Alzheimer's Awareness Family Night

LEADER'S GUIDE

SESSION #5:

Medications, Older Adults, and Alzheimer's Disease

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Basic Guidelines for Hosting a Family Night

Educating the loved ones of those with Alzheimer's disease can help improve not only their caregiving experience, but the quality of life of those with the disease. To this end, we have created a series of family night sessions designed to assist you in addressing major topic areas related to Alzheimer's disease.

Family nights have two goals:

1. To provide practical information for families and friends of those living with Alzheimer's disease.
2. To help reduce the stress associated with having a loved one with Alzheimer's disease by offering that information in a friendly and supportive atmosphere.

To facilitate the first goal, this packet contains both information for you as the session leader and ready-made handouts for attendees. The second goal may be achieved in a variety of ways, for example:

- Make **invitations** to the family night warm, enticing, and clear, and provide directions and any important details.
- When a potential attendee **responds** to the invitation, be sure the person who answers the phone has a smile in her voice and is well-informed about the event.
- Provide an **atmosphere** that delights the senses. The setting for your meetings should look and smell pleasant, be an appropriate temperature, and offer comfortable seating. Tasty refreshments should also be available for attendees.
- **Welcome** each attendee as he or she arrives. If you have invited other staff, residents or volunteers to help you, make sure they are trained to do the same. Provide easy-to-read **name tags** for everyone.
- **Learn** as much as you can about each attendee's situation *before* the program begins by chatting with them when they arrive, rather than spending that time making last-minute notes or other preparations.
- **Introduce** attendees to one another so that each person feels a part of the group.
- Do your best to **present information with ease and confidence**. Remember that your audience WANTS you to succeed. They want to learn new information and come away with tips for being better caregivers, and they will be grateful that you are genuinely interested in their individual needs and experiences.
- Encourage **participation** from attendees by acknowledging their responses and answering additional questions with a positive demeanor.
- **Follow up** by inviting them back to future sessions. Provide them with handouts even if they miss a session. Get back to them with any questions you could not answer initially.
- **Seek attendees' input** about the session, as well as how to improve future sessions.

Room arrangement

If possible, arrange the room in a circle or semi-circular rows so that people can see each other. This automatically adds an element of friendliness. If there are rows, keep them wide. Because many older adults need to get up and move around regularly to prevent stiffness, make sure they feel free to do so – or build breaks and/or stretches into your session.

Using the materials effectively

- Make sure you have enough pens or pencils and that you have made enough copies of handouts for each attendee before everyone arrives.
- When attendees arrive, we suggest you give them only *Handout #1: Opening Exercise* and a pen or pencil. Each session begins with a puzzle, exercise or conversation starter related to the evening's topic that is intended to arouse their curiosity, along with the questions we expect to answer during the session. These activities will always be labeled as "Handout #1: Opening Exercise."
- Once attendees have completed Handout #1, and you have offered a brief explanation of its relevance, give each participant a copy of *Handout #2: No-Pressure Quiz*. Remember to keep the introduction of the opening quiz light and humorous. The quiz is not intended to measure attendees' knowledge as much as is it is designed to be a vehicle for a discussion of the evening's important topics.
- Wait until the end of the session to pass out *Handout #3: Important Points and Resources*, but let attendees know at the beginning of the session that you will be providing an additional handout before they leave. We want to promote discussion and draw out the experiences and knowledge of the attendees. If they are given the discussion points at the outset, they are less likely to give original thought to the questions, and it is their comments that are most likely to enliven the session.

Using the leader's guide

- Material intended for the session leader only is provided in Arial type.
- Material to be presented to attendees (such as questions to ask or directions to be given) is provided in Times New Roman type.
- Each leader's guide provides a fair amount of detail about session topics. If your time is limited, you may wish to consider incorporating less of this detail.

General instructions for each session

- Begin the session by welcoming the group and introducing yourself and any assistants you have asked to help.
- Try to avoid discussing "housekeeping" issues during the session. Instead, provide information, such as the location of restrooms, on a flip chart so that even late-comers will be informed.
- Posting a session agenda is also recommended and should include any planned breaks. If you are not planning a session break, direct attendees' attention to the restroom flip chart, and encourage them to 'get up and go' anytime. Doing so lends a touch of humor while letting attendees know you realize they are adults who can make their own choices about comfort.
- One of the principles on which this material is based is that those in your audience are the best teachers. Throughout each session, we offer questions to ask attendees. Their answers are likely to vastly enrich each session, provide many concrete examples related to various subtopics, and spark interesting and relevant conversations. Offering attendees a chance to respond to questions, and *then* filling in whatever details they don't mention is an excellent way to keep attendees involved.
- Practice going through the materials before you begin, not only to become familiar with them but to have a sense of how much time each section will take. Assign a time period – depending upon the total amount of time you have – for each section, and be sure to allot enough time for attendee input and questions related to each section. Do your best to adhere to your planned schedule so you don't feel rushed. You may opt to offer to stay after the session to discuss the experiences of anyone who didn't have the opportunity to share during the session.
- Make the material your own. Add your own stories, insights, and creativity as time and topics allow.
- Begin and end on time. This is always appreciated – even by late-comers.
- At the end of the session, create a simple parting ritual: Let attendees know when the group will meet again and what topics will be addressed. Invite them to stay for more refreshments and to visit with each other and with you. Thank them sincerely for their shared insights and their devoted efforts as caregivers.

Training techniques to keep in mind

Dealing with the "gotta-have-an-answer" question

As you lead family nights, you are likely to encounter an attendee who has come to your session for the express purpose of finding an answer to a specific question about a particular situation. Once he has asked the question, there are essentially two ways to answer:

- If the question is relevant to the topic being discussed, give a time limit, which you announce ("This is a complex issue, but we can devote the next three minutes to an answer."). You may wish to ask for more detail about the situation (What interventions has he tried? What were the results?) When you feel you have the needed detail, ask for input from other members of the audience – they may have terrific ideas. If there is still time, provide any answers of your own as well as you are able.
- If the question is *not* relevant, or if your allotted time has run out, write the question on a post-it note and put it in a "parking lot" –a flip chart, white board, or wall that is reserved for unanswered questions. Tell the person you can't answer his question now, but that you will be happy to address it either at the end of the session if time allows or after the session.

When you don't know the answer

When you don't know the answer to an attendee's question it's best to say so, but promise you'll do your best to find out and follow-up. Once you have found an answer, report back to the person who asked by phone, email or in writing. If it's important to multiple people, provide the answer to the whole group in your next session.

When one person dominates the session

Often, people don't realize they are monopolizing a group discussion, but as the session leader, you have a responsibility to remedy the situation. Depending on your personal style, you may choose to be straightforward or subtle in your approach. You can say something direct, such as, "I appreciate your input, Mrs. Jones, *and* now I would like to hear from other members of the group." (Using "and" instead of "but" validates Mrs. Jones's input while sending the message that others deserve a turn to speak as well.) A more subtle approach might be to toss a Koosh ball, Nerf ball, or beach ball, and establish that only the person holding the ball can speak. That tends to liven up a session with color and motion, and keeps the discussion spread out. Whatever approach you choose, do your best to encourage active participation among all attendees without allowing one person to control the conversation.

When someone doesn't participate at all

In any group there is likely to be someone who chooses to simply listen. Respect that choice. If a ball is tossed to him (such as in the approach above), make sure he understands he can pass it to someone else without commenting. At the same time, after the session or during a break, make a point of talking with him to find out if he is finding the session useful or if he has any specific questions. He will appreciate not being put on the spot in front of everyone and will probably give you honest feedback. Often, those who choose to listen are perfectly content, but just don't wish to speak in front of a group.

Opening Exercise and No-Pressure Quiz

As attendees arrive, welcome them, give each person a copy of Handout #1, and ask them to answer the questions with the first thing that pops into their minds. Give attendees a few minutes, read each question aloud, and ask them for their answers.

1. A man was visiting a mental institution when he asked the director, "How do you determine who needs to be admitted?" The director answered, we fill a bathtub with water and offer the person a teaspoon, a teacup, and a bucket and ask him to empty the tub." Which would you choose?

   Most people will say the bucket, assuming they are to take the largest object in order to remove the most water at a time. The answer, however, is "None of the above. A normal person will empty the bathtub by pulling the plug." Did anyone realize that? For those who didn't, ask them if they would like a bed next to yours at the institution!

2. Say "silk" five times. What do cows drink?

   Cows drink water, of course, but by asking you to repeat the rhyming word "silk" multiple times, many people are led to automatically answer "milk." Were you one of them?

3. If a red house is made from red bricks and a blue house is made from blue bricks and a yellow house is made from yellow bricks what is a green house made from?

   Greenhouses are made from glass. Are your attendees catching on? Tell them you would like to ask one more question. This particular one works better when read aloud:

4. You are driving a bus from east Springfield to west Springfield. At the first stop 6 people get on. Now without using a calculator, try to follow along. At the second stop you pick up 5 people. At the next stop 3 more people get on and 5 get off. At the next stop 7 people get on and 8 get off. Now, what was the name of the bus driver?

The point of this exercise is threefold:

1. To have attendees recognize how easy it is to be misled.
2. To see how quickly we can become flustered and confused.
3. To realize that answers aren't always what we think they should be.

Those are three main points of tonight's lesson that are intended to help attendees to better understand their loved ones with AD.

Tonight, we're going to talk about medications and older adults. The first half of this session is focused on the risks and problems older adults face in relation to their medications. The second half focuses on the basics of current Alzheimer's disease treatments.

To get us started, once again we have a short quiz for you to take. It's called a "no-pressure quiz" because it's just that. It won't be graded, and no one will see your answers but you. And those of you with real test anxiety can choose to leave your quiz paper blank for now, and just fill in the correct answers as we go!

Once attendees have finished completing their no-pressure quizzes, use the quiz questions to facilitate discussion. The answers to each question are highlighted. (You will notice that each question is followed by related discussion topics in this leader's guide.)

Many Pains, Many Pills

A few years ago, an email circulated with some new words Julie Andrews supposedly sang to "My Favorite Things" at an AARP concert. The chorus went like this:

> When the pipes leak,
>
> When the bones creak,
>
> When the knees go bad,
>
> I simply remember my favorite things,
>
> and then I don't feel so bad.

Simply remembering favorite things, however, doesn't help most older adults thrive as age-related physical changes occur. On the contrary, many – perhaps most – older adults rely on a variety of pills, ointments, creams, salves, eye drops, nasal sprays, herbs, vitamins, and dietary supplements. This frequently means they may be at risk for:

- Adverse interactions to medication
- Taking incorrect dosages of medications
- Using medications after its expiration date
- Continuing to use medications that are no longer appropriate

Ask attendees for their answers to the first question.

Question #1

Older adults need their medications and other products used to treat various ailments evaluated approximately every six months to prevent adverse interactions. Which of the following is LEAST likely to need to be evaluated?

a. Prescription medications, drops, ointments
b. Over the counter medications, drops, ointments
c. Lipstick and face powder
d. Vitamins and dietary supplements
e. Health food store products including anti-aging creams

The reality is that most older adults not only do not have their medications evaluated by their physician or pharmacist every six months, but most who ask for an evaluation of them fail to mention many other items that can also contribute to problems. It is estimated that only about 10 percent of older adults obtain such a thorough evaluation. This means that most older adults are at risk, not just because of their *physical* conditions, but because the products they are taking to *alleviate* those conditions may be harmful.

Give attendees an opportunity to respond to this information with questions or comments. Then ask attendees for their answers to the second question.

Question #2

All of the following are common reasons older adults are at risk for adverse drug reactions EXCEPT:

a. Drug dosages are commonly developed based on recommendations for healthy young males.
b. They absorb, metabolize, and eliminate drugs at different rates than younger people.
c. For many reasons, older adults may not accurately follow the directions for taking their medications.
d. They tend to take multiple medicines.
e. They pay more attention to diet and exercise than their medications.

While we *wish* they paid closer attention to diet and exercise, that is not generally the case.

A study by the American Public Health Association (APHA) estimated that although people over 65 make up only 12 percent of the population, they account for 34 percent of all prescription medication use and 30 percent of all over the counter (OTC) drug use. The APHA also estimates that about 60 percent of older adults take their prescriptions improperly. As a result, the APHA states that more than a million older adults are hospitalized, and over 100,000 people die annually either as a result of the side effects of the drugs or from taking them improperly.

There are many reasons that older adults are at risk for adverse drug reactions. For example:

- Most drug dosages are developed for a 150 pound male, aged 22 - 26. Older adults absorb, metabolize, and eliminate medicines from their bodies at different rates than do younger people, and they usually require lower dosages of most drugs. Not all physicians take this into account.
- Older adults also tend to have multiple health conditions not generally found in young males.
- Many older adults were lifelong smokers and/or abusers of alcohol.
- Many do not eat healthy diets or get regular exercise.

All of these things influence not only older adults' overall health but how their bodies respond to medication.

Furthermore, most older adults see multiple doctors, and those physicians don't always coordinate treatment. A person may receive two prescriptions from two separate doctors for high blood pressure, for example, and have a toxic reaction.

There is also a strong tendency among many physicians to continue prescribing a drug they've started, rather than periodically evaluating the need for continuing its use. This, too, can cause toxic reactions over time.

Additionally, few doctors know all of the medications - including over the counter drugs and things like dietary supplements, herbal medicines and topical creams - their patients are using, which is why "the brown bag solution" (bringing everything in for periodic evaluation by a pharmacist or physician) is so helpful.

To begin to overcome these challenges, caregivers can help older adults compile a list of all their drugs, dosages, and directions, and make multiple copies of it. One should be carried in the person's purse or wallet, one in the caregiver's, and other copies should be given to each physician and the person's emergency contacts, such as neighbors or relatives. If the list is stored on a computer, it is easy to make changes and print more copies as needed.

Give attendees an opportunity to respond to this information with questions or comments.

Now let's talk about another challenge, by looking at your answer to question #3.

Non-compliance vs. nonadherence

Question #3

People are said to be noncompliant if they willfully fail to take their prescribed drugs as directed.

a. True
b. False

Most older adults take multiple medications, and physicians are often frustrated by patients who fail to take those drugs as prescribed. Patients are called *noncompliant* when they *unintentionally* fail to follow the instructions of doctors or pharmacists. *Nonadherence* is a *deliberate choice* made by patients to go against the physician's wishes. But there are many reasons for both. Let's look at your answer to question #4:

Question #4

The following are examples of nonadherence:

a. They are worried about the cost of their medicines
b. They are confused by what to take when and don't want to admit it
c. They start taking fewer pills because they don't like the side effects
d. B only
e. A and C only

Let's talk about this in more detail. People may be *noncompliant* because they:

- Have a hearing or vision deficit or a poor understanding of English and a reluctance to share this information with their doctors. This often creates misunderstandings about directions and interferes with their ability to read the labels or side effect warnings.
- Are confused about a complex regimen of 8 – 10 medicines, some of which must be taken multiple times a day, some with food or without. Again, they often don't admit their confusion, in part because it's a threat to their self-esteem and independence.
- If they have memory problems and do not yet have a diagnosis of AD, they may forget to take the meds or forget they have already taken them and take them again.

Older adults may be *nonadherent* – willfully not taking medicines as prescribed – for any of the following reasons or some combination of all of them:

- They worry about the cost and try to stretch their prescriptions by, for example, taking only two a day when four are prescribed. This is a common problem and is not limited to people who are poor.
- They resist taking certain medications because they are in denial about their own aging.
- They experience unpleasant side effects and rather than telling their doctors, they simply stop taking the medicine or lower the dose on their own.
- They may not believe it is essential to avoid alcohol or caffeine or to follow other directions precisely.

- They may stop taking the medication as soon as they feel better, failing to understand the importance of continuing it.
- If they are depressed, they may be unmotivated to take any medicine at all.
- They may fear addiction (especially with pain medications), or their caregivers fear their addiction and influence their care receivers' intake.

Give attendees an opportunity to respond to this information with questions or comments.

On the other hand, many people may have adverse or unintended reactions to medicines, even when they take them according to directions. Medicine is a complicated science, and our understanding is imperfect. Here, for example, are a few oddities related to drug interactions:

- Aspirin and alcohol interfere with vitamin C absorption; anti-inflammatory drugs interfere with the absorption of B vitamins; diuretics cause potassium loss.
- Diabetics who are also smokers require higher doses of insulin.
- The combination of antidepressants and aged cheese can cause high blood pressure.
- Aspirin can cause internal bleeding, and it is "hidden" in many other commonly used drugs, such as Alka-seltzer, Anacin, Excedrin, and Pepto-Bismol.

If those examples are not confusing enough, consider that research often produces mixed results, so, for example, as we've seen, one year's recommendation on estrogen supplements may change the next year.

What to ask the doctor

One thing you can do to help prevent all these problems is to be proactive in getting answers to your questions about medication. When a new medicine is prescribed for you or your care receiver, ask these questions before leaving the doctor's office:

- What is the name of the medicine? What is it for?
- How often, when and with what (food, water?) should I take the medicine?
- Are there any risks for me in taking this medicine with my other medicines (prescribed and over the counter)?
- How will I know the medicine is working? How soon am I likely to notice? How long must I take it?
- What side effects are likely, and which ones should I be concerned about?
- What should I do if I miss or forget a dose?
- Should I avoid any foods, drinks, other medicines, dietary supplements, or activities while taking this medicine?

If needed and possible, get directions in large print or translated into your primary language.

Give attendees an opportunity to respond to this information with questions or comments.

Be an advocate

In terms of helping your loved one, it's also important to be an advocate. Let's talk about your answer to questions #5.

Question #5

All of the following are important reasons to become an advocate for people with Alzheimer's disease who are taking various medications, EXCEPT:

a. When they are in pain, they can seldom ask directly for medicine.
b. Without your intervention they may become addicted to pain meds.
c. They may not recognize that their diarrhea is a possible side-effect of a medication.
d. Since they already have a diagnosis of Alzheimer's disease, others may not recognize a sudden increase in confusion as a possible drug side effect.
e. Their loss of sense of time puts them at risk for failing to take medication or taking pills too often.

The answer is B. Many people are worried about their loved ones becoming addicted to pain medications, but it is much more likely that the pain of people with dementia is under-treated or treated with the wrong drug than that they will take too many pain pills. Try not to get too involved in this discussion, however, because pain is the main topic for the next session.

As caregivers for older adults, one of our primary roles is that of advocate. When people have Alzheimer's disease, they can seldom verbally express their discomfort with a medication, so it is up to us to give them a voice.

First, we can try to make sure they are being given the right medicine. People with AD often express pain through anxious behavior. Far too often, they have been (and still are) given psychotropic or anti-psychotic drugs to treat their behaviors when what they really needed was a pain-killer.

Second, we can watch for other sudden changes, behaviors, or conditions that may be the result of the wrong drug or the wrong dose such as:

- dry mouth, nausea, vomiting, diarrhea, skin rashes
- involuntary tics such as sticking out one's tongue (tardive dyskenesia)
- increased balance and movement problems
- increased confusion

Give attendees an opportunity to respond to this information with questions or comments.

Now let's spend some time talking specifically about Alzheimer's disease.

The Long Road to Cause, Cure, and Prevention

Ask attendees for their response to question #6. We hope they understand that "risk factors" are just that – risk factors, not guarantees.

Question #6

The two most common risk factors for Alzheimer's disease are increasing age and certain genetic factors. Not everyone who gets old will develop AD, but everyone with those genetic risk factors will.

a. True
b. False

When you touch a hot stove, you know you will burn your finger. In this situation, the cause of your burned finger is clear. The causes of Alzheimer's disease, however, are not clear. Research indicates that the causes are both complex and elusive, with genetic, environmental, and lifestyle factors working together to trigger the disease and cause it to progress. The individual impact of each factor, however, differs for each person affected.

As you may know, Alzheimer's disease is named after Alois Alzheimer, who discovered abnormal protein plaques and tangles in the brain of a woman who died of dementia. These plaques and tangles are now considered the hallmarks of Alzheimer's disease pathology, but in recent years, researchers have found that they also appear in the brains of many people who *don't* show signs of AD.

One well-known and ongoing study of Alzheimer's disease is the Rush Memory and Aging Project. It involves 1200 elderly volunteers who are evaluated yearly and have agreed to donate their brains after death. Eighty of the 141 participants who have died had significant plaques and tangles in their brains. It would be reasonable to expect that they would have shown signs of Alzheimer's disease in life. Yet only 47 of them had been diagnosed with probable AD. Why didn't the other 33 exhibit signs of dementia? Obviously, their brains were protected in some way, but exactly how remains a mystery.

The two most common risk factors for Alzheimer's disease are age and genetics, neither of which we can control, but they are only a part of the story. Millions of people grow old *without* developing dementia. As for genetics, a rare form of Alzheimer's disease called early-onset AD, which occurs in people between the ages of 30 and 65, is related to mutations on three chromosomes. Late-onset AD, which is much more common, develops after the age of 65. The highest genetic risk factor found to date is the presence of the gene apolipoprotein (pronounced AY-poh-lip-oh-protein) E4 (APOE4). However, even this gene appears in only about 40% of people with AD, according to the National Institute on Aging (NIA). Obviously, other factors are at work.

Now let's see what you know about new research directions by looking at your answer to question #7.

Question #7

Current research on the cause or causes of Alzheimer's disease involves studying various other diseases, including:

a. Diabetes
b. Heart disease
c. Arthritis and other inflammatory diseases
d. All of the above
e. A and B only

The answer is, "All of the above." The National Institute on Aging is looking at relationships between Alzheimer's disease and numerous other conditions. For example, we know that people who have high blood pressure and high cholesterol levels are at higher risk for heart attacks and other heart conditions. Researchers are now interested in determining whether lowering blood pressure and cholesterol might also play a role in lowering the risk for Alzheimer's disease.

People with diabetes are at higher risk for vascular dementia (dementia caused by strokes). Researchers are particularly interested in the possible role of insulin resistance, which occurs when the body produces insulin, but cells don't use it properly. According to the NIA (National Institute on Aging), too much insulin in the blood may encourage inflammation and "oxidative stress" – that is, when the body's anti-oxidant levels are too low. These are conditions that contribute to the damage seen in AD. This also explains why Alzheimer's research is being done with anti-inflammatory drugs and anti-oxidant vitamins (particularly C and E).

In all, there are currently hundreds of research studies and about 150 clinical trials devoted to learning more about Alzheimer's disease – and, we hope, finding a cure. The resource list on the handout you will receive at the end of tonight's session provides information on how to learn more.

In the meantime, we do know that maintaining a healthy lifestyle – eating right, exercising regularly – can help stave off a multitude of diseases!

Give attendees an opportunity to respond to this information with questions or comments. Then move on to question #8, and ask for attendees' responses.

Current Treatments for AD

Question #8

Currently, five drugs have been approved by the Food and Drug Administration for the treatment of Alzheimer's disease. Only two of them actually stop the progression of the disease.

a. True
b. False

Unfortunately, no drug currently approved by the U.S. FDA (Food and Drug Administration) actually *stops* the progression of Alzheimer's disease.

Interestingly, many diseases for which we know neither cause nor cure can still be effectively treated. Although there is currently no cure for AD, with each passing year, we are getting better at treating it.

The (FDA) has approved five drugs to treat its cognitive symptoms, however. Four of them are called cholinesterase (KOH-luh-NES-ter-ays) inhibitors, which seem to prevent the breakdown of acetylcholine (a-SEA-til-KOH-lean). Acetylcholine is a chemical messenger that helps connect the brain's nerve cells, and it is important for learning and memory. Cholinesterase inhibitors are prescribed for the treatment of mild to moderate AD to temporarily help delay symptoms or prevent them from becoming worse for a limited time. As AD progresses, the brain produces less and less acetylcholine; therefore, cholinesterase inhibitors eventually seem to lose their effect. Some people benefit more dramatically from these drugs than others and for a longer period.

In the list below, the drugs are listed first by their trademarked name, and second – in parentheses – by their generic name.

The cholinesterase inhibitors (in the order they were approved by the FDA) are:

- Cognex® (tacrine). (Cognex® is no longer actively marketed by the manufacturer.)
- Aricept® (donepezil)
- Exelon® (rivastigmine)
- Razadyne® (formerly known as Reminyl®) (galantamine)

The fifth drug currently approved by the FDA is Namenda® (memantine), which works by regulating the activity of glutamate, a different chemical messenger involved in learning and memory. It was approved in 2003 for treatment of moderate to severe Alzheimer's disease, and it has benefits similar to the other four drugs. It is sometimes used in combination with the cholinesterase inhibitor Aricept®, because Aricept® has also been FDA approved for treatment of moderate to severe Alzheimer's disease.

While these drugs are imperfect, and in some people have side effects that limit the dosage a person can tolerate, they have been beneficial to many. Caregivers of people on these medications tend to appreciate the extension of time that a loved one with AD can manage self-care issues such as dressing and using the bathroom. People with AD tend to appreciate the increased clarity they feel as a result of the medication.

Another advance is that current drugs are becoming available in more user-friendly forms, requiring, for example, fewer pills. Exelon® is now available as a patch, eliminating the need for pills altogether.

Give attendees an opportunity to respond to this information with questions or comments. Then move on to question #9. Ask for attendees' responses.

Question #9

People who take dietary supplements such as Ginkgo Biloba or Omega-3 Fatty Acids should do so only under the supervision of their physicians because:

a. Dietary supplements are not well-regulated for safety and effectiveness
b. Composition varies among different brands
c. Side effects and interactions with other drugs can be harmful
d. All of the above
e. A and C only

Answer D is correct - let's talk about it. Many people use dietary supplements in an attempt to prevent dementia or delay its effects. While some of these, such as Ginkgo Biloba and Omega-3 fatty acids, show some promise and are currently being studied, supplements should *always* be used only under a doctor's supervision because:

The FDA does not require rigorous scientific research for dietary supplements.

- Their purity, safety, and effectiveness are not well-regulated, so the composition of one brand may be quite different from another.
- Adverse reactions are not routinely monitored.
- Some supplements have known side effects that are potentially harmful. Ginkgo Biloba, for example, is known to reduce the ability of blood to clot, which could cause internal bleeding. It should not be taken in combination with other blood-thinning drugs, such as aspirin or Warfarin.

Give attendees an opportunity to respond to this information with questions or comments. Then move on to the last question which talks about what all of us can do to keep our minds and bodies in good shape.

There are things you CAN do

Ask for attendees' responses to question #10.

Question #10

Not all treatments for Alzheimer's disease are related to taking medicine. While all of the following are helpful, which of the following is likely to be LEAST beneficial in preventing or delaying AD?

a. Pleasant social interaction with family and friends
b. Eating a healthy diet
c. Waiting to begin an improved lifestyle after retirement when you have time to devote to it
d. Getting regular exercise
e. Keeping your brain active with mentally stimulating activities

The answer to this question is intended to motivate people to begin improving their lifestyles *now,* rather than waiting for some future time. It is also particularly important to emphasize that answer A, engaging in pleasant social interaction with family and friends, is also beneficial. Many people may be surprised to know that our social networks are an important element in brain health.

Brain imaging is one new development in AD research, offering a possible way to identify damage to parts of the brain involved in memory before symptoms of the disease occur. Research suggests that the propensity to develop Alzheimer's disease begins long before old age. In one NIA-funded study comparing healthy older people and people diagnosed with possible or probable AD, scientists found that the healthy group had engaged in more mentally stimulating activities and spent more hours doing them during their early and middle adulthood than did those who ultimately developed AD.

What may be surprising, however, was that most so-called "stimulating activities" were relatively simple, such as:

- reading newspapers
- listening to the radio
- playing puzzle games and
- going to museums.

This research offers one more good reason to pursue lifelong learning!

Give attendees an opportunity to respond to this information with questions or comments. Then close the session with the advice in the following section.

Choose what's right for you

In the last 15 years, the options for people with Alzheimer's disease and their caregivers have increased tremendously. Now, caregivers and those with AD can choose from various types of support and methods of coping with AD. For example:

- The person with AD can take an FDA approved drug or participate in a clinical trial.
- Support groups for both the person with the disease and his family caregiver abound
- Local Alzheimer's chapters offer multiple practical services.
- There are hundreds of books and thousands of websites with valuable information and insights.

Rather than being comforted by all these options, however, family caregivers are often overwhelmed by the choices and doubt their decisions. Therefore, we would like to close by asking you to take comfort in these two facts:

1) No decision you make needs to be final. You can always start or stop attending a particular support group, participating in a clinical trial, or taking certain medications.
2) As we noted above, research has shown that positive social interactions – getting together with family and friends – have tremendous benefits for both caregivers and care receivers.

As you end the session, give them their last handout. Consider closing with this story:

Finally, because we always like to end on a light note, I'd like to tell you about another study I found on the Internet. This study in 2006 found that the average American walks about 900 miles a year. Another study found that Americans drink an average of 22 gallons of beer a year. That means, on average, Americans get about 41 miles per gallon. Keep up the good work.

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