of our voice (angry),

-- the *posture* of our body (hands folded across chest), and our

### >>Communication: What is “heard”

Much of what we communicate is nonverbal, *even though we often don't pay a great deal of attention to our nonverbal messages*. That part tends to be unconscious and unintentional. We do it "automatically" and without an awareness of what the other person might be "getting out of it."

### >>Nonverbal “connections”: What are you communicating?

As result, caregivers need to be sensitive to those “nonverbal connections” that are made with older adults – *ones that may unintentionally communicate anger, frustration, or other negative emotions!!!* To be more effective with older adults (and everyone else) we need to "tune in" and be really self aware. *How we say it is as important as what is said!* How we look, and carry ourselves, and what kind of eye contact we make (or don't make) is sending out a message, even when *we haven't "said" a word!*

### >>Feedback: Internal & external

Verbal and nonverbal messages are sent back and forth between people – a process that is often called "giving FEEDBACK." Although that seems simple, there is often *a lot more to it than just sending and receiving the message!*

### >>Context: Where and how

We also need to think about the CONTEXT in which the messages are given. We all “hear different things” depending on where and how the message was said – which is the *context*. The context of communication often includes the *setting or environment* in which the communication takes place. Context also includes the *type and quality of relationships* we have with the other person – how comfortable or familiar we with them, and how much we trust them. This is particularly true when personal issues are being discussed.

For example, a simple question, like *"What are you doing?"* might have an entirely different meaning depending on the setting in which it is said. For example, if you were sneaking a piece of candy [*What are you doing?*] or if a friend just called on the telephone [*So, what are you doing?*].

The same is true for questions that caregivers may ask older adults – *where and how a question is asked may influence the outcome of the interaction!*

### >>Sensitive Listening

Although we tend to place a lot of emphasis on how we “send” messages, it is just as important – *and perhaps MORE important* – to think about “receiving” messages! LISTENING is often a *neglected aspect* of effective communication. Instead of listening, we

- interrupt, and start talking because we have jumped to a conclusion about what the other person is going to say;
- begin thinking about our response, which blocks our ability to “hear” the message; or
- “tune out,” ignoring the person and their message.

These behaviors send their OWN message: “What you think, or have to say, is unimportant to me,” and in turn, “*You are unimportant.*” Communication difficulties often follow, as the person being cut off or ignored feels hurt or angry, and become defensive or irritable in response.

“Sensitive listening” requires that we STOP TALKING – out loud and to ourselves. Instead, look at the person, and listen carefully – not just to the words or even the tone of voice or body language used – but listen for the person’s MEANING. What are they trying to say? *What is the INTENT of their words, behaviors, or actions?*

Remember, what a person means to “say” (communicate) and what the person listening “hears” may not match!

### >>Perception, evaluation, transmission

Another way of thinking about the *communication process* is to think in terms of what is perceived, how it's evaluated, and the process of transmitting messages.

It's pretty obvious that the communication process depends on the ability to transmit the message. We have to be able to form the words and have enough "wind" (respiratory capacity) to speak, to communicate verbally.

### >>Perception, evaluation, transmission

But communication also depends on our ability to accurately perceive the information – our perception. Perception is the *process by which we select, organize, and interpret sensory information into an understandable and meaningful picture of the world.*

That means that *we take information in through all of our five senses* -- what we see, hear, feel, smell, taste -- and then interpret it and use it to understand our world. So, accurate sensory information is critically important!

### >>Perception, evaluation, transmission

At the same time, we are evaluating what we perceive. We analyze the information and assign meaning to it - a kind of "*what do you mean by that?*" And how we evaluate it depends on our ability to “process” the information and on our past experiences!

The “perception-evaluation loop” of communication is important to think about. There can easily be a gap between what is really going on and what we think is going on! Caregivers may

*completely misunderstand* an older adult's "message" – and likewise, the older adult may completely misunderstand you, and your intentions!

### >>How a person behaves depends on what is perceived

*How a person behaves depends on their perception and evaluation of the situation, not the actual events themselves!!*

That means that when an older adult responds in a way that we don't understand – in what they say, or how they look at us, or how they act – we need to ask ourselves

- What was communicated to them??
- What did they perceive?
- How did they evaluate it?
- Are you and the person on the same "wave length?" or not?

It is important to keep some of these "basics" in mind as you think about older adults in your care!! Like Virginia Satir said, "*communication is at the heart of what happens to us in the world.*" That is important to the older person, but it is also important to YOU, as a *person*, and as a *caregiver*.

## ATTITUDES AND BELIEFS

### >>Attitudes & beliefs

One of the most powerful influences on communication with older people is our general attitude toward elders and our beliefs about aging.

This is directly linked to the perception and evaluation scheme. When evaluating the older person, caregivers use their own values and beliefs, as well as their knowledge and past experiences. And as before, *behavior is the result of PERCEPTION -- not the events themselves!!*

Simply stated, that means both knowledge and values have tremendous effects on

- what caregivers see;
- how that information is interpreted and understood; and
- what caregivers select to do, or not do, in response!!

### >>New Admission: Ann

Let's review a case history to think about how this may work.

You are working in a long-term care center. The charge nurse tells you that you are going to get an admission this afternoon. The new resident, Ann, is a female who appears her stated age. The transfer note states that Ann babbles incoherently and is disoriented to time, place, and person, although she does seem to recognize her name. Ann is sometimes friendly and happy, but she also becomes agitated without apparent cause. Ann totally disregards her physical appearance and needs to be fed, bathed, and clothed by others. She is edentulous (has no teeth), and does not ambulate. Her sleep patterns tend to be erratic and she is incontinent of both urine and bowel.

**//Trainer: Ask the question and encourage honest answers about what staff think about this type of caregiving. Read the key words again to provoke discussion if needed. E.g. incontinent, agitated, disoriented, erratic sleep patterns. Look for negative reactions.**

How do you feel about providing care to Ann? Is this a resident that you look forward to caring for? Or is this one that you would rather avoid?

### >>6 month old infant

Now, what if the new "resident" looked like this?

The caregiving requirements are the same, you know. But most people react quite differently to the needs of infants compared to dependent older people. *So labels are important.* And so are attitudes. And although positive images of aging on the rise, our society continues to have a lot of negative attitudes and beliefs about growing older.

Most of us would deny that we are prejudiced against elderly people. *But it DOES show up, in some of the most subtle ways:* in our language, in our assumptions about what the problem is, and in our efforts to help people manage health-related needs.

### >>Think about common labels

Let's think about language. How many here have used the words or phrases listed on the slide in relationship to an older person?

**//Trainer: Don't read all. Give the audience time to read the slide.**

Old biddy, granny, old maid, codger, coot, geezer, doddering, crotchety, withered, wrinkled, decrepit, senile, sexless, useless, futile, hopeless, irreversible, meddlesome, rigid, insecure, conservative, old-fashioned, mindless, irrational, foolish, curmudgeon, pathetic, incompetent, worthless, difficult, distressing, disruptive, problem, better-off-dead.

The consequences of negative attitudes among health care providers include both *avoidance and altered expectations* for recovering from illness. That means that we just "steer clear" of them, or we "write them off" as a hopeless case. *And both of those end up creating even MORE problems, for the older person and for the people who provide care.*

## AGE-RELATED CHANGES

### >>Age-related changes

#### **\*\*Refer to handout: Barriers to Communication: Age-related changes**

Another area of concern related to “age-related” changes may influence communication, including the following:

- Normal age-related changes, like hearing and sight;
- Diseases and disabilities, particularly ones that influence the brain; and
- Environmental factors that are common in health facilities and other places that older people with health conditions tend to live.

### >>Sensory changes

One of the most important age-related changes that caregivers can influence is sensory loss and change. Remember, we have to get the information in the first place before we can evaluate it and respond!

And as we noted earlier, *all of five senses tend to decline with advancing age*. We don't see as well, hear as well, smell or taste or feel things like we used to.

### >>Sensory declines

So, when we're trying to understand words or behaviors that “don't make sense,” stop and ask:

- Is any part of the “problem” related to the elder NOT GETTING ACCURATE INFORMATION because of *sensory changes*?
- Is their behavior related to “misinformation” because they are not wearing their glasses or hearing aids?
- Was the person “taken off guard” because they did not hear or see you?

*Remember*, lots of people have great social skills. They nod, and smile, and say, "Oh yes, that's right" and "I'm fine" when *they haven't heard a word that was said!*

In some cases, the person may be embarrassed that they cannot hear you – or don't understand what you are asking – and try to “cover up” by being pleasant or funny. They make a joke, or say something distracting, but don't really answer the question. If caregivers are in a hurry, they may not bother to clarify – *and may not really appreciate what the older person is NOT able to hear or see!*

### >>Reaction time

Another common change that may influence communication is REACTION TIME – which influences how quickly the elder responds to questions or comments. An older person may be slower to respond or react – requiring that caregivers PAUSE and *let the elder and respond to the question or request*. If we get in a hurry, we may actually INTERFERE with the person’s train of thought about the question, and the answer becomes further away instead of closer.

## DISEASE AND DISABILITY

### >>Disease and disability

#### **\*\*Refer again to handout: Barriers to Communication” Disease and disability**

Another set of problems are the result of mental and physical health problems that tend to cluster in later life. When we are trying to interact and connect with the older person, we need to think about all the possible ways that health-related problems might interfere. Although many different health problems can interfere with communication, some of the most common problems are discussed here.

### >>Dysarthria

DYSARTHRIA is the medical term that is used to mean that the person has difficulty speaking because they aren't able to form (articulate) the words. The person's speech may be slurred and hard to understand *because they aren't able to pronounce the words clearly*. Dysarthria can result from various diseases that affect the nervous system (neurological diseases). In dysarthria, the person understands the message, but they aren't able to form the words because of weakness or paralysis of the muscles needed for speech.

### >>Oral health problems

Likewise, having TEETH becomes important to being able to speak clearly! Even the amount of SALIVA that we have in our mouth affects how clearly we are able to speak.

### >>Lung diseases

Likewise, lung (a.k.a, pulmonary or respiratory) diseases that interfere with having enough “WIND,” or respiratory capacity, to speak is also critically important. That means chronic obstructive pulmonary diseases (called COPD for short) like emphysema and asthma may negatively affect the older person's ability to communicate their needs. Likewise, the person with lung cancer may not be able to express themselves effectively.

However, in all of the above situations, *the person is still able to understand and interpret what goes on around them!* They still know how to use language – both written and spoken. However, *caregivers may mistakenly treat these individuals as if they are mentally impaired, like they don't "get it" because they don't respond or they are hard to understand!* The other common error is that caregivers raise their voices like the person is deaf, which also risks insulting the person and causing more problems!

## >>Brain disease and injury

Disease and injury that cause *brain cell loss or brain cell dysfunction* may result in loss of ability to use language. Some of the more common problems include strokes, head traumas, and dementias like Alzheimer's disease.

The medical term that is often used for disease-related language loss is APHASIA. The letter “A” is used to mean “without,” so APHASIA means “*without speech*.” There are two types of aphasia:

- Expressive aphasia involves the *loss of ability to express oneself through speech*.
- Receptive aphasia involves the *loss of ability to understand the spoken word*.

Aphasia is typically NOT an “all or nothing” thing. It may be mild, moderate or severe – meaning that the person has some abilities that caregivers can build on. Also, whether the aphasia is stable, or get worse over time, depends on the cause, as described next.

## >>Strokes, head trauma

One of the most common causes of aphasia is STROKE, or cardiovascular accidents, which may destroy part of the person's “language center.” The loss of language caused by a stroke tends to be permanent and fairly stable. That is, persons who experience stroke may get back some or all of their lost abilities, but after 6 to 12 months they tend to level off. They don't get better, but they also don't get worse. The type of language problems that they have depends on where the damage was in their brain and how extensive the damage was.

Likewise, any type of severe HEAD INJURY could also cause language problems. And like strokes, the problems would tend to be permanent and fairly stable.

## >>Dementia

Another common cause of aphasia is dementia. There are several different types of dementia: Alzheimer's, Vascular, Frontotemporal, Lewy Body, and Pick's disease, just to name a few. Although different types of dementia have somewhat different symptoms, they all involve loss of language. In contrast to strokes and head trauma, elders with dementia tend lose their ability to communicate gradually – a little bit at a time.

In dementia, aphasia is progressive, starting with word-finding problems, and becoming more severe over time. And unlike strokes and head traumas, dementia will interfere with *every aspect of the person's ability to communicate!!* Over a period of time, the person with dementia will lose their ability to communicate their thoughts, feelings or needs. At the end stages, many people with dementia are mute.

## >>Multiple problems related to loss of ability

Caregivers need to remember that the person who has suffered some kind of brain insult, whether head trauma or stroke, and particularly people with dementia, often have lost *MORE than just the ability to speak the words!!* Other types of disability may contribute to the person's behavior – and may overlap on top of sensory loss, other health problems, longstanding personality traits, and coping methods.

The combination of problems can cause difficulties for the elder, and for you, the caregivers. As before, *observing, reading, listening and asking* often helps explain behavior that is confusing or “out of context.” Taking “a minute” to discuss the behavior with other team members, look in the chart for medical information, talk to family, or talk with elders about their experience may save time in the long run!!

## ENVIRONMENTAL FACTORS

### >>Physical Environment

#### **\*\*Refer again to handout: Barriers to Communication: Environmental factors**

A final and very important consideration is the ENVIRONMENT in which communication occurs. Interactions between health care providers (e.g., caregivers) and older adults often occur in some health-related setting – clinics, hospitals, nursing homes, and residential or assisted living facilities.

These PHYSICAL SETTINGS may easily influence the quantity and quality of interactions. For example, characteristics of group living environments, like nursing homes or residential care facilities, may affect both the elder's *ability and willingness* to communicate. Large, multi-purpose rooms where elders are congregated for activities, meals, or socialization are often

- noisy,
- lack privacy, and
- do not have seating arrangements that are conducive to conversation!

This “context” of communication is very important to the outcome we achieve! Stop and think about the physical setting in which YOU work. *How might it contribute to, or get in the way of, good quality interactions?*

### >>Social Environment: Expectations

Another set of problems relates to ROLES in health care settings. There are certain unstated “expectations” about HOW to interact. A common “assumption” is that providers (doctors, nurses, nursing assistants, other care providers) are IN CHARGE of making decisions AND providing the care “needed” by care recipients – who are labeled patients, residents or tenants, depending on the setting.

The emphasis placed on providing PHYSICAL CARES too often interferes with caregivers asking about recent events, issues, problems or needs *that may influence the person's outlook or ability to cooperate.*

The task-orientation contributes to feeling that communicating with patients is a “LUXURY.” Likewise, caregivers may fear being viewed as “lazy” for taking time to talk with patients.

The hurried pace and emphasis on “efficiency” reduces efforts to help older persons be independent by guiding them through cares. In turn, unwanted dependency, or being “done to,” increases the risk of uncooperative or resistive behaviors. In response to this “noncompliance,” caregivers may verbally correct or admonish the older person, *resulting in even more distress, discomfort and miscommunication.* In short, a downward spiral of distress too often results.

### >>Organizational Environment: Unstated policies

Regrettably, the emphasis placed on “doing tasks” vs. “talking” is driven by the philosophies of the facility itself. Unwritten “policies” which are part of the institutional “culture” may include the value that “talking is not working.” In this type of setting, caregivers may WANT to take more time to talk and interact with older adults – but feel guilty for doing so because their supervisors and peers will call them “slackers” who avoid doing “real work.”

However, institutional values may also PROMOTE positive social interactions between care providers and care recipients. Considerable evidence supports the fact that “top-down” provision of social support, encouragement, respect, and open communication – from administrative personnel to nurses and other day-to-day caregivers – has a profound and positive effect on care provided. In other words, when caregivers are supported, assisted, and provided needed knowledge, patient care outcomes related to effective communication, cooperation, and satisfaction with care is likewise enhanced!

## INTERVENTIONS

### >>Interventions

#### **\*\*Refer to handout: Interventions to Improve Communication**

Just as there are many barriers to effective communication, there are also many things that caregivers (and others around the impaired older person) can do to enhance interactions and understanding. Although it takes time and energy to identify the older person's abilities and limitations so that individual needs can be best accommodated, the time spent is often rewarded with

- better quality relationships,
- fewer behavioral incidents, and
- improved quality of life for older adults and quality of work-life for staff!

### >>Communicate concern

First and foremost, we can let the older person know that we *CARE ABOUT THEM*, that we are interested in them, and willing to talk and to listen. We can “tell them” we care through

- the tone of our voice,
- our facial expressions,
- our words,
- our gestures, AND
- *through our ability to listen to criticism, complaints or sadness without disagreeing, “correcting,” retaliating, or withdrawing from them.*

Remember the value of SENSITIVE LISTENING – listening until the person has finished talking. As before, that means *listening*

- without interrupting, cutting the person off, or “tuning out” what is being said, but instead, and
- *listening for MEANING*. What is the REAL issue or problem?

### >>Show interest: Positive & negative

It is also important to remember that while we may be trying to discover information related to some difficulty or problem, we need to take time to see the positives as well as the negatives. Our “problem-oriented” approach can sometimes leave the person feeling worse.

Taking time to listen to “stories” that may seem irrelevant or unimportant to “task at hand” may be VERY important to our relationship with the older person. We learn something about the person as an individual – and that information may be very useful at some point in the future!! The older person may also be trying to tell us “It’s not ALL BAD. *I am still a good and capable person!*”

Remember: *Being supportive and encouraging* while trying to examine “the problem” is very important to maintaining self worth!

### >>Slow down & focus on the person

As noted before, one of the most serious barriers to effective communication is *the hurried and task-oriented pace of most health care settings*. Caregivers and other health providers often feel pressure to “do something” and may feel GUILTY for taking time to “just talk.”

However, the time spent talking with the older person is as important as physical “tasks” or “chores” – like dressing, grooming, ambulating or bathing. In many cases, slowing down, talking

*while you complete activities of daily living, and listening carefully for meaning can actually SAVE TIME in the long run.*

### >>Adjust the environment & routines

There are lots of things caregivers can do to help the older person communicate their needs, problems, or concerns. Changing the APPROACH that is used and adjusting factors in the ENVIRONMENT in which the interaction occurs can make huge difference in the outcome.

### >>Sensory system -- changes in vision

First, think about all the things that caregivers can do to *compensate* for SENSORY LOSS. Some of the best basic principles include the following:

- Provide more light so that the person can see you, and what you are doing.
- Avoid standing too close to the person. Close objects, even faces, may actually become blurry to the aging eye.
- Stay in front of the person where they can see you. Peripheral vision decreases with age, and being in the person's field of vision is very important!
- If you are using signs or color contrast to promote function, use bright colors like red and yellow. Greens and blues tend to be more difficult to see in later life, but our ability to see yellows and reds lasts longer.
- Be sure that the person wears her/his glasses – and they are clean and fit comfortably!

### >>Sensory system: Changes in hearing

**//Trainer: When speaking the following paragraphs, overemphasize the "s, sh, and ch" sounds to illustrate; vary the pitch of your voice from high to low as a demonstration.**

We also need to remember that our ability to hear certain sounds may change in late life. For example, "S, SH, and CH" aren't heard as well. Likewise, high frequencies also tend to be lost. This is an important point because women's voices are generally higher in frequency than men's voices – and most caregivers are women!

Caregivers can help older people compensate for these changes by adjusting their routines and approaches. For example,

- Make sure that the person can see you *so that they can read your lips*. Stand in front of them – and as before, make sure they are wearing clean glasses if needed!
- If you need to talk louder, lower the tone of your voice.

- Check for buildup of earwax. Lots of hearing problems are related to earwax – and it is an easy problem to resolve!
- Make sure the person is wearing their hearing aid, AND that it is working! Remember that batteries will need to be replaced periodically – so remember to check with the person about their ability to hear you AFTER the hearing device is in place.

### >>Adjust the environment: Noise, distraction

We also need to think about *distractions* and *noise* that can interfere with the person communicating with us, and us with them!!

Caregivers may become “immune” to how noisy or confusing the environment is – how many people are talking at once, people coming and leaving an area, the sound of radio or television, or other distractions that may interfere with effective communication. Noise and confusion in the environment may easily interfere with the person *paying attention to you, or hearing what is said*. Stop and ask yourself:

- Is noise interfering with your attempt to communicate?
- Is the person distracted by other stimuli, like a pet seeking attention, television show, or other things going on around him/her?
- What else is going on that might interfere with the person hearing or seeing you AND understanding your message?

### >>Consider personal comfort

As you think about the environment, be sure to evaluate the older person’s level of COMFORT, including both his/her psychological and physical comfort.

First, think about the *type of information being shared* – and the person’s need for PRIVACY. Talking about personal issues, like feelings, problems, or even past experiences, may be uncomfortable or embarrassing. Stop and think about who else may be present and “listening” to the conversation. How might that influence how much, and what type of information is shared?

As important, try to think about the older person’s level of physical comfort. Things like being hungry, or having a full bladder can be a distraction, and keep the person from focusing on your question or request. Stop and think about the older person’s experience – what are THEY thinking or feeling? What is going on with them?

### >>Adjust your approach: Language

Remember that the resident may need more time to consider a question and provide an answer. Adjust the pace of your interaction accordingly! Slow down and give the person a chance *to think about what has been said, and the respond!!*

Also, be sure to use language that is familiar and understandable to the person. Too many health providers slip into using medical jargon that is NOT understood by the average person. For example, the word “urination” (or even “peeing”) may be more understandable than “voiding.” Likewise, using slang terms that are unfamiliar – or UNCOMFORTABLE to the person – may also hinder good quality interactions.

And to the extent possible, be clear and concise. Long, wordy, or vague language often interferes with good quality communication.

### **>>Adjust your approach: Reception**

Caregivers may also need to change the way that they frame questions or requests to best accommodate the older person’s loss of language. Start by thinking about their RECEPTIVE abilities. Stop and consider: Can the person

- understand a yes/no question?
- read simple instructions?
- understand simple verbal cues? (e.g., use of one-step instructions)
- understand verbal cues if they are given with physical gestures to cue the person? (e.g., motioning as if to brush teeth while saying “brush your teeth”)
- make a choice if presented with two options? (e.g., wear blue or brown pants? Do now or later?)

Adjust what you do, and how you do it, according to the person’s level of ability. For example, using simple, direct “yes/no” questions may reduce frustration and help the person perform. Likewise, providing large print written cues may help the person be successful.

### **>>Adjust your approach: Cue**

Sometimes it is important to know “when” something happened, or “how long” it’s been going on. The older person may respond to your questions with something vague like “a long time” or even “oh, I don’t know.” That type of answer does not help get the facts!

So you may need to *give them cues*. For example, “Your daughter visited on Sunday. Were you having this pain when she was here?”

### **>>Adjust your approach: Nonverbals**

Be sure to tune into the “unspoken” messages that the resident is sending you and follow up with questions to “check out” what you think you see. Sometimes caregivers misinterpret a look, or an action, and think that there’s a problem *when there isn’t!!*

Likewise, take responsibility for your possible contribution to miscommunication. For example, if you find yourself frowning, grimacing, or otherwise “looking” unhappy or upset, *apologize and tell the person what you are thinking* – that you are trying to understand and are still confused about what they want, need, or are saying.

### >>Adjust your approach: Expression

In some cases, the older person may have considerable difficulty expressing ideas or needs. As noted earlier, expressive aphasia may be caused by dementia, stroke, or other diseases that effect language. Take a minute to think about the person’s use of words, and what it may actually mean. Does the person

- have difficulty finding the right word (or words)? (e.g., stammer, pause, not respond, or say “oh, you know...”)
- substitute a pronoun (e.g., it, that) or general term (e.g., thing, “what-cha-ma-call-it,” “thing-a-ma-jig”) for the “right” word?
- have trouble putting their ideas together in a logical sentence? Do they seem to ramble or say things that “don’t make sense”?
- curse or become irritable when trying to communicate needs or wishes?

As before, adjust what you do to help the person make their needs, preferences, and desires known. Although “guessing” what the person is trying to say may work in some instances, in other cases it may be confusing and frustrating to the person. (How well you know the person often will make a difference in whether guessing is effective.) Listen for meaningful words and ideas, trying to identify key ideas. Respond to the person’s emotional tone and validate their feelings. As before, apologize for misunderstandings and acknowledge their frustration or anger is understandable, given the situation. And as before, make sure your nonverbal messages – the look on your face, your posture and gestures, the tone of your voice – are all saying “I am interested. I want to understand.”

## SUMMARY

### >>Summary

IN SUMMARY, caregivers need to think carefully about all the factors that could influence the “chain of events” that may lead to behavioral and psychological symptoms in older people. GETTING THE FACTS involves thought-full listening, reading, observing and asking to collect the information needed to understand behavioral symptoms. By looking for the underlying causes of behavior, caregivers are better prepared to adjust their approach and routines, and offer interventions designed to comfort, reassure, and assist older people. Getting the facts relies heavily on EFFECTIVE COMMUNICATION between caregivers and older adults, making this topic and important one for all health care providers!

Key Ingredients related to effective communication with older adults includes the following main points.

1. *Communication* is much *more than words*, and the exchange of information – it is a fundamental aspect of all human relationships – the way we “connect” with other people. Caring about and communicating with the older person cannot really be separated. Taking time to connect with the older person, and thinking about the individual as a person first, is as important as physical care provided.
2. *Understanding the communication process* can help caregivers decipher difficult-to-understand behaviors. Thinking carefully about verbal and nonverbal messages, and the context in which communication occurs often helps caregivers understand the situation from the older adult’s perspective. How a person behaves is based on their perception and evaluation of the situation – not the actual events themselves.
3. *Attitudes, beliefs, and assumptions* about the elder and his/her problem make a big difference in what caregivers *perceive about the older adult’s behavior*, how that information is *evaluated*, and then *what is done, or not done, in response*. Negative attitudes and labels regularly contribute to lower quality care.
4. *Age-related changes, like sensory losses* may affect older persons’ ability to respond “appropriately” because they are not getting accurate information from their environment. Taking time to understand the older person’s perspective and adjust approaches and routines improves outcomes.
5. *Diseases and disability* may directly and indirectly interfere with communication. Illness-related problems often combine with other challenges to cause complex behavioral symptoms. Understanding illness-related problems helps caregivers adjust approaches to care and improve function.
6. *Environmental influences*, including the physical and social environments, and the “culture” or values of the facility which care is provided, often communicate powerful messages to both older adults and caregivers. Indirect and unwritten policies that “talking is not working” may contribute to a downward spiral of care. In contrast, when caregivers are supported, assisted and provided needed knowledge related to psychosocial care, outcomes are enhanced.
7. *Many interventions* may be used by day-to-day care provider to promote clear, understandable communication with older adults. Adjusting approaches used in daily care and modifying care routines better assures that that older adults accurately perceive their environment, are viewed as a person first, and are provided care that enhance dignity and shows respect.