A STUDENT SPEAKS
During the years I worked as a food server I grew accustomed to waiting on older people. They can’t always read the menu, they complain that the lighting in the restaurant is too low, they like their dinner experience to be slower, they can’t find their silver when they need it, the soup is never hot enough and the cup of coffee is never full enough. They would yell at me because they could not hear me. It used to make me mad, but now I understand they are just real people experiencing growing old. Yes, they may have problems like losing some of their senses and other physical changes, but in actuality they are the same as me.

Debbie, age 27

AN ELDER SPEAKS
One of the great frustrations is the matter of eyesight. One can get used to large print and hope for black letters on white paper but why do modern publishers seem to prefer the shiny, slick off-white paper and pale ink in minuscule print? And, my new prescription glasses have not restored my ability to cut my own toenails without danger of wounding myself. I find myself wishing for some treatment for incipient cataracts. Please, researchers, let’s get rid of this scourge of the elderly.

Lyn, age 85

LEARNING OBJECTIVES
On completion of this chapter, the reader will be able to:
1. Describe the importance of communication to the lives of older adults.
2. Discuss how ageist attitudes affect communication with older adults.
3. Discuss diseases of the eye and ear that may occur in older adults.
4. Describe the importance of screening, health education, and treatment of eye diseases to prevent unnecessary vision loss.
5. Identify effective communication strategies for older adults with speech, language, hearing, vision, and cognitive impairment.
6. Describe interventions that facilitate communication individually and in groups.
7. Understand the significance of the life story.
8. Discuss the modalities of reminiscence and life review.
9. Understand how health literacy affects communication and learning and design interventions to enhance understanding.

Communication is the single most important capacity of human beings, the ability that gives us a special place in the animal kingdom. Little is more dehumanizing than the inability to communicate effectively and engage in social interaction with others. The need to communicate, to be listened to, and to be heard does not change with age or impairment. Meaningful communication and active engagement with society contributes to healthy aging and improves an older adult’s chances of living longer, responding better to health care interventions, and maintaining optimal function (Rowe and Kahn, 1998; Williams, 2006; Williams et al., 2008; Herman and Williams, 2009; Levy, 2009; Levy et al., 2009a,b; VanLeuven, 2010).

For some older people, opportunities for social interaction may be more limited as a result of loss of family and friends, illnesses and hearing, vision, and cognitive impairment. The ageist attitudes of the public, as well as health professionals, also present barriers to communicating effectively with older people. Good communication skills are the basis for accurate assessment, care planning, and the development of therapeutic relationships between the nurse and the older person.

This chapter discusses the effect of health professionals' attitudes toward aging on their communication with older people; communication skills essential to therapeutic interaction with older adults; diseases of the eye and ear; screening, health education and treatment of eye diseases to prevent unnecessary vision loss; adaptation of communication for older adults with vision and hearing impairments, inadequate health literacy, speech or language disorders, and cognitive impairment. The significance of the life story, reminiscence, and life review, and communication with groups of elders, are also included in this chapter.

AGEISM AND COMMUNICATION

Beliefs in myths and stereotypes about older adults and ageist attitudes can interfere with the ability to communicate effectively. For example, if the nurse believes that all older people have memory problems, or are unable to learn or process information, he or she will be less likely to engage in conversation, provide appropriate health information, or treat the person with respect and dignity. Ageism, a term coined by Robert Butler (1969), the first director of the National Institute on Aging (Bethesda, MD), is the systematic stereotyping of, and discrimination against, people because they are old, just as racism and sexism accomplish this with skin color or gender. Ageism will affect us all if we live long enough. Although ageism is found cross-culturally, it is essentially prevalent in the United States where aging is viewed with depression, fear, and anxiety (International Longevity Center, 2006).

Ageist attitudes, as well as myths and stereotypes about aging, can be detrimental to older people. On the other hand, holding a positive self-perception of aging can contribute to a longer life span. The survival advantage of a more positive self-perception of aging can add 7.5 years to the life span and contributes more to added years of life than low body mass index, no smoking history, and exercise (Levy et al., 2002). While older people, collectively, have often been seen in negative terms, a most striking change in attitudes toward aging has occurred in the past 25 years. Undoubtedly, this will continue to change as the baby boomers reach retirement age. The impact of media presentation is enormous, and it is gratifying to see robust images of aging; fewer older people are portrayed as victims or as those to be pitied, shunned, or ridiculed by virtue of achieving old age.

Ageism affects health professionals as well and, with few exceptions, studies of attitudes of health professional students toward aging reflect negative views. Examples of the effect of ageism include the few number of students who choose to work in the field of aging, and the lack of education of health professionals in the care of older people, even though the majority of their patients are older adults. It is important for nurses who care for older people to be aware of their own attitudes and beliefs about aging and the effect of these attitudes on communication and care provision. Enhancing one's interpersonal communication skills is the foundation for therapeutic interactions with older adults.

Elderspeak

Elderspeak is a form of ageism in which younger people alter their speech, based on the assumption that older people have difficulty understanding and comprehending (Touhy and Williams, 2008). It is especially common in communication between health care professionals and older adults in hospitals and nursing homes, but occurs in non–healthcare settings as well (Williams et al., 2003, 2004, 2008; Williams, 2006; Williams and Tappen, 2008; Herman and Williams, 2009). Elderspeak is similar to “baby talk,” which is often used to talk to very young children (Box 6-1).

Nurses may not be aware that they are using elderspeak, but research has shown that use of this form of speech is patronizing and conveys messages of dependence, incompetence, and control (Williams, 2006; Williams et al., 2008). Some features of elderspeak (speaking more slowly, repeating, or paraphrasing) may be beneficial in communication with older people with dementia, and further research is needed. Other examples of communication that conveys ageist attitudes are ignoring the older person and talking to family and friends as if the person were not present, and limiting interaction to task-focused communication only (Touhy and Williams, 2008).

THERAPEUTIC COMMUNICATION WITH OLDER ADULTS

Basic communication strategies that apply to all situations in nursing, such as attentive listening, authentic presence, nonjudgmental attitude, cultural competence, clarifying, giving information, seeking validation of understanding, keeping focus, and using open-ended questions, are all applicable in communicating with older adults. Basically, elders may need more time to give information or answer questions simply because they have a larger life experience to draw from. Sorting through thoughts requires intervals of silence, and therefore listening carefully without rushing the elder is important. Word retrieval may be slower, particularly for nouns and names.

Open-ended questions are useful but difficult for some elders. Those who wish to please, especially when feeling vulnerable or somewhat dependent, may wonder what it is you want to hear rather than what it is they would like to say. Communication that is most productive will initially focus on the issue of major concern to the elder, regardless of the priority of the nursing assessment. When using closed questioning to obtain specific information, be aware that the elder may feel on
the spot and thus the appropriate information may not be immediately forthcoming. This is especially true when asking questions to determine mental status. The elder may develop a mental block because of anxiety or feel threatened if questions are asked in a quizzing or demeaning manner. Older people may be reluctant to disclose information for fear of the consequences. For example, if they are having problems remembering things or are experiencing frequent falls, sharing this information may mean that they might have to leave their home and move to a more protective setting.

When communicating with individuals in a bed or wheelchair, position yourself at their level rather than talking over a side rail or standing above them. Pay attention to their gaze, gestures, and body language, and the pitch, volume, and tone of their voice to help you understand what they are trying to communicate. Thoughts unstated are often as important as those that are verbalized. You may ask, “What are you thinking about right now?” Clarification is essential to ensure that you and the elder have the same framework of understanding.

Many generational, cultural, and regional differences in speech patterns and idioms exist. Frequently seek validation of whatever you think you heard. If you tend to speak quickly, particularly if your accent is different from the elder’s, try to slow down and give the person time to process what you are saying.

**COMMUNICATING WITH OLDER ADULTS WITH SENSORY IMPAIRMENTS**

Sensory impairments, such as hearing and vision deficits, place older people at risk for communication difficulties. We rely on our senses to perceive the environment and to enjoy the pleasures of life. Gerontological nurses need to have special knowledge and skills to promote effective communication with older people who have these deficits. This section describes adaptations to enhance communication with elders with hearing and vision impairments.

**Hearing Impairment**

Although both vision and hearing impairment significantly affect all aspects of life, Oliver Sacks (1989), in his book *Seeing Voices*, presents a view that blindness may in fact be less serious than loss of hearing. Hearing loss interferes with communication with others and the interactive input that is so necessary to stimulate and validate. One elderly man said that a great annoyance of hearing loss is in the subtle aspects of living with a partner, who most probably has a hearing loss as well. “You must often repeat what you say, and in lovemaking, whispering sweet words becomes a gesture for yourself alone.” Helen Keller was most profound in her expression: “Never to see the face of a loved one nor to witness a summer sunset is indeed a handicap. But I can touch a face and feel the warmth of the sun. But to be deprived of hearing the song of the first spring robin and the laughter of children provides me with a long and dreadful sadness” (Keller, 1902).

Hearing loss is the third most prevalent chronic condition in older Americans and the foremost communicative disorder of older adults. The prevalence of hearing loss is 90% in those older than 80 years. Hearing loss is a common condition in middle-aged adults as well. Estimates are that 20.6% of adults aged 48 to 59 years have impaired hearing. A recent study suggests that cardiovascular disease risk factors may be important correlates of age-related auditory dysfunction. Hearing loss may not be an inevitable part of aging and if detected early, it may be a preventable chronic disease because the same healthy lifestyle changes that improve cardiovascular health may also prevent or delay hearing loss (University of Wisconsin School of Medicine and Public Health, 2011). In all age groups, men are more likely than women to be hearing-impaired.

Hearing loss diminishes quality of life and is associated with multiple negative outcomes including decreased function, miscommunication, depression, falls, loss of self-esteem, safety risks, and cognitive decline (Wallhagen and Pettengill, 2008). Hearing impairment increases feelings of isolation and may cause older adults to become suspicious or distrustful or to display feelings of paranoia. Because older persons with a hearing loss may not understand or respond appropriately to conversation, they may be inappropriately diagnosed with dementia. Older people may be initially unaware of hearing loss because of the gradual manner in which it develops (Box 6-2). The Better Hearing Institute (Washington DC) provides an online hearing test for older adults who want to check their own hearing (see http://www.betterhearing.org/hearing_loss/online_hearing_test/index.cfm).

Hearing impairment is underdiagnosed and undertreated in older people. Although screening for hearing impairment and

**BOX 6-2  DO I HAVE A HEARING PROBLEM?**

- Do I have a problem hearing on the telephone?
- Do I have trouble hearing when there is noise in the background?
- Is it hard for me to follow a conversation when two or more people talk at once?
- Do I have to strain to understand a conversation?
- Do many people I talk to seem to mumble (or not speak clearly)?
- Do I misunderstand what others are saying and respond inappropriately?
- Do I have trouble understanding the speech of women and children?
- Do people complain that I turn the TV volume up too high?
- Do I hear a ringing, roaring, or hissing sound a lot?
- Do some sounds seem too loud?


appropriate treatment are considered an essential part of primary care for older adults, it is rarely done. A single question—Do you feel you have a hearing loss?—has been shown to have reasonable sensitivity and specificity for hearing impairment (Schummm et al., 2009). Findings of a study performed in 2008 (Box 6-3) suggest that hearing loss is an "overlooked geriatric syndrome in primary care settings—an assessment gap that can have significant negative consequences" (Wallhagen and Pettengill, 2008, p. 41).

The screening rate for hearing impairment among older adults is estimated to be as low as 12.9%, and only about 20% of persons with hearing impairments receive hearing aids (Ham et al., 2007; Wallhagen and Pettengill, 2008). Factors associated with lack of hearing aid use include cost, perceived lack of benefit, and denial of hearing loss. Wallhagen (2009) also suggests that the perceived stigma associated with hearing loss and use of hearing aids is another factor that should be examined. The cost of hearing aids is not covered under Medicare and other health plans, but screening for hearing loss is recommended as part of the comprehensive physical for older adults joining Medicare for the first time (Chapter 2).

Types of Hearing Loss

The two major forms of hearing loss are conductive and sensorineural. Sensorineural hearing loss results from damage to any part of the inner ear or the neural pathways to the brain. Presbycusis is a form of sensorineural hearing loss that is related to aging. It is the most common form of hearing loss in the United States. Presbycusis is a bilateral and symmetrical sensorineural hearing loss that also affects the ability to understand speech.

Changes in the middle and inner ear make many elders intolerant of loud noises and incapable of distinguishing among some of the biliteral consonants such as z, s, sh, j, p, k, t, and g. People often raise their voice when speaking to a hearing-impaired person. When this happens, more consonants drop out of speech, making hearing even more difficult. Without consonants, the high-frequency–pitched language becomes disjointed and misunderstood.

Older people with presbycusis have difficulty filtering out background noise and often complain of difficulty understanding women’s and children’s speech and conversations in large groups. The condition progressively worsens with age. The environment is teeming with distracting sounds and noises, such as traffic, television, appliances, crowds, and noisy restaurants and shopping malls. Institutions in which older adults may be patients are also noisy, with many distracting sounds that make communication difficult for sensory and cognitively impaired older adults—intercoms or pagers, clattering equipment, meal and medication carts, and "canned music."

Use of rapid speech when conversing with an older adult with a hearing impairment will make sounds garbled and unintelligible, and even though the problem is related to presbycusis, it is one that is easily remedied. To gain a better understanding of hearing loss, take the Unfair Hearing Test (Sight & Hearing Association, St. Paul, MN), available at http://www.sightandhearing.org/products/knownoise.asp. Sensorineural hearing loss is treated with hearing aids and, in some cases, cochlear implants.

Conductive hearing loss usually involves abnormalities of the external and middle ear that reduce the ability of sound to be transmitted to the middle ear. Otosclerosis, infection, perforated eardrum, fluid in the middle ear, or cerumen accumulations cause conductive hearing loss. Cerumen impaction is the most common and easily corrected of all interferences in the hearing of older people. Cerumen impaction has been found to occur in 33% of nursing home residents (Hersh, 2010).

Cerumen interferes with the conduction of sound through air in the eardrum. The reduction in the number and activity of cerumen-producing glands results in a tendency toward cerumen impaction. Long-standing impactions become hard, dry, and dark brown. Individuals at particular risk of impaction are African Americans, individuals who wear hearing aids, and older men with large amounts of ear canal tragi (hairs in the ear) that tend to become entangled with the cerumen. When hearing loss is suspected, or a person with existing hearing loss experiences increasing difficulty, it is important first to check for cerumen impaction as a possible cause. If cerumen removal is indicated, it may be removed through irrigation, cerumenolytic products, or manual extraction (Hersh, 2010). Box 6-4 presents a protocol for cerumen removal.

Tinnitus

Tinnitus is defined as the perception of sound in one or both ears or in the head when no external sound is present. It is often referred to as “ringing in the ears” but may also manifest as buzzing, hissing, whistling, cricket chirping, bells, roaring, clicking, pulsating, humming, or swishing sounds. The sounds may be constant or intermittent and are more acute at night or in quiet surroundings. The most common type is high-pitched tinnitus with sensorineural loss; less common is low-pitched tinnitus with conduction loss such as is seen in Meniere’s disease.

Tinnitus generally increases over time. It is a condition that afflicts many older people and can interfere with hearing, as well as become extremely irritating. It is estimated to occur in nearly 11% of elders with presbycusis. Approximately 50 million people in the United States have tinnitus and about 2 million are so seriously debilitated that they cannot function on a “normal,” day to day basis. The incidence of tinnitus peaks between ages 65 and 74 and is higher in men than in women; in men, the incidence seems to decrease after this age. Tinnitus is a growing problem for America’s military personnel and is the leading cause of service-connected disability of veterans returning from Iraq or Afghanistan (American Tinnitus Association, 2010).

The exact physiological cause or causes of tinnitus are not known but there are several likely factors that are known to trigger or worsen tinnitus. Exposure to loud noises is the leading cause of tinnitus and the exposure can damage and destroy cilia in the inner ear. Once damaged, they cannot be renewed or replaced. See http://www.ata.org/for-patients/at-risk#Loud for a video of ways to mitigate noise exposure. Other possible causes of tinnitus include head and neck trauma, certain types of tumors, cerumen build-up, jaw misalignment, cardiovascular disease, and ototoxicity from medications. More than 200 prescription and nonprescription medications list tinnitus as a potential side effect, aspirin being the most common.

Assessment

Tinnitus may be described as pulsatile (matching the beating of the heart) or nonpulsatile (unilateral, asymmetric, or symmetric). Tinnitus may be subjective (audible only to the person) or objective (audible to the examiner). Subjective tinnitus is more common. Objective tinnitus is rare and is frequently due to a vascular or neuromuscular condition. The mechanisms of tinnitus are unknown but have been thought to be analogous to cross-talk on telephone wires, phantom limb pain, or transmission of vascular sounds such as bruits. A simulation of the sounds of tinnitus can be found at http://www.sens.com/helps/demo02/helps_d02_demo_check_2.htm.

Interventions

Some persons with tinnitus will never find the cause; for others the problem may arbitrarily disappear. Hearing aids can be prescribed to amplify environmental sounds to obscure tinnitus, and there is a device that combines the features of a masker and a hearing aid, which emits a competitive but pleasant sound that distracts from head noise. Therapeutic modes of treating tinnitus include transcranial electrostimulation, iontophoresis, biofeedback, tinnitus masking with alternative sound production (white noise), dental treatment, cochlear implants, and hearing aids. Some have found hypnosis, cognitive behavioral therapy, acupuncture, chiropractic, naturopathic, allergy, or drug treatment to be effective.

Nursing actions include discussions with the client regarding times when the noises are most irritating and having the person keep a diary to identify patterns. There is some evidence that caffeine, alcohol, cigarettes, stress, and fatigue may exacerbate the problem. Assess medications for possibly contributing to the problem. Discuss lifestyle changes and alternative methods that some have found effective. Also, refer clients to the American Tinnitus Association for research updates, education, and support groups.

Interventions to Enhance Hearing

Hearing Aids

A hearing aid is a personal amplifying system that includes a microphone, an amplifier, and a loudspeaker. There are numerous types of hearing aids. The behind-the-ear hearing aid looks like a shrimp and fits around and behind the ear. It is less commonly used now than the small, in-the-ear aid, which fits in the concha of the ear (Figure 6-1). The appearance and effectiveness of hearing aids have greatly improved, and many can be programmed to meet specific needs. Most individuals can obtain some hearing enhancement with a hearing aid.

Although hearing aids generally improve hearing by about 50%, they do not correct hearing deficits. It is important that hearing-impaired elders understand that the goal of hearing aid
use is to improve communication and quality of life, not to restore normal hearing.

Hearing aids necessitate a period of adjustment and training in correct use. In most states, the purchase of a hearing aid comes with a 30-day trial during which the purchase price is totally refundable. The investment in a good hearing aid is considerable, and a good fit is critical. Before a hearing aid can be purchased, medical clearance must be obtained from a physician. Hearing aids can range in price from about $500 to several thousand dollars, depending on the technology. Batteries are changed every 1 to 2 weeks, adding to overall costs. The cost of hearing aids is not usually covered by health insurance or Medicare.

It is important for nurses in hospitals and nursing homes to be knowledgeable about the care and maintenance of hearing aids. Many older people experience unnecessary communication problems when in the hospital or nursing home because their hearing aids are not inserted and working properly, or are lost. Box 6-5 presents suggestions for the use and care of hearing aids.

**Cochlear Implants**

Cochlear implants are increasingly being used for older adults who are profoundly deaf as a result of sensorineural hearing loss. A cochlear implant is a small, complex electronic device that consists of an external portion that sits behind the ear and a second portion that is surgically placed under the skin (Figure 6-2). Unlike hearing aids that magnify sounds, the cochlear implant bypasses damaged portions of the ear and directly stimulates the auditory nerve. Hearing through a cochlear implant is different from normal hearing and takes time to learn or relearn. For persons whose hearing loss is so severe that amplification is of little or no benefit, the cochlear implant is a safe and effective method of auditory rehabilitation. Most insurance plans cover the cochlear implant procedure. The transplant carries some risk because the surgery destroys any residual hearing that remains. Therefore, cochlear implant users can never revert to using a hearing aid. Individuals with cochlear implants need to be advised not to undergo magnetic resonance imaging (MRI), and the U.S. Food and Drug Administration advises such individuals “not to even be close to a MRI unit.

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**FIGURE 6-1** An In-the-ear Hearing Aid. (Courtesy Kathleen Jett.)

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**BOX 6-5** THE USE AND CARE OF HEARING AIDS

**HEARING AID USE**

- Initially, wear the aid for 15 to 20 minutes per day.
- Gradually increase the wearing time to 10 to 12 hours.
- Be patient and realize that the process of adaptation is difficult but ultimately will be rewarding.
- Make sure your fingers are dry and clean before handling hearing aids. Use a soft dry cloth to wipe your hearing aids.
- Each day, remove any earwax that has built up on the hearing aids. Use a soft brush to clean difficult-to-reach areas.
- Insert the aid with the canal portion pointing into the ear; press and twist until snug.
- Turn the aid slowly to one-third to one-half volume.
- A whistling sound indicates incorrect ear-mold insertion or that the aid is in the wrong ear.
- Adjust the volume to a level for talking at a distance of 1 yard.
- Do not wear the aid when using a hair dryer or when swimming or taking a shower or bath.
- Note that fine particles of hair spray or make-up can obstruct the microphone component of the hearing aid.

**CARE OF THE HEARING AID**

- Insert and remove your hearing aid over a soft surface. When inserting or removing the battery, work over a table or countertop or soft surface.
- Insert the battery when the hearing aid is turned off.
- Store the hearing aid in a marked container in a safe place when not in use; remove the batteries.
- Batteries last 1 week with daily wearing of 10 to 12 hours.
- Common problems include a switch that is turned off, a clogged ear mold, a dislodged battery, and twisted tubing between the ear mold and aid.
- Ear molds need replacement every 2 or 3 years.
- Check the ear molds for rough spots that will irritate the ear.
- If sound is not loud enough, check for the following: Need new battery? Sound channel blocked? Aid turned off? Volume set too low? Battery door not closed? Hearing aid loose?
- Check the battery by turning the hearing aid on, turning up the volume, cupping your hand over the ear mold, and listening. A constant whistling sound indicates that the battery is functioning. A weak sound may indicate that the battery is losing power and needs replacement.

**REMOVING THE HEARING AID**

- Turn the hearing aid off and lower the volume. The on/off switch may be marked by an O (off), M (microphone), T (telephone), or TM (telephone/microphone). If the aid is not turned off, the batteries will continue to run.
- Remove the ear mold by rotating it slightly forward and then pulling outward.
- Remove the battery if the hearing aid will not be used for several days. This will prevent corrosion from battery leakage.
- Store in a safe place, away from heat and moisture, to prevent loss or damage.


since it may dislodge the implant or demagnetize its internal magnet” (Wallhagen et al., 2006, p. 47).

Assistive Listening and Adaptive Devices

Assistive listening devices (also called personal listening systems) should be considered as an adjunct to hearing aids or used in place of hearing aids for people with hearing impairment. These devices are available commercially and can be used to enhance face-to-face communication and to better understand speech in large rooms such as theaters, to use the telephone, and to listen to television. Examples of assistive listening and adaptive devices include text messaging devices for telephones and closed-caption television, now required on all televisions with screens 13 inches and larger. Alerting devices, such as vibrating alarm clocks that shake the bed or activate a flashing light, and sound lamps that respond with lights to sounds, such as doorbells and telephones, are also available. Assistive devices, such as personal amplifiers, that amplify sound and send it to the user’s ears through earphones, clips, or headphones, are helpful in health care situations in which accurate communication and privacy are essential.

Any facility that receives financial aid from Medicare is required by the Americans with Disabilities Act to provide equal access to public accommodations. This includes access to sign language interpreters, telecommunication devices for the deaf (TDDs), and flashing alarm systems. Nurses working in these facilities should be able to obtain appropriate devices to improve communication with hearing-impaired individuals.

PROMOTING HEALTHY AGING: IMPLICATIONS FOR GERONTOLOGICAL NURSING

Hearing impairment is common among older adults and significantly affects communication, function, safety, and quality of life. Inadequate communication with older adults with hearing impairment can also lead to misdiagnosis and affect adherence to a medical regimen. The gerontological nurse must be able to assess hearing ability and use appropriate communication skills and devices to help older adults minimize or even avoid problems. The Hartford Institute for Geriatric Nursing (New York, NY) Try This series provides guidelines for hearing screening (see http://consulgerirn.org/uploads/File/trythis/try_this_12.pdf). An evidence-based guideline for nursing management of hearing impairment in nursing facility residents is also available (Adams-Wendling and Pimple, 2008). Box 6-6 presents communication strategies for elders with hearing impairment.

Vision Impairment

Blindness and visual impairment are among the 10 most common causes of disability in the United States and are associated with shorter life expectancy and lower quality of life. Visual impairment (low vision) is generally defined as a Snellen chart reading of worse than 20/40 but better then 20/200. Legal blindness is defined as a reading equal to or worse than 20/200.
For older adults, visual problems have a negative impact on quality of life, equivalent to that of life-threatening conditions such as heart disease and cancer. The leading causes of visual impairment are diseases that are common in older adults: age-related macular degeneration (AMD), cataract, glaucoma, diabetic retinopathy, and optic nerve atrophy. Vision loss is becoming a major public health problem and is projected to increase substantially with the aging of the population (National Eye Institute, 2010a).

Vision loss from eye disease is a global concern, particularly in the developing countries, where 90% of the world’s blind individuals live. Estimates are that more than 75% of the world’s blindness is preventable or treatable. Vision 2020 is a global initiative for the elimination of avoidable blindness, launched jointly by the World Health Organization (WHO) and the International Agency for the Prevention of Blindness (http://v2020.org/default.asp).

Older adults represent the vast majority of the visually impaired population. More than two-thirds of those with visual impairment are over age 65. Although there are no gender differences in the prevalence of vision problems in older adults, there are more visually impaired women than men because, on average, women live longer than men. Racial and cultural disparities in vision impairment are significant. African Americans are twice as likely to be visually impaired than are white individuals of comparable socioeconomic status, and Hispanics also have a higher risk of visual complications than the white population. A recent survey conducted in the United States reported that among all racial and ethnic groups participating in the survey, Hispanic respondents reported the lowest access to eye health information, knew the least about eye health, and were the least likely to have their eyes examined (National Eye Institute, 2008).

Estimates of visual impairment among nursing home residents range anywhere from 3 to 15 times higher than for adults of the same age living in the community (Owsley et al., 2007). A study examining the effect of visual impairment among nursing home residents with Alzheimer’s disease reported that one in three were not using or did not have glasses that were strong enough to correct their vision. They had either lost their glasses or broken them, had prescriptions that were no longer adequate, or were too cognitively impaired to ask for help (Koch et al., 2005). Routine eye care is sorely lacking in nursing homes and is related to functional decline, decreased quality of life, and depression (Owsley et al., 2007).

Because visual impairment affects most daily activities, such as driving, reading, maneuvering safely, dressing, cooking, and social activities, assessing the effect of vision changes on functional abilities, safety, and quality of life is most important. Decreased vision has also been found to be a significant risk factor for falls. Results of one study (Rogers and Langa, 2010) suggested that untreated poor vision is associated with cognitive decline, particularly Alzheimer’s disease. Certain signs and behaviors of visual problems that should alert the nurse to action are noted in Box 6-7.

**BOX 6-6  COMMUNICATION STRATEGIES FOR ELDERS WITH HEARING IMPAIRMENT**

- Never assume hearing loss is from age until other causes are ruled out (infection, cerumen buildup).
- Inappropriate responses, inattentiveness, and apathy may be symptoms of a hearing loss.
- Face the individual, standing or sitting at the same level, and don’t turn away to face a computer when speaking.
- Gain the individual’s attention before beginning to speak. Look directly at the person at eye level before starting to speak.
- Determine whether hearing is better in one ear than the other, and position yourself appropriately.
- If a hearing aid is used, make sure it is in place and that the batteries are functioning.
- Ask the patient or family what helps the person to hear best.
- Keep your hands away from your mouth and project your voice by controlled diaphragmatic breathing.
- Do not turn away while speaking.
- Avoid conversations in which the speaker’s face is in glare or darkness; orient the light on the speaker’s face.
- Careful articulation and moderate speed of speech are helpful.
- Lower your tone of voice, use a moderate speed of speech, and articulate clearly.
- Label the chart, note on the intercom button, and inform all caregivers that the patient has a hearing impairment.
- Use nonverbal approaches: gestures, demonstrations, visual aids, and written materials.
- Pause between sentences or phrases to confirm understanding.
- Restate with different words when you are not understood.
- When changing topics, pref ace the change by stating the topic.
- Reduce background noise (e.g., turn off television, close door).
- Use assistive listening devices such as a personal amplified.
- Verify that the information being given has been clearly understood. Be aware that the person may agree to everything and appear to understand what you have said even when he or she did not hear you (listener blunting).
- Share resources for the hearing-impaired and refer as appropriate.


**BOX 6-7  SIGNS AND BEHAVIORS THAT MAY INDICATE VISION PROBLEMS**

**INDIVIDUAL MAY REPORT:**

- Pain in eyes
- Difficulty seeing in darkened area
- Double vision/distorted vision
- Migraine headaches coupled with blurred vision
- Flashes of light
- Halos surrounding lights
- Difficulty driving at night
- Falls or injuries

**HEALTH CARE STAFF MAY NOTICE:**

- Getting lost
- Bumping into objects
- Straining to read or no reading
- Stumbling/falling
- Spilling food on clothing
- Social withdrawal
- Less eye contact
- Facial expression
- TV viewing at close range
- Decreased sense of balance
- Mismatched clothes
A new program focused on vision and aging has been developed by The National Eye Health Education Program (NEHEP) of the National Eye Institute. The program provides health professionals with evidence-based tools and resources that can be used in community settings to educate older adults about eye health and maintaining healthy vision (www.nei.nih.gov/SeeWellToolkit). The program emphasizes the importance of annual dilated eye examinations for anyone over 50 years of age and stresses that eye diseases often have no warning signs or symptoms, so early detection is essential. Clearly, prevention and treatment of eye diseases is an important priority for nurses and other health care professionals.

Diseases of the Eye

Glaucoma

Glaucoma is a leading cause of blindness and visual impairment in the United States, affecting as many as 2.2 million people. An additional 2 million are unaware they have the disease. There are no symptoms of glaucoma in the early stages of the disease. Types of glaucoma include: congenital glaucoma, primary open-angle glaucoma, low tension or normal tension glaucoma, secondary glaucoma (complication of other medical conditions), and acute angle-closure glaucoma, which is an emergency. The etiology of glaucoma is variable and often unknown. However, when the natural fluids of the eye are blocked by ciliary muscle rigidity and the buildup of pressure, damage to the optic nerve occurs. Glaucoma can be bilateral, but it more commonly occurs in one eye.

Open-angle glaucoma accounts for about 80% of cases and is asymptomatic until very late in the disease, when there is a noticeable loss in visual fields. However, if detected early, glaucoma can usually be controlled and serious vision loss prevented. Signs of glaucoma include headaches, poor vision in dim lighting, increased sensitivity to glare, “tired eyes,” impaired peripheral vision, a fixed and dilated pupil, and frequent changes in prescriptions for corrective lenses. Figure 6-3-A shows normal vision and Figure 6-3-B illustrates the effects of glaucoma on vision.

An acute attack of angle-closure glaucoma is characterized by a rapid rise in intraocular pressure (IOP) accompanied by redness and pain in and around the eye, severe headache, nausea and vomiting, and blurring of vision. It occurs when the path of the aqueous humor is blocked and intraocular pressure builds up to more than 50 mm Hg. If untreated, blindness can occur in two days. An iridectomy, however, can ease pressure. Many drugs with anticholinergic properties including antihistamines, stimulants, vasodilators, clonidine, and sympathomimetics, are particularly dangerous for patients predisposed to angle-closure glaucoma. Older people with glaucoma should be counseled to review all medications, both over-the-counter and prescribed, with their primary care provider.

Low tension or normal tension glaucoma is a type of glaucoma that also occurs in older adults. In this type, intraocular pressure is within normal range but there is damage to the optic nerve and narrowing of the visual fields. The cause is unknown, but risk factors include a family history of any kind of glaucoma, Japanese ancestry, and cardiovascular disease. Management consists of the same medications and surgical interventions that are used for chronic glaucoma (Glaucoma Research Foundation, 2008).

A family history of glaucoma, as well as diabetes, steroid use, and past eye injuries have been noted as risk factors for the development of glaucoma. Age is the single most important predictor of glaucoma, and older women are affected twice as frequently as older men. Among African Americans, glaucoma is the leading cause of blindness. African Americans develop glaucoma at younger ages, and the incidence of the disease is five times more common in African Americans than in whites and fifteen times more likely to cause blindness. Factors contributing to this increased incidence include earlier onset of the disease as compared with other races, later detection of the disease, and economic and social barriers to treatment (National Eye Institute, 2010b).

Screening and Treatment

Adults over the age of 65 should have annual eye examinations, and those with medication-controlled glaucoma should be examined at least every 6 months. Annual screening is also recommended for African Americans and other individuals with a family history of glaucoma who are older than 40. A dilated eye examination and tonometry are necessary to diagnose glaucoma. These procedures can be performed by a primary care provider, optometrist, or a nurse practitioner, who will then refer the person to an ophthalmologist if glaucoma is suspected. Medicare pays for annual screening for glaucoma but only in high-risk patients.

Management of glaucoma involves medications (oral or topical eye drops) to decrease IOP and/or laser trabecuoplasty. Medications lower eye pressure either by decreasing the amount of aqueous fluid produced within the eye or by improving the flow through the drainage angle. Beta blockers are the first-line therapy for glaucoma, and the patient may need combinations of several types of eye drops. When caring for older adults in the hospital or long-term care settings, it is important to obtain a past medical history to determine if the person has glaucoma and to ensure that eye drops are given according to the person’s treatment regimen. Without the eye drops, eye pressure can rise and cause an acute exacerbation of glaucoma (Capezuti et al., 2008). Usually medications can control glaucoma, but laser surgery treatments ( trabecuoplasty) may be recommended for some types of glaucoma. Surgery is usually recommended only if necessary to prevent further damage to the optic nerve.

Cataracts

Cataracts are a prevalent disorder among older adults caused by oxidative damage to lens protein and fatty deposits (lipofuscin) in the ocular lens. By age 80, more than half of all Americans either have a cataract or have had cataract surgery. When lens opacity reduces visual acuity to 20/30 or less in the central axis of vision, it is considered a cataract. Cataracts are categorized according to their location within the lens and are usually bilateral. They are virtually universal in the very old but may be only minimally visible, particularly in individuals with pale irises.

Cataracts are recognized by the clouding of the ordinarily clear ocular lens; the red reflex may be absent or may appear as a black area. The cardinal sign of cataracts is the appearance of halos around objects as light is diffused. Other common
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PART I Foundations of Healthy Aging

have poor dietary habits, diabetes, hypertension, kidney disease, eye trauma, or history of alcohol intake and tobacco use. Cataracts are more likely to occur after glaucoma surgery or other types of eye surgery. There is some evidence that a high dietary intake of lutein and zeaxanthin, compounds found in yellow or dark leafy vegetables, as well as intake of vitamin E from food

symptoms include blurring, decreased perception of light and color (giving a yellow tint to most things), and sensitivity to glare. Figure 6-3, C illustrates the effects of a cataract on vision.

The most common causes of cataracts are heredity and advancing age. They may occur more frequently and at earlier ages in individuals who have been exposed to excessive sunlight, have poor dietary habits, diabetes, hypertension, kidney disease, eye trauma, or history of alcohol intake and tobacco use. Cataracts are more likely to occur after glaucoma surgery or other types of eye surgery. There is some evidence that a high dietary intake of lutein and zeaxanthin, compounds found in yellow or dark leafy vegetables, as well as intake of vitamin E from food


and supplements, appears to lower the risk of cataracts in women. Further research is indicated (Moeller et al, 2008).

When visual acuity decreases to 20/50 and the cataract affects safety or quality of life, surgery is recommended. Cataract surgery is the most common surgical procedure performed in the United States. Most often, cataract surgery involves only local anesthesia and is one of the most successful surgical procedures, with 95% of patients reporting excellent vision after surgery. The surgery involves removal of the lens and placement of a plastic intraocular lens (IOL). If the plastic lens is not inserted, the patient may wear a contact lens or glasses. This is not commonly done because the older adult may have difficulty placing and removing the contact lens, and the glasses would be very thick. Cataract surgery is performed with local anesthesia on an outpatient basis, and the procedure has greatly improved with advances in surgical techniques.

Nursing interventions when caring for the person experiencing cataract surgery include preparing the individual for significant changes in vision and adaptation to light and insuring that the individual has received adequate counseling regarding realistic postsurgical expectations. Postsurgical teaching includes covering the need to avoid heavy lifting, straining, and bending at the waist. Eye drops may be prescribed to aid healing and prevent infection. If the person has bilateral cataracts, surgery is performed first on one eye with the second surgery on the other eye a month or so later to ensure healing.

Although race is not a factor in cataract formation, racial disparities exist in cataract surgery in the United States, with African-American Medicare recipients only 60% as likely as whites to undergo cataract surgery (Miller, 2008; Wilson and Ezzuduemho, 2005). Cataracts are of even greater concern in Africa and Asia and account for at least half of the blindness in those countries despite the well known technology that can restore vision at an extremely low cost. Recommendations from Vision 2020 include reducing the backlog of the cataract-blind by increased training of ophthalmic personnel, strengthening of the health care infrastructure, and provision of needed surgical supplies in these countries (www.who.int/ncd/vision2020_actionplan/documents/V2020priorities.pdf2004).

Unfortunately, cataracts and other related eye diseases such as maculopathy, diabetic retinopathy, or glaucoma often occur simultaneously, which complicates the management of each. Individuals who have had cataract surgery are less likely to be effectively treated with surgery for glaucoma.

**Diabetic Retinopathy**

Diabetes has become an epidemic in the United States (Chapter 15). Diabetic eye disease is a complication of diabetes and a leading cause of blindness. Diabetic retinopathy is a disease of the retinal microvasculature characterized by increased vessel permeability. Blood and lipid leakage leads to macular edema and hard exudates (composed of lipids). In advanced disease, new fragile blood vessels form that hemorrhage easily. Because of the vascular and cellular changes accompanying diabetes, there is often rapid worsening of other pathologic vision conditions as well (Figure 6-3, D).

There are no symptoms in the early stages of diabetic retinopathy. Estimates are that 40.8% of adults aged 40 and older with diabetes have diabetic retinopathy, and the incidence increases with age. Most diabetic patients will develop diabetic retinopathy within 20 years of diagnosis. Prevalence rates for diabetes and diabetic retinopathy are higher among racially and culturally diverse individuals and among American Indian and Alaska Native populations (National Eye Institute, 2010c).

**Screening and Treatment** There is little to no evidence of retinopathy until 3 to 5 years or more after the onset of diabetes. Early signs are seen in the funduscopic examination and include microaneurysms, flame-shaped hemorrhages, cotton wool spots, hard exudates, and dilated capillaries. Constant, strict control of blood glucose, cholesterol, and blood pressure and laser photocoagulation treatments can halt progression of the disease. Laser treatment can reduce vision loss in 50% of patients. Annual dilated funduscopic examination of the eye is recommended beginning 5 years after diagnosis of diabetes type 1 and at the time of diagnosis of diabetes type 2.

**Macular Degeneration**

Age-related macular degeneration (AMD) is the leading cause of vision loss in Americans 60 years and older. The prevalence of AMD increases drastically with age, with more than 15% of white women over the age of 80 having the disease. Whites and Asian Americans are more likely to lose vision from AMD than African Americans. With the number of affected older adults projected to increase over the next 20 years, AMD has been called a growing epidemic (National Eye Institute, 2010d).

AMD is a degenerative eye disease that affects the macula, the central part of the eye responsible for clear central vision. The disease causes the progressive loss of central vision, leaving only peripheral vision intact. Early signs of AMD include blurred vision, difficulty reading and driving, increased need for bright light, colors that appear dim or gray, and an awareness of a blurry spot in the middle of vision. Figure 6-3, E illustrates the effects of AMD on vision.

AMD results from systemic changes in circulation, accumulation of cellular waste products, tissue atrophy, and growth of abnormal blood vessels in the choroid layer beneath the retina. Fibrous scarring disrupts nourishment of photoreceptor cells, causing their death and loss of central vision. The greatest risk factor for AMD is age. Although etiology is unknown, risk factors are thought to include genetic predisposition, smoking, obesity, family history, and excessive sunlight exposure.

There are two forms of macular degeneration, the “dry” form and the “wet” form. Dry AMD accounts for the majority of cases and rarely causes severe visual impairment, but can lead to the more aggressive wet AMD. Dry AMD generally affects both eyes, but vision can be lost on one eye while the other eye seems unaffected. Dry AMD has three stages, which may occur in one or both eyes. As dry AMD gets worse, the individual may see a blurred spot in the center of vision. One of the most common early signs is drusen. Drusen are yellow deposits under the retina and are often found in people over the age of 60. The relationship between drusen and AMD is not clear, but an increase in the size or number of drusen increases the risk of developing either advanced AMD or wet AMD (National Eye Institute, 2010d).
Wet AMD occurs when abnormal blood vessels behind the retina start to grow under the macula. These new blood vessels are fragile and often leak blood and fluid, which raise the macula from its normal place at the back of the eye. With wet AMD, the severe loss of central vision can be rapid, and many people will be legally blind within two years of diagnosis. Peripheral vision usually remains normal, but the person will have difficulty seeing at a distance or doing detailed work such as sewing or reading. Faces may begin to blur, and it become harder to distinguish colors. An early sign may be distortion that causes edges or lines to appear wavy.

An Amsler grid is used to determine clarity of central vision (Figure 6-4). A perception of wavy lines is diagnostic of beginning macular degeneration, and vision loss can occur in days. In the advanced forms, the person may begin to see dark or empty spaces that block the center of vision. People with AMD are usually taught to test their eyes daily using the Amsler grid so that they will be aware of any changes.

Patients in the early stage of the disease may attribute their vision problems to normal aging or cataracts. Early diagnosis is the key, and individuals over the age of 40 should have a dilated eye examination at least every 2 years. The National Eye Institute’s Age-Related Eye Disease Study (AREDS) (www.nei.nih.gov/) found that a high-dose formulation of antioxidants and zinc significantly reduces the risk of advanced AMD and associated vision loss. Individuals with intermediate AMD in one or both eyes or advanced AMD (wet form) in one eye but not the other should consider taking the formulation (National Eye Institute, 2010d).

Treatment of wet AMD includes photodynamic therapy (PDT), laser photocoagulation (LPC), and anti-VEGF therapy. LPC uses a laser to destroy the fragile, leaky blood vessels, but it may also destroy healthy tissue and some vision so it is used in only a small number of people with wet AMD. Lucentis and Avastin (anti-vascular endothelial growth factor (VEGF) therapy), are biological drugs that are the most common form of treatment in advanced AMD. Abnormally high levels of a specific growth factor occur in eyes with wet AMD, which promote the growth of abnormal blood vessels. Anti-VEGF therapy blocks the effect of the growth factor. These drugs are injected into the eye as often as once a month and can help slow vision loss from AMD, and in some cases can improve sight. Photodynamic therapy involves the injection of the drug verteporfin into the arm followed by shining a light into the eye for about 90 seconds. The activated drug destroys the new blood vessels and leads to a lower rate of vision decline but does not stop vision loss or restore vision (National Eye Institute, 2010d).

**Detached Retina**

This condition can develop in persons with cataracts or recent cataract surgery or trauma, or can occur spontaneously. It manifests as a curtain coming down over the person’s line of vision. It necessitates immediate emergency treatment.

**Dry Eye**

Dry eye is not a disease of the eye but is a frequent complaint among older people. Tear production normally diminishes as we age. The condition is termed keratoconjunctivitis sicca. It occurs most commonly in women after menopause. There may be age-related changes in the mucin-secreting cells necessary for surface wetting, in the lacrimal glands, or in the meibomian glands that secrete surface oil, and all of these may occur at the same time. The older person will describe a dry, scratchy feeling in mild cases (xerophthalmia). There may be marked discomfort and decreased mucus production in severe situations.

Medications can cause dry eye, especially antihistamines, diuretics, beta blockers, and some sleeping pills. The problem is diagnosed by an ophthalmologist using a Schirmer tear test, in which filter paper strips are placed under the lower eyelid to measure the rate of tear production. A common treatment is artificial tears, but dry eyes may be sensitive to them because of preservatives, which can be irritating. The ophthalmologist may close the tear duct channel either temporarily or permanently. Other management methods include keeping the house air moist with humidifiers, avoiding wind and hair dryers, and the use of artificial tear ointments at bedtime. Vitamin A deficiency can be a cause of dry eye, and vitamin A ointments are available for treatment. Sjögren’s syndrome, which can occur in older people, is often associated with dry eye.

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**Figure 6-4** Macular degeneration: distortion of center vision, normal peripheral vision. (Illustration by Harriet R. Greenfield, Newton, Mass.)
people, is a cell-mediated autoimmune disease whose manifestations include decreased lacrimal gland activity. Systemic manifestations of the autoimmune disease include Raynaud’s phenomenon, polyarthritis, interstitial pneumonitis, vasculitis, psychiatric manifestations, and loss of exocrine functions.

**Interventions to Enhance Vision**

General principles in caring for the older adult with visual impairment include the following: use warm incandescent lighting; increase intensity of lighting; control glare by using shades and blinds; suggest yellow or amber lenses to decrease glare; suggest sunglasses that block all ultraviolet light; select colors with good contrast and intensity; and recommend reading materials that have large, dark, evenly spaced printing.

**Use of Contrasting Colors**

Color contrasts are used to facilitate location of items. Sharply contrasting colors assist the partially sighted. For instance, a bright towel is much easier to locate than a white towel hanging on a beige wall. When choosing color, it is best to use primary colors at the top end of the spectrum rather than those at the bottom. If you think of the colors in the rainbow, it is more likely that people will see reds and oranges better than blues and greens. Figure 6-5 illustrates the use of color in a nursing home.

**Low-vision Assistive Devices**

Technology advances in the past decade have produced some low-vision devices that may be used successfully in the care of the visually impaired elder. Persons with severe visual impairment may qualify for disability and financial and social services assistance through government and private programs including vision rehabilitation programs. An array of low-vision assistive devices are now available, including insulin delivery systems, talking clocks and watches, large-print books, magnifiers, telescopes (handheld or mounted on eyeglasses), electronic magnification through closed circuit television or computer software, and software that converts text into artificial voice output. Because individual needs are unique, it is recommended that before investing in vision aids, the client consult with a low-vision center or low-vision specialist. See Resources available at http://evolve.elsevier.com/Ebersole/TwdHlthAging.

**Communicating through Touch**

A significant amount of vestibular stimulation, information, and sensual gratification comes about through touching. Touch is used for awareness and protective responses. Touch intensifies bonding and defines boundaries of self. Those who have visual and hearing impairments often compensate by cultivating the sense of touch to a high degree. Touch is often lacking in the older person’s environment and can contribute to a diminishing sensorium.

Although it varies in individuals, it is thought that touch sensitivity diminishes with aging. Many of these losses are caused by disease processes such as diabetes mellitus. Changes in the sense of touch predispose older people to skin damage, particularly to the development of pressure ulcers. Loss of sensitivity to hot or cold, or thermal sensitivity, predisposes older people to burns and hyperthermia, or to frostbite and hypothermia. Degenerative changes in Meissner’s corpuscles in the hands and feet result in diminished sensitivity of the palms and soles. This may cause a decrease in reaction time when stepping on a sharp object or touching a burner on the stove.

Less obvious is the deprivation of tactile senses. Introducing texture (e.g., textured upholstery, soft blanket) into the older adult’s environment can enhance tactile input and contribute to safety. The use of caring, expressive touch by nurses is important (Chapter 21).

**PROMOTING HEALTHY AGING: IMPLICATIONS FOR GERONTOLOGICAL NURSES**

Vision impairment is common among older adults in connection with aging changes and eye diseases and can significantly affect communication, functional ability, safety, and quality of life. To promote healthy aging and quality of life, nurses who care for elders in all settings can improve outcomes for visually impaired elders by assessing for vision changes, adapting the environment to enhance vision and safety, communicating appropriately, and providing appropriate health teaching and referrals for prevention and treatment. Suggestions for
communicating effectively with older adults with vision impairment are presented in Box 6-8.

COMMUNICATING WITH OLDER ADULTS WITH NEUROLOGICAL DISORDERS

Three major categories of impaired verbal communication arise from neurological disturbances: (1) reception, (2) perception, and (3) articulation. Reception is impaired by anxiety or is related to a specific disorder, hearing deficits, and altered levels of consciousness. Perception is distorted by stroke, dementia, and delirium. Articulation is hampered by mechanical difficulties such as dysarthria, respiratory disease, destruction of the larynx, and cerebral infarction with neuromuscular effects. Specific difficulties include the following:

- **Anomia**: Word retrieval difficulties during spontaneous speech and naming tasks.
- **Aphasia**: Aphasia is an acquired communication disorder that impairs a person’s ability to process language, but does not affect intelligence. Aphasia impairs the ability to speak and understand others, and most people with aphasia experience difficulty in reading and writing. It results from damage to the side of the brain dominant for language. For most people, this is the left side. Aphasia usually occurs suddenly and often results from a stroke or head injury, but it can also develop slowly because of a brain tumor, an infection, or dementia.
- **Dysarthria**: Impairment in the ability to articulate words as the result of damage to the central or peripheral nervous system that affects the speech mechanism.

Aphasia

The most commonly occurring language disorder after a cerebral vascular accident is aphasia. Cerebral vascular accidents are discussed in Chapter 15. Aphasia, in varying degrees, affects a person’s ability to communicate in one or more ways, including speaking, understanding, reading, writing, and gesturing. Depending on the type and severity of the aphasia, there may be little or no speech, speech that is fragmented or broken, or speech that is fluent but empty in content. Broca’s area and Wernicke’s area in the cerebral cortex are integral to the expression and understanding of language. The National Aphasia Association (New York, NY) categorizes the two major types of aphasia as fluent and nonfluent. The following is a description of several types of aphasia that the nurse may encounter with older adults:

- **Fluent aphasia** is the result of a lesion in the superior temporal gyrus, an area adjacent to the primary auditory cortex (Wernicke’s area). This type is also known as sensory, posterior, or Wernicke’s aphasia. In this form of aphasia the ability to grasp the meaning of spoken words is chiefly impaired, whereas the ease of producing connected speech is not much affected. Therefore Wernicke’s aphasia is referred to as a “fluent aphasia.” However, speech is far from normal. Sentences do not hang together and irrelevant words intrude—sometimes to the point of jargon, in severe cases. Reading and writing are often severely impaired. Persons with fluent aphasia speak easily with many long runs of words, but the content does not make sense. There are word-finding problems and errors of word and sound substitution. These persons also have difficulty understanding spoken language and may be unaware of their speech difficulties.

- **Nonfluent aphasia** typically involves damage to the posterior inferior portions of the dominant frontal lobe (Broca’s area). This type is also called motor, anterior, or Broca’s aphasia. In this form of aphasia, speech output is severely reduced and is limited mainly to short utterances of less than four words. Vocabulary access is limited and the formation of sounds by persons with Broca’s aphasia is often laborious and clumsy. The person may understand speech relatively well and be able to read, but be limited in writing. Broca’s aphasia is often referred to as a “nonfluent aphasia” because of the halting and effortful quality of speech.

- **Mixed nonfluent aphasia** applies to patients who have sparse and effortful speech, resembling severe Broca’s aphasia. However, unlike persons with Broca’s aphasia, they remain limited in their comprehension of speech and do not read or write beyond an elementary level.

- **Verbal apraxia** or **apraxia of speech** is a motor speech disorder that affects the ability to plan and sequence voluntary muscle movements. The muscles of speech are not paralyzed; instead there is a disruption in the brain’s transmission of signals to the muscles. When thinking about what to say, the person...
may be unable to speak at all or may struggle to say words. In contrast, the person may be able to say many words or sentences correctly when not thinking about the words. Apraxia frequently occurs with aphasia.

Anomic aphasia is associated with lesions of the dominant temporoparietal regions of the brain, although no single locus has been identified. Persons with anomic aphasia understand and speak readily but may have severe word-finding difficulty. They may be unable to remember crucial content words. This is a frequent form of aphasia characterized by the inability to name objects. The individual struggles to come forth with the correct noun and often becomes frustrated at his or her inability to do so.

Global aphasia is the result of large left hemisphere lesions and affects most of the language areas of the brain. Persons with global aphasia cannot understand words or speak intelligibly. They may use meaningless syllables repetitively.

In addition to the foregoing syndromes that are seen repeatedly by speech clinicians, there are many other possible combinations of deficits that do not exactly fit into these categories. Some of the components of a complex aphasia syndrome may also occur in isolation. This may be the case for disorders of reading (alexia) or disorders affecting both reading and writing (alexia and agraphia), following a stroke. Severe impairments of calculation often accompany aphasia, yet in some instances patients retain excellent calculation in spite of the loss of language (National Aphasia Association, 2010; www.aphasia.org).

A speech–language pathologist (SLP) should be consulted for each type of aphasia to develop appropriate rehabilitative plans as soon as the individual is physiologically stabilized. SLPs bring expertise in all types of communication disorders and are an essential part of the interdisciplinary team. The SLP can identify the areas of language that remain relatively unimpaired and can capitalize on the remaining strengths. Much can be done in aggressive speech–retraining programs to regain intelligible conversational ability. For those who do not regain meaningful speech, assistive and augmentative communication devices can be most helpful. Happ and Paull (2008) note the importance of consulting with the SLP in acute and critical care settings, as well as in rehabilitation and long-term care, and describe a program to improve communication with ICU patients who are unable to speak.

Alternative and Augmentative Speech Aids

Alternative or augmentative systems are frequently used, and communication tools exist for every type of language disability. These can be low tech or high tech. An example of a low-tech system would be an alphabet or picture board that the individual uses to point to letters to spell out messages or to point to pictures of common objects and situations. High-tech systems include electronic boards and computers. Studies have shown that computer-assisted therapy can help people with aphasia improve speech. An example is speech therapy software that displays a word or picture, speaks the word (using prerecorded human speech), records the user speaking it, and plays back the user’s speech.

For individuals with hemiplegic or paraplegic conditions, electronic devices and computers can be voice-activated or have specially designed switches that can be activated by just one finger or by slight contact with the ear, nose, or chin. In addition to speech therapy, some experimental studies indicate that drugs may help improve aphasia in the acute phase of stroke and assist after the acute situation and in chronic aphasia.

PROMOTING HEALTHY AGING: IMPLICATIONS FOR GERONTOLOGICAL NURSING

Nurses are responsible for accurately observing and recording the speech and word recognition patterns of the patient and for consistently implementing the recommendations of the SLP. Communication with the older adult experiencing aphasia can be frustrating for both the affected person and the nurse as they struggle to understand each other. It is important to remember that in most cases of aphasia, the person retains normal intellectual ability. Therefore communication must always occur at an adult level but with special modifications.

Hearing and vision losses can further contribute to communication difficulties for older adults with aphasia. Sensitivity and patience are essential to promote effective communication. In hospitals and nursing homes, it is most helpful if staff caring for the person remain consistent so that they can come to know and understand the needs of the person and communicate these to others. It is exhausting for the person to have to continually try to communicate needs and desires to an array of different people. Plans of care should include specific communication strategies that are helpful for the individual person so that all staff, as well as families and significant others, know the most effective way to enhance communication. Suggestions for communicating with patients with aphasia are presented in Box 6-9.

Dysarthria

Dysarthria is a speech disorder caused by a weakness or incoordination of the speech muscles. It occurs as a result of central or peripheral neuromuscular disorders that interfere with the clarity of speech and pronunciation. Dysarthria is second in incidence only to aphasia as a communication disorder of older adults and may be the result of stroke, head injury, Parkinson’s disease, multiple sclerosis, and other neurological conditions. Dysarthria is characterized by weakness, slow movement, and a lack of coordination of the muscles associated with speech. Speech may be slow, jerky, slurred, quiet, lacking in expression, and difficult to understand. It may involve several mechanisms of speech, such as respiration, phonation, resonance, articulation, and prosody (the meter, or rhythm of speech). A weakness or lack of coordination in any one of the systems can result in dysarthria. If the respiratory system is weak, then speech may be too quiet and be produced one word at a time. If the laryngeal system is weak, speech may be breathy, quiet, and slow. If the articulatory system is affected, speech may sound slurred and be slow and labored.

Treatment of dysarthria depends on the cause, the type, and the severity of the symptoms. An SLP works with the individual to improve communication abilities. Therapy for dysarthria focuses on maximizing the function of all systems. In progressive neurological disease it is important to begin treatment early.

and continue throughout the course of the disease, with the goal of maintaining speech as long as possible.

The gerontological nurse needs to be familiar with techniques that facilitate communication with persons with dysarthria as well as strategies that can be taught to the person to improve communication. Boxes 6-10 and 6-11 present suggestions for the person with dysarthria and the listener to improve communication.

The nurse may encounter older people in the acute or long-term phase of an illness that affects communication. Although early intensive rehabilitation efforts are the most effective, all older adults with communication deficits should have access to state-of-the-art techniques and devices that enhance communication, a basic human need. In addition to being knowledgeable about appropriate communication techniques, it is important for the nurse to be aware of equipment and resources available to the person with aphasia or dysarthria so that hope can be offered. Teaching families and significant others effective communication strategies is also an important nursing role. Several resources for people with aphasia and dysarthria are presented at http://evolve.elsevier.com/Ebersole/TwdHlthAging.

**Communicating with Older Adults with Cognitive Impairment**

The experience of losing cognitive and expressive abilities is both frightening and frustrating. One type of cognitive impairment that affects memory, speech, and communication is dementia (Chapter 19). Older adults experiencing dementia have difficulty expressing their personhood in ways easily understood by others. However, the need to communicate and the need to be treated as a person remain despite memory and communication impairments. No group of patients is more in need of supportive relationships with skilled, caring health care providers. People with cognitive and communication impairments “depend on their relationship with and trust of others to provide emotional support, solve problems, and coordinate complex activities” (Buckwalter et al., 1995, p. 15). Communication with elders experiencing cognitive impairment requires special skills and patience. “Caregivers are subject...
to frustration and anxiety when their attempts to communicate with the person who has cognitive limitations are unsuccessful” (Williams and Tappen, 2008, p. 92). Dementia affects both receptive and expressive communication components and alters the way people speak. Early in the disease, word finding is difficult (anomia), and remembering the exact facts of a conversation is challenging. The following quotes, in the words of older adults with dementia, illustrate:

“I’m aware that I’m losing larger and larger chunks of memory…I lose one word and then I can’t come up with the rest of the sentence. I just stop talking and people think something is really wrong with me. For awhile, I’ll search for a word and I can see it walking away from me. It just gets littler and littler. It always comes back, but at the wrong time. You just can’t be spontaneous” (Snyder, 2001, pp. 8, 11, 16)

“There are a range of things you want to say over and over because I think it was a word that was important to say and I’ll forget…I hope that what I am saying makes sense” (Hain et al., 2010).

People with dementia often use nonsensical or “made-up” words such as calling an electric razor a “whisker grinder.” Automatic language skills (e.g., hello) are retained for the longest time. The person may wander from the topic of conversation and bring up seemingly unrelated topics. The person with dementia may fail to pick up on humor or sarcasm or abstract ideas in conversation. Nonverbal and behavioral responses become especially important as a way of communication as verbal skills become more limited. As the disease progresses, verbal output may become less frequent although the grammar and sounds of the language being spoken remain relatively intact.

Williams and Tappen (2008) remind us that even in the later stages of dementia, the person may understand more than you realize and still needs opportunities for interaction and caring communication, both verbal and nonverbal. Often, health care providers do not communicate with older adults with cognitive impairment, or they limit communication only to task-focused topics.

To effectively communicate with a person experiencing cognitive impairment, it is essential to believe that the person is trying to communicate something. It is just as essential for nurses to believe that what the person is trying to communicate is important enough to make the effort to understand. The best thing we can do is to treat everything the person says, however jumbled it may seem, as important and an attempt to tell us something. It is our responsibility as professionals to know how to understand and respond. The person with cognitive impairment cannot change his or her communication; we must change ours (Box 6-12).

Classic research conducted by Ruth Tappen of Florida Atlantic University (Boca Raton, FL) and colleagues (Tappen et al., 1997, 1999) provided insight into communication strategies that were helpful in creating and maintaining a therapeutic relationship with people in the moderate to later stages of dementia. In these studies, conversations between 23 participants in the middle and late stages of Alzheimer’s disease were analyzed to clarify what type of communication techniques were helpful in creating and maintaining a therapeutic relationship. Interviewers were told to “avoid frequent correction of the individual, encourage the individual to engage in conversation, attempt to make the conversation as meaningful as possible, and to assume that any attempt at communication had some meaning to it, however difficult it was to ascertain that meaning” (Tappen et al., 1997, p. 250). Findings were compared with recommendations in the literature, and specific communication strategies were developed. More than 80% of the participants’ responses were relevant in the context of the conversation. The research challenged some of the commonly held beliefs about communication with persons with cognitive impairment, for example, avoiding the use of open-ended questions and keeping communication focused only on simple topics, task-oriented topics, and questions that can be answered with yes or no.

Findings of this study provided suggestions for specific communication strategies effective in various nursing situations as well as hope for nurses to establish meaningful relationships that nurture the personhood of people with cognitive impairments (Box 6-13). Communication strategies differ depending on the purpose of communication (e.g., performing activities of daily living [ADLs], encouraging expression of feelings). “Approaches to communication must be adapted not only to the person’s ability to understand but to the purpose of the interaction. What is appropriate for assessment may be a barrier to conversation that is designed to facilitate expression of concerns and feelings” (Williams and Tappen, 2008, p. 93). The Hartford Institute for Geriatric Nursing Try This series (http://consultgerinn.org/uploads/File/trythis/try_this_d7.pdf) provides an evidence-based practice guide for communicating with hospitalized older adults with dementia.

In the past, structured programs of reality orientation (RO) (orienting the person to the day, date, time, year, weather, upcoming holidays) were often used in long-term care facilities and chronic psychiatric units as a way to stimulate interaction and enhance memory. This intervention is still often noted as being of benefit to persons with dementia. However, it has been found that structured RO may place unrealistic expectations on persons with middle- to late-stage dementia and may be distressing when they cannot remember these things. Families, and professional caregivers, can often be heard asking people with dementia to name relatives, state their birth year, and remember other current facts. One can imagine how...
upsetting and demoralizing this might be to a person unable to remember.

Students reading this book may liken the feeling to being told they are taking a pop quiz on content not yet assigned for study, and that this will constitute their final course grade. An often-told story in gerontological nursing is about a researcher who was visiting a nursing home daily to administer the Mini-Mental State Examination (MMSE) to residents with dementia as part of her study. One morning, one of the residents hurried to the nursing station; she was quite agitated and frantically kept asking, “What day is today?” The nurse asked her why she was so upset about the day and she responded, “It’s not me, but there is a young woman who comes in every day asking that question and I want to help her out.”

This is not to say that we should not orient the person to daily activities, time of day, and other important events, but it should be offered without the expectation that they will remember. Caregivers can provide orienting information as part of general conversation (e.g., “It’s quite warm for December 10, but it will be a beautiful day for our lunch date”). Rather than structured RO, a better approach is to go where the person is in their world rather than trying to bring them into yours. Identifying with elements of the individual’s past and helping them and their caregivers appreciate the connections and feelings are more therapeutic approaches. Validation therapy, developed by Naomi Feil in the 1980s, involves following the person’s lead and responding to feelings expressed rather than interrupting to supply factual data.

Deborah Hoffmann, in her wonderful film Compliments of a Dutiful Daughter, chronicles her mother’s journey through Alzheimer’s disease and humorously describes her frustration with trying to keep her mother oriented and in the present. When her mother thought Deborah was one of her sorority sisters from college and talked to her about all the good times they had, she would correct her mother and remind her that she was her daughter and did not go to college with her. After many such conversations and corrections, she finally realized that it was okay if her mother thought she was one of the sorority girls—it made her mother happy to talk about good times and they could laugh and reminisce together.

### BOX 6-13 FOUR USEFUL STRATEGIES FOR COMMUNICATING WITH INDIVIDUALS EXPERIENCING COGNITIVE IMPAIRMENT

<table>
<thead>
<tr>
<th>SIMPLIFICATION STRATEGIES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Simplification strategies are useful with ADLs:</td>
<td>• Recognize the hidden meanings (what did the person mean to say?).</td>
</tr>
<tr>
<td>• Give one-step directions.</td>
<td>SUPPORTIVE STRATEGIES</td>
</tr>
<tr>
<td>• Speak slowly.</td>
<td>Supportive strategies are useful in encouraging continued communication and supporting personhood:</td>
</tr>
<tr>
<td>• Allow time for response.</td>
<td>• Introduce yourself, and explain why you are there. Reach out to shake hands, and note the response to touch.</td>
</tr>
<tr>
<td>• Reduce distractions.</td>
<td>• If the person does not want to talk, go away and return later. Do not push or force.</td>
</tr>
<tr>
<td>• Interact with one person at a time.</td>
<td>• Sit closely, and face the person at eye level.</td>
</tr>
<tr>
<td>• Give clues and cues as to what you want the person to do. Use gestures or pantomime to demonstrate what it is you want the person to do—for example, put the chair in front of the person, point to it, pat the seat, and say, “Sit here.”</td>
<td>• Limit corrections.</td>
</tr>
<tr>
<td></td>
<td>• Use multiple ways of communicating (gestures, touch).</td>
</tr>
<tr>
<td></td>
<td>• Search for meaning.</td>
</tr>
<tr>
<td></td>
<td>• Know the person’s past life history as well as daily life experiences and events.</td>
</tr>
<tr>
<td>FACILITATION STRATEGIES</td>
<td>• Remember there is a person behind the disease.</td>
</tr>
<tr>
<td>Facilitation strategies are useful in encouraging expression of thoughts and feelings:</td>
<td>• Recognize feelings, and respond.</td>
</tr>
<tr>
<td>• Establish commonalities.</td>
<td>• Treat the person with respect and dignity.</td>
</tr>
<tr>
<td>• Share self.</td>
<td>• Show interest through body posture, facial expression, nodding, and eye contact. Assume a pleasant, relaxed attitude.</td>
</tr>
<tr>
<td>• Allow the person to choose subjects to discuss.</td>
<td>• Attend to vision and hearing losses.</td>
</tr>
<tr>
<td>• Speak as if to an equal.</td>
<td>• Do not try to bring the person to the present or use reality orientation. Go to where the person is, and enjoy the conversation.</td>
</tr>
<tr>
<td>• Use broad openings, such as “How are you today?”</td>
<td>• When leaving, thank the person for his or her time and attention as well as information.</td>
</tr>
<tr>
<td>• Employ appropriate use of humor.</td>
<td>• Remember that the quality, not the content or quantity, of the interaction is basic to therapeutic communication.</td>
</tr>
<tr>
<td>• Follow the person’s lead.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPREHENSION STRATEGIES</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Comprehension strategies are useful in assisting with understanding of communication:</td>
<td></td>
</tr>
<tr>
<td>• Identify time confusion (in what time frame is the person operating at the moment?).</td>
<td></td>
</tr>
<tr>
<td>• Find the theme (what connection is there between apparently disparate topics?). Recognize an important theme, such as fear, loss, or happiness.</td>
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ADLs, activities of daily living.
only insensitive and dehumanizing, but also often lead to diminished self-image and angry, agitated responses on the part of the patient with cognitive impairment” (Buckwalter et al., 1995, p. 15).

THE LIFE STORY

Older people bring us complex stories derived from long years of living. In caring for older adults, listening to life stories is an important component of communication. The life story can tell us a great deal about the person and is an important part of the assessment process. Stories provide important information about etiology, diagnosis, treatment, prognosis, and experience of living with an illness from the patient’s point of view. Listening to memories and life stories requires time and patience and a belief that the story and the person are valuable and meaningful. A memory is an incredible gift given to the nurse, a sharing of a part of oneself when one may have little else to give. The more personal memories are saved for persons who will patiently wait for their unveiling and who will treasure them. Stories are important, as Robert Coles states (1989, p. 7): “The people who come to see us bring us their stories. They hope they tell them well enough so that we understand the truth of their lives. They hope we know how to interpret their stories correctly.”

The life story as constructed through reminiscing, journaling, life review, or guided autobiography has held great fascination for gerontologists in the last quarter-century. The universal appeal of the life story as a vehicle of culture, a demonstration of caring and generational continuity, and an easily stimulated activity has held allure for many professionals. The most exciting aspect of working with older adults is being a part of the emergence of the life story: the shifting and blending patterns. When we are young, it is important for our emotional health and growth to look forward and plan for the future. As one ages, it becomes more important to look back, talk over experiences, review and make sense of it all, and end with a feeling of satisfaction with the life lived. This is important work and the major developmental task of older adulthood that Erik Erikson called ego integrity versus despair. Ego integrity is achieved when the person has accepted both the triumphs and disappointments of life and is at peace and satisfied with the life lived (Erikson, 1963).

Reminiscing

Reminiscing is an umbrella term that can include any recall of the past. Reminiscing occurs from childhood onward, particularly at life’s junctures and transitions. Reminiscing cultivates a sense of security through recounting of comforting memories, belonging through sharing, and self-esteem through confirmation of uniqueness. Robert Butler (2002) pointed out that 50 years ago, reminiscing was thought to be a sign of senility or what we now call Alzheimer’s disease. Older people who talked about the past and told the same stories again and again were said to be boring and living in the past. From Butler’s seminal research (1963), we now know that reminiscence is the most important psychological task of older people.

For the nurse, reminiscing is a therapeutic intervention important in assessment and understanding. The work of several gerontological nursing leaders, including Irene Burnside, Priscilla Ebersole, and Barbara Haight, has contributed to the body of knowledge about reminiscence and its importance in nursing. The International Institute for Reminiscence and Life Review (University of Wisconsin, Superior, WI), an interdisciplinary organization bringing together participants to study reminiscence and life review, is another valuable resource for nurses and members of other disciplines involved in research or practice.

Reminiscence can have many goals. It not only provides a pleasurable experience that improves quality of life, but also increases socialization and connectedness with others, provides cognitive stimulation, improves communication, and can significantly decrease depression scores (Haight and Burnside, 1993; Grabowski et al., 2010). The process of reminiscence can occur in individual conversations with older people, be structured as in a nursing history, or can occur in a group where each person shares his or her memories and listens to others sharing theirs. Group work is discussed later in this chapter.

Reminiscence and life story have entered the computer age through the use of digital storytelling. Digital storytelling is another medium that can be used with older people to record their stories and memories in a format that can be shared with others. The digital story is a first-person narrative created by combining recorded voice, still and moving images, and music or other sounds. A study producing personalized multimedia biographies for individuals with cognitive impairment reported that the biography stimulated reminiscence, brought mostly joy but occasionally moments of sadness, aided family members in remembering and better understanding their loved ones, and stimulated social interactions with family members and formal caregivers (Damianakis et al., 2010). Buron (2010) presents a lovely format for person-centered life history collages for use in a nursing home. There are many resources available for those interested in digital storytelling and community centers and educational institutions, as well as the Internet, provide instruction on this medium (http://www.storycenter.org/about.html; http://digitalstorytelling.coe.uh.edu/; http://milehighstories.com/?page_id=21).

The nurse can learn much about a resident’s history, communication style, relationships, coping mechanisms, strengths, fears, affect, and adaptive capacity by listening thoughtfully as the life story is constructed. Box 6-14 provides some suggestions for encouraging reminiscence.

Life Review

Robert Butler (1963) first noted and brought to public attention the review process that normally occurs in the older person as the realization of his or her approaching death creates a resurgence of unresolved conflicts. Butler called this process life review. Life review occurs quite naturally for many persons during periods of crisis and transition. However, Butler (2002) noted that in old age, the process of putting one’s life in order increases in intensity and emphasis. Life review occurs most frequently as an internal review of memories, an intensely private, soul-searching activity.

Life review is considered more of a formal therapy technique than reminiscence and takes a person through his or her life in a structured and chronological order. Life review therapy (Butler and Lewis, 1983), guided autobiography (Birren and...
Deutchman, 1991), and structured life review (Haight and Webster, 2002) are psychotherapeutic techniques based on the concept of life review.

Gerontological nurses participate with older adults in both reminiscence and life review, and it is important to acquire the skills to be effective in achieving the purposes of both. Life review may be especially important for older people experiencing depressive symptoms and those facing death (Pott et al., 2010). The Hospice Foundation of America provides A Guide for Recalling and Telling Your Life Story (http://store.hospicefoundation.org/home.php?cat=5) that nurses and families may find helpful.

Life review should occur not only when we are old or facing death but also frequently throughout our lives. This process can assist us to examine where we are in life and change our course or set new goals. Butler (2002) commented that one might avoid the overwhelming feelings of despair that may surface when there is no time left to make changes if life review had been conducted throughout one’s lives.

### PROMOTING HEALTHY AGING: IMPLICATIONS FOR GERONTOLOGICAL NURSING

One of the greatest privileges of nursing elders is to accompany them in the final journey of life. As each person confronts mortality, there is a need to integrate events and then to transcend the self. The human experience, the person’s contributions, and the poignant anecdotes within the life story bind generations together, validate the uniqueness of each brief journey in this level of awareness, and provide the assurance that one will not be forgotten. When the nurse takes the time to listen to an older person share memories and life stories, it communicates respect and valuing of the individual and provides important data for assessment and coming to know the person. What more can one ask at the end of life than to know that who one is and what one has accomplished holds personal meaning and meaning for others as well! This is the essence of life’s final tasks—achieving ego integrity and self-actualization.

### COMMUNICATING WITH GROUPS OF OLDER ADULTS

Group work with older adults has been used extensively in institutional settings to meet myriad needs in an economical manner. Nurses have led groups of older people for a variety of therapeutic reasons. Expert gerontological nurses, such as Irene Burnside and Priscilla Ebersole, have extensively discussed advantages of group work for both older people and group leaders and have provided in-depth guidelines for conducting groups. Box 6-15 presents some of the benefits of group work.

Many groups can be managed effectively by staff with clear goals and guidance and training. Volunteers, nursing assistants, students, and recreation staff can be taught to conduct many types of groups, but groups with a psychotherapy focus require a trained and skilled leader. Perese, Simon and Ryan (2008) and Heliker (2009) provide excellent suggestions for group reminiscence therapy and story-sharing interventions. Some basic considerations for group work are presented in this chapter, but nurses interested in working with groups of older people should consult a text on group work for more in-depth information.

Groups can be implemented in many settings, including adult day health programs, retirement communities, assisted living facilities, nutrition sites, and nursing homes. Examples of groups include reminiscence groups, psychoeducational groups, caregiver support groups, and groups for people with memory impairment or other conditions such as Parkinson’s disease or stroke. Groups can be organized to meet any level of human need; some meet multiple needs.

**CHAPTER 6 Communicating with Older Adults**

**BOX 6-15 BENEFITS OF GROUP WORK WITH ELDERS**

- Group experiences provide older adults with an opportunity to try new roles—those of teacher, expert, storyteller, or even clown.
- Groups may improve communication skills for lonely, shy, or withdrawn older people as well as those with communication disorders or memory impairment.
- Groups provide peer support and opportunities to share common experiences, and they may foster the development of warm friendships that endure long after the group has ended.
- The group may be of interest to other residents, staff, and relatives and may improve satisfaction and morale. Staff, in particular, may come to see their patients in a different light—not just as persons needing care but as persons.
- Active listening and interest in what older people have to say may improve self-esteem and help them feel like worthwhile persons whose wisdom is valued.
- Group work offers the opportunity for leaders to be creative and use many modalities, such as music, art, dance, poetry, exercise, and current events.
- Groups provide an opportunity for the leader to assess the person’s mood, cognitive abilities, and functional level on a weekly basis.


**GROUP Structure and Special Considerations**

Implementing a group intervention follows a thorough assessment of environment, needs, and the potential for various group strategies. Major decisions regarding goals will influence the strategy selected. For instance, several older people with diabetes in an acute care setting may need health care teaching regarding diabetes. The nurse sees the major goal as education and restoring order (or control) in each individual’s lifestyle. The strategy best suited for that would be motivational or educational. A group of people experiencing early-stage Alzheimer’s disease may benefit from a support group to express feelings or a group that teaches memory-enhancing strategies. Successful group work depends on organization, attention to details, agency support, assessment and consideration of the older person’s needs and status, and caring, sensitive, and skillful leadership.

Group work with older people is different from that with younger age groups; and there are some unique aspects that require special skills and training and an extraordinary commitment on the part of the leader. Although these unique aspects may not apply to all types of groups of older adults, some strategies are presented in Box 6-16.

**REMINISCING AND STORYTELLING WITH INDIVIDUALS EXPERIENCING COGNITIVE IMPAIRMENT**

Cognitive impairment does not necessarily preclude older adults from participating in reminiscence or storytelling groups. Research suggests that communication skills training that involves memory book and life review activities with those who have dementia and their families can (1) increase the quantity and quality of communication between care recipients and caregivers, (2) lower caregiver stress and burden, and (3) reduce behavioral problems (Damianakis et al., 2010). Opportunities for telling the life story, enjoying memories, and achieving ego integrity and self-actualization should not be denied to individuals on the basis of their cognitive status. Modifications must be made according to the cognitive abilities of the person, and although individual life review from a psychotherapeutic approach is not an appropriate modality, individuals with mild to moderate memory impairment can enjoy and benefit from group work focused on reminiscence and storytelling.

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When the nurse is working with a group of cognitively impaired older adults, the emphasis in reminiscence groups is on sharing memories, however they may be expressed, rather than specific recall of events. There should be no pressure to answer questions such as “Where were you born?” or “What was your first job?” Rather, discussions may center on jobs people had and places they have lived. Additional props, such as music, pictures, and familiar objects (e.g., an American flag, an old coffee grinder), can prompt many recollections and sharing.

The leader of a group with participants who have memory problems must be more active. Many resources are available to guide these groups, including books such as I Remember When (Thorsheim and Roberts, 2000), that offer numerous ways to adapt the reminiscing process for those with cognitive impairment. StoryCorps Memory Loss Initiative (www.storycorps.net/special-initiatives/mili) is an innovative program featuring the stories of people with memory loss. Other helpful resources can be found on Evolve at http://evolve.elsevier.com/Ebersole/TwdHlthAging.

The TimeSlips program (Bastings, 2003, 2006; Fritsch et al., 2009) is an evidence-based innovation, cited by the Agency for Healthcare Research and Quality (Rockville, MD; www.innovations.ahrq.gov), that uses storytelling to enhance the lives of people with cognitive impairment. Positive outcomes associated with the program include enhanced verbal skills and provider reports of positive behavioral changes, increased communication, and sociability, and less confusion. TimeSlips is a beneficial and cost-effective therapeutic intervention that can be used in many settings.

Group members, looking at a picture, are encouraged to create a story about the picture. The pictures can be fantastic and funny, such as from greeting cards, or more nostalgic, such as Norman Rockwell paintings. All contributions are encouraged and welcomed, there are no right or wrong answers, and everything that the individuals say is included in the story and written down by the scribe. Stories are read back to the participants during the session, using their names to identify their contributions. At the beginning of each session, the story from the last session is read to the participants. Care is taken to compliment each member for his or her contribution to the wonderful story. The stories that emerge are full of humor and creativity and often include discussions of memories and reminiscing.

One of the authors (T.T.) has used the storytelling modality extensively with mild to moderately impaired older people with great success as part of a research study on the effect of therapeutic activities for persons with memory loss. Qualitative responses from group participants and families indicated their enjoyment with the process. At the end of the 16-week group, the stories are bound into a book and given to the participants with a picture of the group and each member’s name listed. Many of the participants and their families have commented on the pride they feel at their “book” and have even shared them with grandchildren and great-grandchildren. In work by Bastings (2003), some of the stories were presented as a play.

**HEALTH LITERACY AND COMMUNICATION**

*Health literacy* is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (Kobylarz et al., 2010). Limited health literacy has been linked to increased health disparities, poor health outcomes, inadequate preventive care, increased use of health care services, higher risk of mortality for older adults, and several health care safety issues, including medical and medication errors. Improving health literacy for all Americans has been identified as one of the 20 necessary actions to improve health care quality on a national scale (Agency for Healthcare Research and Quality, 2011: Centers for Disease Control and Prevention [CDC], 2009.)

Health literacy is more than the ability to read and write and includes the ability to listen, follow directions, complete forms, perform basic math calculations, and interact with health professionals and health care settings. Educational level cannot be relied on as an indicator of literacy skills for medical information. Health literacy is “approximately five grade levels lower than the last school year completed” (Hayes, 2000, p. 7). Many health education materials, as well as information on the Internet, are written at reading levels above the recommended fifth-grade reading level.

Being health literate “involves a multitude of cognitive processes that are challenging for any one at any age” (Speros, 2009). Nearly nine of 10 adults do not have the level of proficiency in health literacy skills necessary to successfully navigate the health care system. Older adults are disproportionately affected by inadequate health literacy. Chronic illness and sensory impairments further contribute to challenges related to communication and understanding. Among adult age groups, those aged 65 and older have the smallest proportion of persons with proficient health literacy skills. This group also has the highest proportion of persons with health literacy defined as “below basic.” More than half of individuals over the age of 65 years are at the below-basic level (CDC, 2009; Kobylarz et al., 2010) (Figure 6–6).

Older adults are a heterogeneous group in their characteristics and literacy skills, and therefore strategies to enhance their understanding of health information need to be individualized. Individuals residing in urban areas, those with poor education or low income, and people for whom English is a second

language are more likely to perform at lower levels of literacy. Other factors influencing health literacy include the person’s basic literacy skills and situations encountered in the health care system as well as the cultural competence and communication skills of health professionals.

Improving Health Literacy for Older Adults (CDC, 2009) provides health professionals with information related to health literacy and strategies for communicating effectively. Resources for assisting health professionals in constructing low-literacy materials for use with older adults are found on Evolve at http://evolve.elsevier.com/Ebersole/TwHthAging.

**LEARNING IN LATE LIFE**

Basic intelligence remains unchanged with increasing years, and older adults should be provided with opportunities for continued learning. Adapting communication and teaching to enhance understanding requires knowledge of learning in late life and effective teaching-learning strategies with older adults. Geragogy is the application of the principles of adult learning theory to teaching interventions for older adults.

The older adult demands that teaching situations be relevant; new learning must relate to what the person already knows and should emphasize concrete and practical information. Aging may present barriers to learning, such as hearing and vision losses and cognitive impairment. Moreover, the process of aging may accentuate other challenges that had already been factors in a person’s life, such as cultural and cohort variations and education. Many older adults may have special learning needs based on educational deprivation in their early years and consequent anxiety about formalized learning.

Attention to literacy level and cultural variations is important to enhance learning and the usefulness of what is learned. Mood is extremely important in terms of what individuals (young and old) will recall. In other words, when we attempt to measure recall of events that may have occurred in a crisis situation or an anxiety state, recall will be impaired. This is significant for health care professionals who give information to older adults who are ill or upset, particularly at times of crisis such as hospital discharge. They are not likely to remember the information provided, which contributes to problematic transitions (Chapter 16). Box 6-17 presents strategies to enhance the learning of older adults.

Opportunities for older adults to learn are available in many formal and informal modes: self-teaching, college attendance, participation in seminars and conferences, public television programs, CDs, Internet courses, and countless others. In most universities, older people are taking classes of all types. Fees are usually lower for individuals older than 60 years, and elders may choose to work toward a degree or audit classes for enrichment and enjoyment. The Elderhostel program is an example of a program designed for older people that combines continued learning with travel (www.elderhostel.org).

Older adults comprise the fastest growing population using computers and the Internet. According to data from the Pew Research Center’s Internet and American Life Project, 92% of adults aged 50-64 years and 89% of those 65 years and over send and receive emails (Pew Research Center, 2010). Older adults also comprise the fastest growing group using social-networking sites such as Facebook. More than any other age group, older adults perceive the Internet as a valuable resource to help them connect to loved ones and more easily obtain information.

AARP and other organizations such as CyberSeniors provide basic computer and Internet training for older people. Although there has been little research on the use of computers among nursing home residents or among those with dementia, the technology has great potential to meet psychosocial needs for family contact, enjoyment, and stimulation (Tak et al., 2007).

**BOX 6-17 GUIDING OLDER ADULT LEARNERS**

- Make sure the client is ready to learn before trying to teach. Watch for cues that would indicate that the client is preoccupied or too anxious to comprehend the material.
- Be sensitive to cultural, language, and other differences among the older adults you serve.
- Provide adequate time for learning, and use self-pacing techniques.
- Create a shame-free environment where older adults feel free to ask questions and stay informed.
- Provide regular positive feedback.
- Avoid distractions, and present one idea at a time.
- Present pertinent, specific, practical, and individualized information. Emphasize concrete rather than abstract material.
- Use past experience; connect new learning to what has already been learned.
- Use written material to supplement verbal instruction. Use a list format, a low-literacy level, and large readable font (e.g., Arial, 14 to 16 points).
- Use high contrast on visuals and handout materials (e.g., black print on white paper).
- Consider using Braille and audiotaped information whenever necessary.
- Pay attention to reading ability; use tools other than printed material such as drawings, pictures, and discussion.
- Use bullets or lists to highlight pertinent information.
- Sit facing the client so he or she can watch your lip movements and facial expressions.
- Speak slowly.
- Keep the pitch of your voice low; older people can hear low sounds better than high-frequency sounds.
- Encourage the learner to develop various mediators or mnemonic devices (e.g., visual images, rhymes, acronyms, self-designed coding schemes).
- Use shorter, more frequent sessions with appropriate breaks; pay attention to fatigue and physical discomfort.


**PROMOTING HEALTHY AGING: IMPLICATIONS FOR GERONTOLOGICAL NURSING**

Throughout this chapter we have tried to convey the potential for honest and hopeful communication regardless of the impairment the elderly may be experiencing. Communicating with older people calls for special skills, patience, and respect. We must break through the barriers and continue to reach toward the humanity of the individual with the belief that communication...
is the most vital service we offer. This is the heart of nursing. Skilled, sensitive, and caring individual and group communication strategies with older adults are essential to meeting needs and are the basis for therapeutic nursing relationships. Just as all people have the need to communicate and have their basic needs met, they also have the right to experiences that are meaningful and fulfilling. Age, language impairment, or mental status do not change these needs.

Creation of care environments that are rich with pleasant experiences—a good cup of coffee, a meal shared with friends, a sunrise, beautiful music, learning something interesting, or sharing experiences from the life one has lived—is as important as getting enough to eat. Our nursing care with older people experiencing cognitive and communication impairments must be more than keeping their bodies alive, safe, and clean, or preventing injury. The unique contribution that nursing brings to the care of people is the intimate, personal knowing of the person behind the disease and the creation of relationships and environments of care that support, validate, and celebrate the person as someone of value and worth (Touhy, 2004). Within this framework, gerontological nurses assist in the meeting of needs at all levels.

**KEY CONCEPTS**

- Communication is a basic need regardless of age or communication or cognitive impairment.
- The sensory apparatus all lose some degree of acuity in the aging process; hearing is the most prevalent loss. The nurse needs to adapt communication to enhance sensory input and enhance communication.
- Group work can meet many needs and is satisfying and rewarding for both the older adult and the group leader.
- In a rapidly changing society, the shared life histories of elders provide a sense of continuity among the generations.
- The life history of an individual is a story to be developed and treasured. This is particularly important toward the end of life.

**CASE STUDY**

**HEARING IMPAIRMENT**

Sonya is a 66-year-old high school nurse/consultant. She retired from the Army Nurse Corps with an officer’s rank after serving 20 years, much of it in the Korean conflict with heavy exposure to shellings in the early part of her career. She became aware of hearing loss at about age 45, and by age 55 years it had become severe. While in the service she had considerable assistance from noncommissioned personnel and functioned well. When she entered civilian life, it became more difficult for her to manage but she was unwilling to admit to others her major hearing deficit. During those years she simply attempted to cover it as much as possible, and some of her coworkers thought she was rather obtuse; others suspected her deafness. When she took the position with the school district, she was involved with three high schools, numerous faculty members, and students, and interpersonal communication was a major aspect of her position. When she was evaluated at the end of the first year, it was pointed out that feedback indicated she was inattentive. She did then admit her hearing problem and was advised to get hearing aids. She said, “I’ve known several people over the years who have hearing aids, and none of them were really satisfied with them. I guess that is why I have not gotten them before now.” She complied but, after a few weeks, rarely wore them. The personnel officer of the school board, after hearing several more complaints of inappropriate communication, told her she must wear the hearing aids if she wished to continue in her position. Sonya knew that hearing aids were essential, not only for communication but also for safety—she had almost been hit by a car while walking because she simply did not hear it coming. Yet she did not want to go back to the audiology clinic, because they did not seem to know what they were doing, and each time she saw someone, the person gave her different information. She tried three different types of aids that seemed of little help. She lost confidence in her ear, rose, and throat specialist because he had been unable to help her resolve the ringing in her ears. Now her school district had contracted with a health maintenance organization, and she was not even sure which health care provider she should see.

On the basis of the case study, develop a nursing care plan using the following procedure*:

- List Sonya’s comments that provide subjective data.
- List information that provides objective data.
- From these data identify and state, using accepted format, two nursing diagnoses you determine are most significant to Sonya at this time. List two of Sonya’s strengths that you have identified from data.
- Determine and state outcome criteria for each diagnosis. These must reflect some alleviation of the problem identified in the nursing diagnosis and must be stated in concrete and measurable terms.
- Plan and state one or more interventions for each diagnosed problem. Provide specific documentation of the source used to determine the appropriate intervention. Plan at least one intervention that incorporates Sonya’s existing strengths.
- Evaluate the success of the intervention. Interventions must correlate directly with the stated outcome criteria to measure the outcome success.

*continued

CASE STUDY—CONT’D

CRITICAL THINKING QUESTIONS
1. What are some of the possible reasons Sonya suffered severe hearing loss at so young an age?
2. Discuss the stigma of hearing loss and hearing aids.
3. Obtain a “hearing aid loaner.” Instruct students to wear it for several hours and report their reactions in writing. List difficulties experienced.
4. How would you advise Sony if you were her nurse/friend?
5. Discuss the various kinds of hearing aids and how they differ.
6. Discuss reasons Sonya may have discontinued wearing her hearing aids.
7. What might you suggest that would be helpful in adapting to wearing a hearing aid?
8. What are some of the options you would discuss with Sonya?
9. Which of the various sensory/perceptual changes of aging would you find most difficult to cope with?
10. Discuss the meanings and the thoughts triggered by the student’s and elder’s viewpoints expressed at the beginning of the chapter. How do these vary from your own experience?

*Students are advised to refer to their nursing diagnosis text and identify possible or potential problems.

RESEARCH QUESTIONS
1. What are the attitudes of nursing students toward older people and those who work in the field of aging?
2. Are there particular care settings and activities in which elderspeak is more prevalent?
3. What do older people think is helpful in enhancing communication with the hearing and vision impaired?
4. What are the major concerns of nurses related to communicating with a person with aphasia and what strategies do they find helpful in enhancing communication?
5. What benefits do older people experience in sharing their life story?
6. What are effective strategies for reminiscence and storytelling for older adults with cognitive impairment?
7. What are effective evaluation measures to measure understanding of health information?

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