



CAREConnections

Information and Inspiration for Caregivers

A Publication of Boulder County Area Agency on Aging

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Dear Caregiver,

Many of us are caring for a loved one with Alzheimer’s disease or another form of dementia, and we may be finding the daily challenges of that care particularly daunting. Bob DeMarco, founder of AlzheimersReadingRoom.com, writes, “I understand why Alzheimer’s caregivers can be so thoroughly disconcerted day after day. We don’t know how long. We don’t know what is coming next. We feel like we are walking ‘up the down staircase’ every day.”

This issue is about caring for a person with dementia, and we hope it contains information that helps caregivers feel a little less disconcerted. We begin by looking at memory evaluation, which can help the person with dementia and the caregiver get a better sense of what they’re facing—and may help with treatment and planning too. And we continue with articles about the most effective ways to be with a person with dementia—from a spiritual perspective, through music, or by using the wonderfully caring approach called Validation therapy.

Take care—and happy new year!

The Editors



The Importance of Assessing Memory

by Dr. Haleh Nekooraad-Long

As we get older and listen to the news about dementia statistics, we all start to worry about our own capacity. We worry about our loved ones’ memory. At present, 5.3 million Americans suffer from dementia, and with the “silver tsunami” hitting our nation we will see these numbers increase.

Age is the number one risk for dementia. After age 65, one in nine people (11%) have Alzheimer’s disease, and this number jumps to one-third of people at age 85 and older. Some of us are in the “worried well” group. A normal aging brain has a slower processing time. It takes longer to do things or remember information, but one is still able to reach the information and perform daily living activities at baseline. Most healthy older adults experience mild decline in some areas of cognition. These changes may occur in the areas of visual and verbal memory, immediate memory, or the ability to name objects.



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If there are subtle symptoms—a change from baseline functions—with a family history of dementia with aging, then this is a good time to bring up the issue with a healthcare provider. Mild cognitive impairment may be the earliest sign of evolving Alzheimer's dementia, but it can be difficult to diagnose. There is the need to rule out any medical problems contributing to memory loss. Neuropsychiatric testing is very helpful to reach the diagnosis given the subtle changes.

Dementia is a series of symptoms, including memory loss, personality changes, difficulty making decisions, impairment in judgment, difficulty with speech, and difficulty with performing tasks, to name a few. If you start noticing any of the above changes in yourself or a loved one, it is a good idea to bring this up with your healthcare provider.

There are many different types of dementia, and a comprehensive evaluation is needed to get the right diagnosis. Alzheimer's type accounts for 50-60% of all dementias. The second type is vascular dementia which accounts for 10-15%; in 50% of cases brain autopsies of many demented patients show a combination of both types. Lewy Body dementia, frontotemporal dementia, Parkinson's disease with dementia, chronic alcohol use, brain tumors, and Progressive Supranuclear Palsy are the other top causes of dementia.

Reasons for delayed diagnosis are many, but the main issue can be denial at many levels: denial by the person suffering from the symptoms which can sometimes be secondary to poor insight from the illness, or denial by family or the healthcare providers because it's a difficult subject to discuss and there is a fear of future decline and planning. The onset and course of dementia can be insidious and gradual, so it can be missed by blaming normal aging. Other medical problems such as depression can be considered the source and at times are misdiagnosed as pseudodementia.

In order to get a good evaluation, talk to your family about the concerns, write them down, and have a copy of the medical history that includes information on past surgeries, current medications, allergies, family history, any head injuries, and any chemical/toxin exposures, along with any current labs or brain scan results. Make an appointment for a comprehensive physical and neurological exam, labs, and a baseline brain scan to rule out any medical issues. Labs should include vitamin B12, folic acid, vitamin D, blood count, basic metabolic blood work, and thyroid function. A simple Brain CT scan without contrast is sufficient unless the

physician believes an MRI would be more beneficial. A brain scan usually does not need to be repeated after the initial baseline unless there is an acute change from a fall or a possible stroke.

If the person with memory loss is resistant to talk to their physician, plan to attend the appointment with them. If they refuse for you to attend the visit, leave a message or send a note regarding your concerns to the physician prior to the appointment.

If the diagnosis is still not clear after a complete exam, neuropsychiatric testing can be helpful. If there are questions regarding competency, neuropsychiatric testing can be beneficial to determine the extent of the illness. This test can also be helpful in determining the person's ability to drive. Neuropsychiatric testing is done by a neuropsychologist and can take anywhere from two to five hours. Medicare covers the cost if the provider accepts Medicare. Driving evaluations can be done by certain occupational therapists to fully evaluate the person who refuses to stop driving. Medicare does not cover the cost for driving evaluations.

Sometimes there is noticeable change in someone before they notice any changes, or they are trying to cover their symptoms in fear of diagnosis or of future decline and upcoming restrictions. They can be reluctant to get a diagnosis or even bring it to anyone's attention. As humans we often wait until a disaster to act. The sooner you know the reason for the change in function, the better you will be able to make a treatment plan, healthcare decisions, future living situation arrangements, and legal and financial decisions.

Sometimes the evaluation needs to be done for safety reasons; this can be a difficult conversation to have with the affected person or their spouse. If the person has poor insight and poor judgment while continuing to live on their own, paying their own bills, managing their own medications,

cooking, and driving and getting lost, then the affected person can put themselves or others in danger. Recurrent visits to the ER can be simply from not being able to follow instructions at home. Continuing to cook could cause death by catching themselves or the house on fire. Continued driving is a self-explanatory danger; we are allowing someone to be behind a 3000-pound weapon. And there have been numerous counts of elder fraud where people are taken advantage of because of an inability to understand their finances. At times a referral to Adult Protective Services is needed if safety is a concern and no one else is available or willing to look into the person's best interest.

I believe it's always better to know and be able to plan as much as we can for the future. The person and family can come up with the appropriate legal paperwork such as wills, medical and durable powers of attorney, and living wills. With the help of your physician you can have a diagnosis, prognosis, treatment plan, and safety planning.

Dr. Haleh Nekoora-Long is a Board-certified Geriatric Psychiatrist and the Medical Director of AltaVita Memory Care Centre, an assisted living community for the memory impaired. She primarily deals with aging adults and their issues regarding dementia, depression, and bipolar disorder, as well as with multiple medications and the possible interactions between medications.

**“Caregiving often calls us to lean into
love we didn’t know possible.”**

— Tia Walker, *The Inspired Caregiver*



Dementia in the Light of Spirit

by Claudia Helade, Ph.D.

Dementia refers to nervous system disorders of varying etiologies and severities causing changes in brain function. Symptoms may include abnormal forgetfulness, cognitive impairment in thinking and judgment, and increasing inability to perform daily activities including self-care. Currently, 50% to 60% of all dementias are diagnosed as Alzheimer's disease, and the rest result from other causes. Nearly all dementias are incremental in their unfolding and present varying degrees of challenges for those diagnosed as well as those who care for them. Understandably, dementia is often feared and misunderstood whether it occurs to us or to someone we know or love. When we approach this new territory with only aversion or fear we lose opportunities to open to another way of perceiving essential personhood independent of rational capacity. Is it possible to meet *inside* dementia?

A person's essence remains alive inside the cognitive decline of dementia, and it is this core that we are attentive to as we address the needs of those with dementia whom we accompany. What does it mean to be "human?" What are the larger implications of touching the soul of another? Can anyone *really* know the inner experience of another with dementia? Does core essence survive the declining rational self? What kind of communication is possible between someone with dementia and another who wishes to touch their reality? These questions invite an exploration of spiritual capacities and consciousness within dementia and how we might deepen opportunities for an expanded perspective and experience of dementia for all involved.

Aside from the physical and emotional care of loved ones with dementia, as the questions above illustrate, the essence of the person with dementia needs recognition and value in order

to maximize the quality of life for the diagnosed and their caregivers. This care partnership is based on the "personhood" of each participant in the journey. Personhood is defined as "a standing or status that is bestowed on one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust." (*Dementia Reconsidered: The Person Comes First*, by T. Kitwood, Open University Press, 1997) Personhood is not limited to specific memories, the personality, or the unique history of any individual, aspects of self that are often eclipsed by dementia. Holistic care for those with dementia, by definition and necessity, includes addressing the person's spiritual core. Spirituality refers to what gives meaning and purpose to life and includes dignity, joy, satisfaction, generativity, wonder, love, and a sense of what may be beyond the self. Spirituality makes room for the mystery of life.

It is this spiritual personhood remaining at the center of an individual with dementia which offers valuable lessons in living for all of us. Slowing down, being and living in the present moment, simplicity, and finding joy outside our cultural expectations of self-sufficiency, productivity, and independence are precious life lessons, no matter one's internal or external realities. When we enter that territory with another, essence (our authentic self) is available for contact. When essence meets essence, we experience wonder and joy. One of the greatest gifts we can offer each other is our mindful presence—undistracted, non-judging, and committed to what wants to be revealed if we surrender to the moment. Offering an inner stillness and openness to a person with dementia allows the humanity of both individuals to meet and open to the greater reality beyond the personal. In this *reality* we are all equal, connected, interactive, unique, and valued for our essence. It is here that we are truly seen and received, and it is the requisite ground for healing and transformation.



The spiritual work of old age is not derailed by dementia—it just takes place out of sight and behind the veil of cognitive decline. Who we *really* are is not our body, not our mind. With maturity and age our inner life reveals itself and demands priority. Those with dementia have been invited by the soul to strip away what is no longer important and focus on the simplicity of the *now*—a core directive of all major spiritual teachings. The *content* of what has import to an individual is not essential but the inner focus is. All needs are spiritual, as well as the caring for them. As the saying goes, we are not physical beings having spiritual experiences; we are spiritual beings having physical experiences. Our identities are not finite and solid but rather a flowing continuum which includes and is being informed by all our experience, including dementia. “People with dementia are... primary selves. They are no longer like us, busy and full of purpose, bent on becoming something. Instead they are prisoners of pure being. In this realm there is only now, this instant.” (“A Taste of Ice Cream is All You Know,” by M. Ignatieff, in *The Observer*, July 4, 1992)

Person-centered care invites a perspective which understands that we as caregivers are responding to the essence of a person, not a problem to be managed or fixed. Setting aside preconceptions, labels, and fears, we respond rather than react, and we find a reservoir of stillness and sweetness in these connections, sometimes revealed in a flash amidst the confusion and disorder of dementia. Such care asks us to risk the intimacy which mindful presence requires, allowing the dignity of each partner in the equation to shine and inform each other and the larger human experience; a place where there is no giver or receiver, simply souls joined in acknowledgment of their mutuality and interdependence. In this place, let us celebrate each other.

Crisis

*The circle closes,
and in the Center, masked in grace,
giver and receiver
become one. One.*

*And in this sacred, timeless Center,
all that is known
and all that hopes to be known
become love. Love.*

Claudia Helade, Ph.D., is a psychotherapist, caregiver, and director of Into the Center, providing psychological services for individuals, couples, caregivers. She is a member of the Care Connections Editorial Advisory Committee.

Making the Most of Memories through Music

by Mary Kathleen Rose



When I was a teenager, I remember visiting a nursing home in my small town in Wyoming in the late 1960s. A group of us went there to visit the residents. At one point I sat down at a piano in the sitting room and began to play. I didn't have much of a repertoire, but I do remember playing “Lara's Theme” from the movie *Dr. Zhivago*. Everyone in the room clapped and asked me to play it again, which I did. I did my best to remember a couple of other songs to play before I had to leave.

On my way out the door, a nurse came up to me. She pointed out a frail, little, elderly woman who was sitting near the piano. She told me that “Betty” had come out of her room down the hall when I started to play the piano. She thanked me, saying that the woman never talked to anyone or came out of her room voluntarily. But the music had motivated her to walk down the hall on her own for the first time in many weeks.



Years later, I still remember the seed that was planted for me then. In my work as a massage therapist, I have spent many hours working with clients in senior communities, assisted living homes, and hospices. While my work has primarily been in the offering of nurturing touch, I have also sometimes shared music with my clients—singing to them, or singing with them.

In recent years I've been studying with Gregg Hansen, a musician who has a keen sense of the importance of music as a vehicle for healing and enhancing the quality of life for people in senior communities. In one memory care center he offers a musical program in which the residents play percussion instruments—drums and shakers—as he leads them in singing the familiar songs of their youth. Though they all suffer from dementia, they do remember songs they knew in their past. Gregg says, “Everyone can participate, no matter their physical or mental limitations.” Singing these songs evokes the feelings of happiness and joy associated with the music. That happiness is experienced in the present.

Gregg tells the story of one woman with Alzheimer's, who remembered all the lyrics of the songs as they were singing. Afterwards, he acknowledged her for that, saying to her, “I'm so impressed. You know all the words to all the songs.” She replied, “I do?”

Losing memory is certainly a fearful phenomenon, yet music can be a key that connects the individual to meaningful life experiences—a bridge from the past to the present. Gregg has a specific structure he uses, leading songs in a particular sequence of rhythms and tempos. He has consistent cues, using repetition of the chorus, for example, to end a song. He says, “I have no explanation. I just know it works.” Familiarity with the songs and the structure fosters feelings of safety, inclusiveness, and comfort.

“Music has the ability to stimulate more parts of the brain than any other stimulus,” says neurologist Oliver Sacks, M.D., who speaks in the documentary movie *Alive Inside*. The film, written and directed by Michael Rossato-Bennett, is a testament to the power of music in the lives of people suffering from dementia. It demonstrates the ability of music to combat memory loss and restore a deep sense of self to those suffering from it.

Dr. Sacks says, “The past which is not recoverable in any other way is embedded, as if in amber, in the music, and people can regain a sense of identity, at least for a while. The parts of the brain that respond to music are very close to the parts of the brain concerned with memory, and emotion, and mood. Familiar songs will bring back memories that have been lost, or at least the feeling of it for a while.”

Whether the music is live or recorded, it can provide a way to reach people who are otherwise seemingly unreachable. Laurie Rugenstein, a music therapist with years of experience working with hospice patients, says that she will try to find music from a patient's youth and play it live for them or find recordings of it. It can stimulate pleasant memories and conversations about past events.

Whether you are a professional or family caregiver for someone with memory loss, don't hesitate to experiment with music. You just might be pleasantly surprised to find that music provides a rewarding way to connect with those in your care.

*Mary Kathleen Rose is a licensed massage therapist and author of the textbook *Comfort Touch: Massage for the Elderly and the Ill* (LWW 2009) and DVD of the same title (www.comforttouch.com). She is also a musician. For information about her music visit www.wildrosevine.com.*



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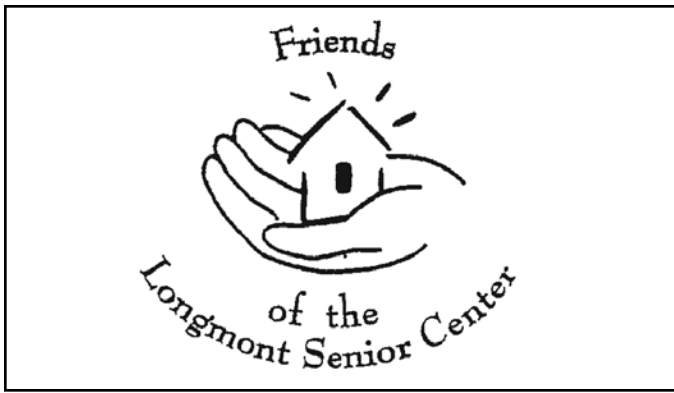
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Sharing the Diagnosis

by Jessica O'Leary

You have met with your loved one's physician and now have confirmation that what your loved one has been experiencing is dementia, and what is causing it is not reversible. Now you ask, do you tell your loved one or keep the news to yourself?

Whether to tell or not is a question that can't be answered with a simple yes or no; many factors need to be considered. A more important question to ask is what are the advantages and disadvantages of telling your loved one the truth? When thinking about this question, consider that your loved one may have known for some time that there is something wrong, long before you recognized it. He or she has done a magnificent job of shielding you and others. Agonizing about whether or not to tell your loved one may be a waste of energy. In some cases individuals are relieved that there is a medical reason for why they feel the way they do and that they are not in fact "crazy." The diagnosis is validating for some, and it is not uncommon to hear, "So that's why I feel like I am losing my mind."

Another consideration is awareness of what stage of the disease your loved one is in. Early stages of the disease permit an opportunity to engage in conversations on planning for future matters such as financial, legal, advance directives, care options, end of life, and so on. Your loved one can be an intricate part of these conversations while they can still express what they would and would not want. Inclusion of your loved one in these conversations alleviates a great deal of pressure later when the time comes for these plans to be carried out. It is much easier to carry out someone else's wishes, compared to guessing what they would have wanted, in an emotionally charged time. During early stages of the disease, the person's participation in a support group for individuals

diagnosed with dementia also can be helpful.

An individual in the middle or later stages of Alzheimer's disease may no longer be able to have a meaningful conversation. Deciding whether or not to disclose the diagnosis to them may depend on their level of understanding. Despite their competency being questioned regarding aspects of decision making, even individuals in advanced stages of dementia can participate in some conversations and decisions, and that should be honored for as long as possible.

The decision to discuss a formal diagnosis of dementia with your loved one is one that must be made on an individual basis. It should be made based on love and on what is best for the person—and in consideration of what they can tolerate. Regardless of the decision, honor the person with dementia and love them for who they are, who they were, and who they will become.

Jessica O'Leary, M.A., C.V.W., is a Gerontologist, Assisted Living Director at Hover Community, Certified Validation Worker, and volunteer instructor of the "Become a Savvy Caregiver" course at the Longmont Senior Center, as well as a speaker on other topics related to aging.



**“You gain strength, courage,
and confidence by every experience
in which you really stop
to look fear in the face.
You must do the things
which you think you cannot do.”**

— Eleanor Roosevelt



COMMUNITY RESOURCES

This column provides information about coming events and classes, services, and other resources that may be of interest to family caregivers in Boulder County. Please remember that it is each person's right and responsibility to research a service provider or resource before taking action. See "Information and Assistance in Boulder County" on the back page for ways to learn more about these and other resources.

The Alzheimer's Association Colorado Chapter offers **Caregiving Tips: Successful Communication**, about skills for interacting with persons with dementia, and observing and responding to challenging behaviors, on Tuesday, January 6, 9 – 11 a.m., at Care Link Day Program, 3434 47th Street, Suite 100, in Boulder; **The Basics: Memory Loss, Dementia, and Alzheimer's**, about detection, possible causes and risk factors, stages of Alzheimer's disease, and treatment, on Friday, January 30, 9 – 11 a.m., at Care Link; **Know the 10 Signs: Early Detection Matters**, about the importance of early detection of Alzheimer's disease for treatment and care planning, on Wednesday, February 11, 1 – 3 p.m., at Longmont Senior Center, 910 Longs Peak Avenue, in Longmont; **Living with Alzheimer's: For Middle Stage Caregivers – Part 1**, about transitioning from being a care partner to a hands-on caregiver and providing safe, effective, and comfortable care, on Tuesday, February 17, 5 – 8 p.m., at Care Link; **Living with Alzheimer's: For Middle Stage Caregivers – Part 2**, on Tuesday, February 24, 5 – 8 p.m., at Care Link; and **Know the 10 Signs: Early Detection Matters (in Spanish)**, on Tuesday, February 24, 12:30 – 2:30 p.m., at Longmont Senior Center. Register at www.alz.org/co (Classes and Workshops, Calendar) or call 1-800-272-3900 (24-hour Alzheimer's Association Helpline).

Medicare Counselors with Boulder County Area Agency on Aging hold **Medicare Basics Classes** for anyone wanting to learn more about enrollment, benefits, costs, and choices under Medicare, on Thursdays, January 8 or February 5, 2 – 4 p.m., at East Boulder Senior Center, 5660 Sioux Drive (call 303-441-1546 to register); on Tuesdays, January 20 or February 17, 10 a.m. – noon, at Longmont Senior Center, 910 Longs Peak Avenue (call 303-651-8411 to register); and on Friday, February 20, 1:30 – 3:30 p.m., at Lafayette GO Services, 103 S. Iowa (call 303-665-9052 to register). There is no charge, but donations are appreciated.

Lafayette GO Services (formerly Lafayette Senior Services) will have a **health fair booth with resources for caregivers** at the Lafayette Oatmeal Festival Health Fair, on Saturday, January 10, at Bob L. Burger Recreation Center, 111 W. Baseline Road, in Lafayette. Contact Lorna Beard, at 303-661-1499, for more information.

Age Well offers **Advance Directives Workshops**, about considering and clarifying one's wishes for medical treatment in the event of incapacitation, with Program Coordinator Peggy Arnold, M.A., on Thursdays, January 8 or February 12, 9:30 – 11 a.m., at Longmont Senior Center, 910 Longs Peak Avenue, in Longmont (\$5 for Longmont residents, \$6 for non-residents). Register at 303-651-8411.

A new **Dementia Caregiver Support Group**, sponsored by the Alzheimer's Association Colorado Chapter, will be held on the second Tuesday of each month (beginning January 13), 11 a.m. – 12:30 p.m., at East Boulder Senior Center, 5660 Sioux Drive, in Boulder. For more

information, call the Alzheimer's Association Helpline at 1-800-272-3900 or email colorado.supportgroups@alz.org.

To help family caregivers take needed breaks, the **Respite Assistance Program**, of Boulder County Area Agency on Aging, offers up to \$500 per calendar year in reimbursement for the costs of respite care (substitute eldercare) provided by a friend, relative, home health care agency, adult day program, or long-term care facility. To apply, contact your local Resource Specialist (see back page for phone numbers).

You Can Become a Savvy Caregiver, a course for family caregivers of persons with dementia, will be held Wednesdays, March 25 – April 29, 6 – 8 p.m., at Longmont Senior Center, 910 Longs Peak Avenue. This training program provides caregivers with a better understanding of dementia, increases their caregiving skills and knowledge, and helps them learn how to manage and care for themselves day to day. It is taught by Jessica O'Leary, M.A., C.V.W., a Gerontologist and specialist in dementia. Attendance at all classes is required; class size is limited. A donation of \$15 to cover material costs is requested. To register, call 303-651-8411.

For a list of all **Caregiver Support Groups** that meet in Boulder County, email InfoCaregiver@bouldercounty.org or call 303-678-6116.

To share information about a resource for family caregivers, email InfoCaregiver@bouldercounty.org or call 303-678-6116. The deadline for the March/April 2015 issue is January 22.



Understanding Validation Therapy

by Megan Carnarius

I was a newly licensed nurse in 1984, and in my very first job at a nursing home there were many elders with memory loss issues. I was expected to orient my “patients,” as we called them. If a 90-year-old was looking for his mother, there was no discussion. I was supposed to say, “My name is Megan. Your mother is dead. Now let’s go to lunch.” I felt this was the wrong thing to do! My nursing school was behind the times, and what they taught during our single day on dementia was outdated. So when I worked with elders, often diagnosed with senility (also an outdated diagnosis), I chose instead to listen, to see what I could respond to without upsetting them, and to provide something from reality if it was helpful. Mostly I just tried to flow along with them as best as I could. Years later, I am grateful that my instincts were correct.

Consider the history. Alzheimer’s was discovered in 1906, but it wasn’t until the 1970s that the Mayo Clinic began making Alzheimer’s diagnoses. This was partially due to advancements in non-invasive scanning methods which assisted with the diagnosis. There still wasn’t much experience in or understanding of how to care for someone with this disease. In 1980, the Alzheimer’s Association was founded by a family caregiver. In 1981, the first book specially addressing care, *The 36 Hour Day*, was published. Because of the growing body of research, there was increasing understanding about the brain and what was being damaged or lost in the process of Alzheimer’s disease.

Between 1963 and 1980, Naomi Feil researched and developed her approach called Validation or Validation Therapy. Her first book came out in 1981. Naomi was brought up in a nursing home in Ohio, where her father was an administrator and her mother the head of social



services. She became a social worker and in her work felt an inherent sense of empathy for elders with dementia. During her education to become a social worker she had studied the work of Abram Maslow, who, from 1943 to 1954, had developed concepts of a Hierarchy of Needs and the Stages of Development. Naomi was influenced by his work and brought the concepts of unfinished needs related to the stages of development to the process of dementia. She had already experienced many elders with dementia in the absence of any proper diagnosis. She had noted a kind of frailty in elders that she identified as “old-old,” who could not make adjustments to change and were often misunderstood by those caring for them.

We know today that individuals with Alzheimer’s can have up to twenty years of changes to their brain prior to the manifestation of outward symptoms. We can’t prevent decline with certain approaches or types of stimuli. But we definitely know we can enhance someone’s quality of life no matter what the stage with Validation therapy approaches and the loving, mindful attention it fosters. I have found this aspect of Naomi’s work to be very clearly facilitating and of great importance to the elders in our care.

We still tend to use orienting information in the early stages of dementia when elders are looking for information and answers. Elders with short-term memory loss are struggling to know what we just did, what we are doing, and what we will be doing. There are lots of questions and repetition. We have to work on our assumptions that they will hold on to the information we give. The elder is fully present and participating in the moment, but the part of their brain that takes the moment and transforms it into long-term memory does not work anymore. It has disappeared. We must remove such questions as “Don’t you remember ...?” from our

language with patients. We change it to “I remember ...,” describing something again with no expectation that it will be remembered.

Our main task in communicating with people with this disease is to avoid causing embarrassment while helping them use their remaining strengths, and helping them feel loved and heard, accepted and safe. If we focus on responding without irritation, and in providing information in loving and kind ways, we are practicing for when words may not be so clear. When that time comes, our listening skills will be honed to respond emotionally instead of rationally.

As a person moves into the middle stages of dementia, they have a tendency to be more emotional and express their emotions more freely. Naomi calls this “incontinence of feelings.” The person loses their filters and some social skills and can “blast” those around them. They may feel paranoid because of the loss of short-term memory. They are also going farther back in time: their short-term memory loss is becoming longer-term loss due to changes in their brain. So, what was lost, “What did I eat this morning?,” shifts to “What did I do last week?” Or “Last year, I did ...” becomes “What did I do the last decade (or three decades)?” When this happens, Naomi speaks of the elder’s mind’s eye projecting long-held memories onto the current situation and the elder trying to make sense of it. It is what they have available to them. They genuinely do not remember things like their parents’ funeral, retiring from work, or selling the large house. Naomi emphasizes listening to how elders describe things. Working to match how they speak about things helps them feel you understand them, which reduces some of their stress.

Another technique is called mirroring. This can be helpful when someone has moved into the late stage of Alzheimer’s and may be nonver-

bal or is doing repetitive motions. By observing what they are doing, physically doing the same thing yourself, and working toward what you are trying to introduce in a slow, gentle way, mirroring can build a bridge of connection between you.

Please view the YouTube short video titled “Gladys Wilson and Naomi Feil” to watch Naomi in action with an elderly woman with Alzheimer’s. The updated version of her book is titled *Validation Breakthrough: Simple Techniques for Communicating with People with Alzheimer’s Type Dementia*. There also is a course sponsored by The Validation Training Institute (<https://vfvalidation.org>) if you are interested in becoming certified in validation therapy. Naomi’s work is an enormous contribution to elders with dementia. Caregivers trained in her approach bring a sensitive, nonjudgmental, empathetic, and supportive experience to many of the five million people currently diagnosed with dementia. Validation is a vital tool in our work.

Megan Carnarius is Executive Director of Balfour Cherrywood Village. She is a nurse, licensed nursing home administrator, and sought after speaker on the topic of Alzheimer’s care.

**“Sometimes our work as caregiver
is not for the faint of heart.
But, you will never know
what you are made of
until you step into the fire.
Step bravely.”**

— Deborah A. Beasley

MEMORY EVALUATION OPTIONS

The following can assess the presence and nature of cognitive impairment. There may be others that provide this service.

Center for Neurorehabilitation Services

Ft. Collins

970-493-6667

www.brainrecov.com

Colorado Mood and Memory Clinic

(Dr. Haleh Nekooraad-Long)

Longmont

303-682-9197

www.coloradomoodandmemoryclinic.com

Longmont Clinic: Memory Clinic

Longmont

720-494-3126

www.longmontclinic.com

Memory Evaluation Clinic of Boulder

Community Health Outpatient

Rehabilitation Services

Boulder

303-726-6960

www.bch.org/

Michelle C. Winston, Psy.D.

Niwot

303-444-1655

mcwinston.psyd@comcast.net

National Jewish Health

Neuropsychological Evaluation

Denver

303-398-1139

<http://www.nationaljewish.org/programs/directory/neuropsychology/clinical-service/>

CARE Connections
Boulder County Area Agency on Aging
P. O. Box 471
Boulder, CO 80306



INFORMATION AND ASSISTANCE IN BOULDER COUNTY

Within Boulder County, there are several ways to access information and assistance about resources and services for older adults and their family caregivers:

- Check out **Network of Care for Seniors and People with Disabilities**, a comprehensive online service directory, at www.BoulderCountyHelp.org
- Call the **ADRC Help Line**, at 303-441-1617, and Boulder County Area Agency on Aging staff will respond to your message.
- Call the **resource specialist** in your community (numbers below). Services vary by community but include identifying needs, exploring options, finding solutions, and providing in-depth assistance.

Allenspark area	303-747-2592
City of Boulder	303-441-4388 (bilingüe: 303-441-3918)
City of Lafayette	303-665-9052, ext. 3
City of Longmont	303-651-8716 (bilingüe)
City of Louisville	303-335-4919
Erie	303-926-2795
Lyons area	303-823-9016
Nederland area	303-258-3068
Niwot area	303-652-3850
Superior	303-441-1617

