



Alzheimer's Awareness Family Night

LEADER'S GUIDE

SESSION #3:

What motivates the actions of a person with Alzheimer's disease?

Please advise patients and caregivers to always consult a health care professional about any medical condition they may have.

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 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

After welcoming attendees to family night, give each person a copy of Handout #1, and ask them to take a moment to look at the optical illusion. Can they see the black diamonds as both the tops and bottoms of cubes? Does one way feel more natural than another? Can they see that both views of the cubes are valid? Can they give an example of a situation when their view was the opposite of the view of their loved one with dementia?

Tonight, we're going to talk about what motivates people with Alzheimer's disease to do what they do. The last time we met, we spoke about communication issues and tried to show that people with AD are doing the best they can to function in a world that is becoming ever more confusing for them as their condition progresses. This is a continuation of that discussion. Many of the behaviors that are unfortunately labeled "inappropriate" have a logical basis. If we understand that, we can respond effectively.

To get us started, 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.)

Note that the wording and examples in each section below are meant to make it easy for you to teach this class. You may not have time to use them all or you or your attendees may have other examples of your own. Use your best judgment about what to include.

Why is he doing that? There's a logical reason.

As people with Alzheimer's disease lose their verbal abilities, they tend to "speak" through their behavior. All behavior has meaning, but it is not always easy for caregivers to decipher that meaning. As a result, people with AD are often labeled: "He's a problem," when what they are trying to do is express that they HAVE a problem. Remember, a person with Alzheimer's disease always makes sense to himself.

This opening paragraph contains two key concepts: 1) All behavior has meaning, and 2) The person with Alzheimer's disease always makes sense to himself. Emphasize these points, and ask attendees if they can give an example of something their loved one has done that initially seemed strange, but which eventually made sense.

When we talk about somebody being "a problem," we often mean, "He won't do what I want him to do." There are many logical reasons for people with AD to resist care. We're going to talk about many of those reasons tonight, but let's start with "The Big Four."

The Big Four

To begin, take a look at the first question on your quiz:

Question #1

Which of the following statements about fatigue in people with AD is NOT true?

- a. It may be related to physical illness.
- b. It is usually more of a problem in the morning.**
- c. It can cause irritability.
- d. It interferes with the person's ability to think clearly.
- e. People with AD tend to tire more easily and more often as their disease progresses.

Ask the attendees for their answers. Ask them to think about how *they* react when they feel fatigued. Remember that we want to emphasize that we ALL react in predictable ways when we are tired. Answers A, C, and D are true for everyone. Answer B may or may not be true for your attendees, depending upon whether they are early birds or night owls; however, the majority of people with AD tend to be most alert early in the day, after a full night of sleep.

Fatigue. When we're tired, we are all irritable and find it hard to "think straight." Most of us have a time of day when we are most alert, and when that time passes, we are no longer at our best. When we are fatigued, we may have trouble remembering items we want to pick up at the grocery store on our way home from work, or we may be more impatient drivers. During these times, tasks take more effort, and we are often irritated that we have to *make* that effort.

People with AD have the same reaction. The difference is that they tend to tire more easily and more often and can't always tell us they need to rest. They tend to be most alert in the morning after a good night's sleep – although waking up can be a slow process – and then slowly fade as the day goes on.

Give attendees a chance to speak about their experiences with their loved ones related to fatigue. Then go on to question #2.

Question #2

Which of the following is LEAST likely to be frustrating to a person with AD?

- a. Being unable to do something he once could do easily, such as get dressed
- b. Being kept from doing something he thinks he is perfectly capable of doing
- c. Not being able to see clearly enough to do things he once enjoyed, such as reading
- d. Not being able to hear and understand directions
- e. Working on a task he enjoys**

Ask the attendees for their answers. This one is quite obvious, but the other choices also inform this topic. Answers A, B, and C each offer an example of a once simple task that is now insurmountable due, at least in part, to the wear and tear of the aging process. Give attendees a chance to talk about their own frustrations with aging – most will likely do so in amusing ways – in order to foster empathy for their loved ones with AD. Frustration is logical.

Frustration. Frustration is a common problem among aging adults, because as we grow older, staying fit takes more work, hearing deteriorates, and vision loses acuity. It's harder to thread a needle or read fine print. Even when we come to accept our aging bodies, most of us are frustrated that, at times, we can no longer move as effortlessly or hear and see as well as we once could.

Our loved ones with AD must deal with both these aspects of normal aging *and* their disease-related changes. For them, something as ordinary as putting on a pair of pants without assistance can become an insurmountable challenge. What's worse, they are often unable to find the right words to express their frustration.

Furthermore, because our loved ones with AD have trouble with *some* tasks, we often mistrust their knowledge and assume they lack skills in *all* tasks. We may keep them from doing things they could accomplish independently and successfully because we fear for their safety or have doubts about their capabilities. That frustrates them, too.

Give attendees a chance to provide examples of ways in which they are now mistrustful of things that perhaps they needn't be. (For example, a family member might realize that just because her father with AD doesn't know what day it is, doesn't mean he is incapable of chopping vegetables for dinner.) Then go on to Question 3.

Question #3

Fear and confusion often go hand-in-hand because a person who is confused about what is expected of him is likely to fear making a mistake and may, therefore, resist doing anything.

- a. True
- b. False

Ask attendees for their answers. Like the previous question, this answer is quite obvious, but many caregivers don't necessarily associate fear and confusion. Fear is a pervasive emotion among many people with AD because as their condition progresses, they are increasingly confused by the world. This is a good place to introduce that idea.

Fear and Confusion. Think of your first day learning a new task, such as cooking, playing an instrument, or riding a bike. You were probably excited but also afraid of making a mistake. If you had a good teacher, you might have felt more confident. Conversely, if you were left alone, and you weren't sure what was expected of you, you were probably fearful and uncertain. When we are confused by directions we don't understand, when we fear making a mistake, or we are afraid for our safety, we will resist an activity or hesitate to act. So will the person with AD.

Ask attendees if they can give examples from their experiences with their loved one. Then go on to the next question.

Question #4

All of the following can cause physical discomfort in people with AD EXCEPT:

- a. Acute or chronic illnesses
- b. Being hungry or cold
- c. Depression or emotional pain
- d. Medication issues (side-effects, wrong dosage, allergic reaction, adverse interaction of multiple medications)
- e. All are valid**

Ask the attendees for their answers. Again, the choices make valid points about this topic.

Pain, discomfort, and other physical causes. This category covers a wide variety of possibilities which we will be discussing in more detail shortly. Some problems are easily solvable. Is your loved one hungry? Provide a snack. Does he need to go to the bathroom? Take him. Is she cold? Bring her a sweater. Are her legs stiff? Help her to take a walk.

Physical discomfort can have many causes

One of the primary problems with identifying physical causes of discomfort in people with Alzheimer's disease is that as their condition progresses, they have trouble "self-reporting." Some causes are easy to figure out: Fidgeting often indicates the need to use the bathroom. Cold hands are a sign of being chilled. However, many causes are trickier to discern. We will be devoting complete classes to some of these later in this series, but here are brief explanations of some of the more common conditions to watch out for:

Pain. Saying "my stomach aches" may seem simple to us, but in reality, people with AD usually express pain non-verbally. Watch for changes in behavior, such as abrupt withdrawal from activities your loved one once enjoyed or a sudden decrease in mobility. Pay attention to self-protective behavior, such as when your loved one holds her arms close to her stomach or holds her hand on her head. Also watch for clenched fists or jaws, glazed eyes, and increased sensitivity to noise or light.

Effects of medication. Although drugs can have huge benefits, all older adults need periodic reviews and re-evaluations of their medicines because many signs of discomfort (including anxiety, agitation and aggression) can be attributed to inappropriate drugs, dosages, or combinations of medications. Side-effects, prolonged use, and allergic reactions may be culprits as well.

Impaired vision or hearing. Most older adults have some hearing and vision loss, and a great many either do not have hearing aids or glasses, or those they use are ill-suited to their current needs. That means many older adults misunderstand directions and misinterpret visual clues. For those with AD, this can cause frustration, fear, and confusion.

Acute illnesses. We certainly hope that you notice and quickly treat your loved one when she has a fever, diarrhea, or is vomiting. When symptoms are less obvious, however, you may just think she is irritable because she is having a bad day. In fact, she may have an ear, bladder, or urinary tract infection. Watch for uncharacteristic fatigue and a sudden onset of symptoms.

Chronic illnesses, such as arthritis and osteoporosis are often accompanied by chronic pain, commonly expressed by irritability or withdrawal. Our loved ones with Alzheimer's disease are often unable to request a pain reliever and, therefore, pain may go untreated.

Dehydration is a common problem among people with AD because they may forget to drink, may not recognize the sensation of thirst, may not know how to pour themselves a glass of water, or may not know how to ask for a drink. People are especially at risk outdoors in hot weather and indoors in cold weather (because of the dry heat produced by most furnaces).

Constipation. Not only does its discomfort produce irritability, it can also have many other side effects if left untreated. Furthermore, bowel impaction can contribute to delusional behavior.

Depression. Many people with AD, particularly early in the disease process when they are aware of their losses and concerned about the future, are mildly or clinically depressed and could benefit from anti-depressants. Later, when their self-awareness diminishes, if they are valued and well cared for, they often have a surprisingly cheerful outlook and sense of well-being.

The bottom line is that caregivers need to be constant advocates for people with AD, looking for stressors in all possible forms.

Give attendees a chance to make comments about their experiences related to this section before moving on.

Violence is not a symptom of AD

Question #5

Violence is a common symptom in people with Alzheimer's disease.

- a. True
- b. False**

Ask the attendees for their answer; then make the points below.

When we hear that someone has kicked a vending machine or thrown a computer out the window, most of us are sympathetic, not shocked. We understand the frustration behind these actions. Yet, we often fail to show the same understanding for our loved ones with AD.

Years ago it was commonly thought that most people with Alzheimer's disease would eventually become violent. Now we know that – barring a history of alcoholism or psychosis or a medication side-effect – people with AD who become verbally or physically combative are essentially saying “No!” to whatever it is we are trying to get them to do. Chances are, we have been pushing them to take a shower or get dressed without paying attention to their confusion, fear, or discomfort. Lashing out is their way of getting us to stop and take notice of their needs.

Give attendees a brief opportunity to comment about their experiences related to this section before moving on.

Now let's talk about what else motivates people with Alzheimer's disease.

Situational motivators

Question #6

People with AD may become anxious in a variety of specific situations. Which of these is NOT likely to be one?

- a. We are invading their sense of personal space.
- b. We have come upon them too quickly, from the side, or from behind, and they are startled by our sudden appearance.
- c. We have tried to bring them into our reality instead of accepting their reality.
- d. We are walking outdoors with them on a cloudy day.**
- e. We have given them a task to do which they are not certain they can do alone.

Ask the attendees for their answers; then make the points below.

The “Big Four” motivators we discussed earlier are all easy to understand because most of us would have exactly the same emotional response as a person with AD. The difference is that we can clearly verbalize our discomfort, whereas people with Alzheimer's disease cannot. The next group of motivators is also logical, but these motivators are often influenced by specific situations or events.

The ideas we are about to discuss were inspired by Graham Stokes. He is an English clinical psychologist who has written extensively about dementia. He was an early convert to the idea that the behavior of people with Alzheimer's disease has logical explanations that reflect what is happening around them. For example:

Defensive reaction to entering one's personal space. We are all uncomfortable when someone invades our personal space. We may back away ourselves or tell the other person to, “Get outa my face!” A person with AD tends to be particularly uncomfortable in two related situations: The first situation occurs when he is part of a crowd, perhaps because he doesn't know how to protect himself from masses of people. The second occurs when he finds himself in various personal care situations.

If a professional caregiver enters the room of a person with AD to help him get dressed, he may become agitated, or even aggressive, if he doesn't recognize that person. Even if you – a familiar and trusted loved one – try to help him get dressed, he may be equally resistive if he doesn't see a need for changing his clothes, feels rushed, or is tired, afraid, or embarrassed.

Calming these defensive reactions requires slowing down, introducing yourself when needed, making small talk to establish a sense of ease, and patiently explaining each step in the care process.

Alarm. Your loved one may also be surprised if you approach unexpectedly from the side, from behind, or simply too rapidly. Remember that people with AD usually have a loss in peripheral vision and are often unsure of where they are. In addition, many older adults have vision and hearing losses that cause them to be easily startled.

Ask the attendees if they have any comments or experiences to share related to this point; then move on to the next question.

Question #7

Many of the situations that produce anxiety in people with AD may also produce anxiety in us. Which of the following is LEAST likely to be a problem for most of us?

- a. The back-breaking straw (A minor incident that sends us “over the edge”)
- b. Reality confrontation**
- c. Adaptive paranoia
- d. Having our competency called into question
- e. Having our personal space invaded

Ask the attendees for their answer; then make the points below. Many may not be familiar with the expression “adaptive paranoia.” Let them know you will explain it shortly. Others may think “reality confrontation” is equivalent to “reality check,” as in “Whoa, get a grip on reality.” That term is also explained below.

Competency questions. Out of pride, we may deny that we need assistance, even when we know we do. People with Alzheimer's disease can be especially sensitive about this. Sometimes, they may *know* they can't do what is being asked, or they *fear* that they won't be able to. This can cause them to refuse to participate or say they aren't interested in order to avoid looking inept. As one caregiver noted, “If she says, she doesn't want to get out the dishes or make the coffee, I've learned to recognize that she probably knows she can't do it.” When this happens, try not to challenge the person's sense of competency. You may find breaking the task down into step-by-step directions is helpful.

Misunderstanding events. People with Alzheimer's disease frequently misinterpret what's happening and may become easily frightened by an increasingly confusing world.

Reality confrontation. As AD progresses, people increasingly revert to a past reality (or drift in and out of present reality) and may perceive themselves as decades younger. Many well-intended caregivers try to bring them back into present reality, but like a rubber band, their minds snap back to the past again. Despite their best efforts, caregivers eventually find that reality simply doesn't compute in the brains of those with AD.

For example, if your mother believes she is 30 years old, and that she must get home before her children arrive from school, she will be utterly confused if you try to tell her that *you* are her child, and she doesn't need to go anywhere. She thinks you are old enough to be her mother, and that you resemble her, too. That confuses her even more. She might ask, “Why don't you believe me?” If you persist in ignoring her concerns, she'll likely become increasingly agitated. While it's impossible to force people with AD to accept *our* reality, we have the ability to join and affirm theirs.

Give attendees a chance to make comments about their experiences related to these motivators before moving on.

Adaptive paranoia. This is something we all do. When we find that our keys are not in the little tray on the entryway table where we usually leave them, the first thing we wonder is, “Who took my keys?” We perceive ourselves as reasonable, competent, orderly people, and if our keys are not where they “should” be, it is *certainly* someone else's fault. It should be no surprise, then, when our loved ones with AD accuse us of taking their money, wallet, or anything else they have misplaced.

The back-breaking straw. We have all had the experience of absolutely “losing it” over some minor irritant after handling a dozen far more significant challenges earlier in the day. Everything a person with Alzheimer's disease does requires exhausting concentration, so an unexpected change in the routine, a forgotten name, or a shoe that won't tie properly can be enough to cause a surprising outburst that is entirely justified in their minds.

Ask attendees if they have any comments or experiences to share related to these points; then move on.

Sometimes it's just a matter of personality

Let's face it; “Be yourself” is not good advice for everyone. Some people have always been crotchety, and neither age nor Alzheimer's disease changes them. If you know your father with Alzheimer's disease was orphaned when he was five and had a hard luck life for many years after that, you may understand where his bitterness originated, but it doesn't necessarily make him easier to live with.

On the other hand, some people with AD really do experience personality changes. Sometimes they become anxious and easily upset by the losses they experience early in the disease process, but later, as they forget what they have forgotten, they often become more easy-going.

Either way, never give up on kindness.

This last line is a key point, so emphasize it. It isn't easy to be kind when we are tired and frustrated ourselves, but if we can manage to do so, chances are, life with our loved one will go more smoothly.

Ask attendees if they have any comments or experiences to share related to these points; then move on.

How do you know the real reason?

We have now discussed a dozen motivating forces that may cause someone with Alzheimer's disease to resist doing what we want him to do. How do we know the actual cause, especially when the person with AD has limited verbal skills remaining?, In her book *Individualized Dementia Care*, Joanne Rader notes that caregivers must take on four roles: magician, detective, carpenter, and jester. Let's go to Question 8 and see if you know what it means to be a magician:

Question #8

The role of the magician is to put herself into the mindset of the person with AD. First and foremost, that requires knowing the person (his life story, routines, preferences, etc.) Understanding Alzheimer's disease is secondary to knowing the person. Are these statements true or false?

- a. True
- b. False

Ask the attendees for their answers; then make the points below.

Since this is a course on Alzheimer's disease, you may be surprised that the correct answer to this question indicates that it is more important to know the *person* who has the disease than to know everything about the *disease* the person has.

Every person is an individual, and AD affects each individual in a slightly different way. In order to understand why our loved ones are likely to be resistant and how we can gain their trust and cooperation, we need to know as much as possible about them as individuals. Since we are talking about your loved ones, people you may have known for 50 years or more, you are already likely to know this information. In other words, you are probably already magicians, or close to it.

Think about your loved one. What are his likes and dislikes? What comforts him? What upsets him? What is his life story? What or who were significant influences on his life? Realizing a certain shirt feels itchy to him, that he dislikes asparagus, that he is unsteady on stairways, and that loud noises remind him of his wartime experiences makes it easier to determine potential causes of discomfort, as well as ways to prevent it from occurring in the first place.

Ask attendees if they have any comments or experiences to share related to these points; then move on to the next question.

Question #9

The role of the detective is to figure out what caused the person's discomfort and how to prevent that discomfort in the future. Assume that a person does not want to take a shower. Which of the following questions is LEAST likely to be relevant in your efforts as a detective?

- a. Does he feel unsafe standing in the shower?
- b. Is the temperature of the room or water uncomfortable?
- c. Is he embarrassed accepting assistance from a female caregiver?
- d. Is he accustomed to only taking baths and only on Saturday nights?
- e. Does he like swimming?

Ask attendees for their answers; then make the points below.

When the cause of your loved one's discomfort isn't obvious, it can be useful to literally put yourself in his place. Joanne described a resident with AD in a long-term care setting who wouldn't stay in bed at night and was having trouble sleeping. An aide lay down in the resident's place and discovered that a light from the hall shone directly into her eyes. When the light was removed, the resident slept fine.

By lying in the resident's bed, the aide was playing what Joanne calls the detective role. Think of whatever problem you are facing with your loved one as a game of Clue or as a CSI mystery. There are five basic questions detective caregivers answer to better understand why problems occur:

- **When** did it occur? (If it has happened more than once, how often? Is the timing consistent?)
- **Where** did it occur? (Is there anything unusual about the surroundings?)
- **Who** was present? (Was your loved one upset by a noisy grandchild? A delivery man? Was he distracted by a playful pet that caused him to forget what he was doing?)
- **What** happened immediately before? What was the context of the event?
- **Why** might it have occurred? (Have you noticed anything that either prevents or aggravates it?)

Note that answering these same questions when something *positive* has happened with your loved one will also help you to maximize his *good* experiences.

The focus of this class is on motivation, so we're just going to touch on Joanne's last two roles. The role of the carpenter is to build a solution. All solutions may not be perfect, but using a variety of tools and teamwork, workable solutions can be achieved. If a solution falls short, be open to re-evaluation and adjustment.

The last role is that of the jester. People with AD usually appreciate humor throughout the disease process. Think of ways to add fun to daily tasks. Fun fuels the brain, so gas up!

Ask attendees if they have any comments or experiences to share related to these points; then move on. Specifically try to draw out any ideas they have about adding a sense of fun and incorporating humor into caregiving tasks.

As you end the session, give attendees their last handout, and let them know that in addition to a summary of the points made in this class, the handout contains some brief advice for handling difficult situations with their loved ones with AD. Consider closing with this story:

Your handout lists eight quick tips for handling difficult situations with your loved one. It's a good list, but you won't always have the presence of mind to remember it. You may lose your temper. When that happens, consider this story that was circulating on the Internet recently:

After putting her grandchildren to bed, a grandmother changed into a pair of old slacks and a droopy blouse and proceeded to wash her hair. As she heard the children getting more and more rambunctious, her patience grew thin. At last she threw a towel around her head and stormed into their room, putting them back to bed with stern warnings. As she left the room, she heard the three-year-old say with a trembling voice, "Who was THAT?"

It's okay to be human.

