

RECREATIONAL ACTIVITY FOR THE DEMENTIA PATIENT

The recreational therapist should consider three types of disability in the Alzheimer patient: (1) Physical, (2) Cognitive, and (3) Psychiatric. The therapist's management strategy includes sufficient flexibility to allow for variation of function for each dementia patient.

Dementia is the progressive loss of multiple intellectual functions as a result of neuronal death. Most dementias are dynamic illnesses that vary on a day-to-day and sometimes hour-to-hour basis. Most dementia will progress over time. This requires a highly flexible approach by the recreational therapist for the Alzheimer patient. Some Alzheimer patients develop worsening of cognitive or psychiatric symptoms in the afternoon (i.e., sundowning) and many patients can have temporary worsening of confusion as a result of medications or medical illness (i.e., delirium). Patient cooperation may also fluctuate based on environmental chaos. The recreational staff must consider all these factors when adjusting the programming for the patient. Each patient should have a second and third plan of activity for each time of the day.

Most elderly patients have some type of physical disability that limits their participation in recreational activities. Arthritis, neurological disease and neuromuscular disability can limit patient's mobility and manual dexterity.

Visual and auditory impairment are common in elderly dementia patients, especially those residing in long-term care facilities. Activities based on auditory perception (e.g., music) or visual ability (e.g., picture sharing, old time movies) can be frustrating to patients with uncorrected auditory or visual impairments. Most elderly patients will deny visual and hearing impairment. Recreational staff should be aware of each type of disability for every patient. Patients should use glasses and hearing aids during recreational activities. If needed, facilities should have them made for the patient.

Cognitive disabilities are common to all types of dementia. The four A's of Alzheimer's disease include: (1) Amnesia, (2) Aphasia, (3) Apraxia, and (4) Agnosia. The recreational therapist should be aware of each cognitive deficit in patients to avoid involving patients in activities for which they lack the cognitive abilities.

AMNESIA

Amnesia is the loss of memory. Recent memory is lost first with dementia and remote memory remains intact until mid-way through the disease. Recent memory includes facts or events that occur within the last several hours and remote memory refers to

events that occur months or years ago. Recreational therapists should avoid tasks that include extensive use of recent memory. The therapists should frequently remind the Alzheimer patient of the therapist's name and the purpose of the activity. Patients will not remember instructions on the performance of tasks, purpose of a group, etc. Older memory is more accessible to Alzheimer patients and can be used for reminiscing groups, discussion about old time pictures, etc.

APHASIA

Aphasia is the inability to understand spoken or written words or the inability to communicate. Most aphasic patients develop communication deficits during the middle stages of the illness. Receptive Aphasia (i.e., the inability to understand spoken word) limits the patient ability to understand instructions and their enjoyment of activity that are heavily dependent upon verbal communication. A patient with severe receptive aphasia may be bored and frustrated with a reminiscent group. Alzheimer patients frequently have difficulty finding the correct words and may be limited in their participation with activities that requires speaking. Alzheimer patients are aware of their deficits and attempt to hide their limitations through withdrawal or non-participation. These patients should have alternative activities programmed or should be allowed to remain passive during specific activities. Language is generally a left brain (hemispheric) function and music is a right brain (hemispheric) function. Some patients may be unable to speak but can sing and curse. Severely aphasic patients may still appreciate music, especially from their time period. Spiritual music that provokes emotions (e.g., religious music, some folk tunes) may help soothe and calm patients.

APRAXIA

Apraxia is the inability to do pre-programmed motor tasks and apraxia will limit patient's ability to participate in specific types of recreational activities. Dementia patients began to lose ability to perform complicated motor tasks early in the disease. The disabilities vary from individual to individual. Some patients cannot dress but still play a musical instrument. Other patients cannot feed themselves but can still shave. Recreational therapists must be aware that motor skills are impaired although motor strength remains unchanged. Patients frequently lose fine motor skills and visual spatial ability limiting their capacity for fine motor tasks. Early dementia patients usually retain good skills; however, middle stage patients have multiple deficits and late stage patients frequently lack basic motor skills (e.g., talking, walking, and self-feeding). Crafts, arts and other manual activities that require visual-spatial coordination may be difficult for dementia patients. The recreational therapist must adjust the physical activities to the patient's cognitive abilities.

AGNOSIA

Agnosia is the inability to recognize pre-programmed sensory inputs. Patients may forget faces, the appearance of specific objects (visual agnosia) or the "feel" of specific

objects as seen in tactile agnosia. Patients may have difficulty recognizing appearances of people or objects while they retain an abundance of information about the person or objects. Patients may be unable to touch objects and recognize from the "feel." Sensory stimulation tasks (e.g., feeling objects in a bag) may present a challenge to some dementia patients while others may retain the ability. Patients also forget specific smells and scents. Patients may not recognize specific objects as sharp or dangerous; although, they can tell you that scissors can cut.

Dementia patients have high rates of psychiatric symptoms. Hallucinations, delusions and depression are frequently found in dementia patients and complicate programming for recreational activities. About 25% of dementia patients have auditory or visual hallucination -- usually in the middle stages of the disease. These symptoms can be distracting or frightening to the confused elderly patients. Antipsychotic medication can lessen the intensity of distress associated with these symptoms. Psychotic patients are convinced that the voice or visual image is real and arguing does not help. Patients may seem distracted, distressed or attempt to flee. Staff should redirect, distract and reassure patients who are distressed by hallucinations. Delusions (i.e., false beliefs with no basis in fact) occur in over one-third of dementia patients. Delusions usually focus on family caregivers, staff or other known individuals. Delusions can be intricate and quite believable. Do not confront or dispute patients with delusions because the patients are convinced of their beliefs. Distraction and reassurance are most effective with delusional patients. Do not agree with the delusional idea; however, avoid openly disputing the belief. Antipsychotic medication will usually lessen the intensity of these abnormal thoughts. Depression is common in dementia (30%) and is improved with antidepressant medication. Demented patients have little capacity to benefit from insight or confine efforts to reassuring patients, programming achievable tasks and distracting patients from depressive pre-occupations.

The dementia patients present a genuine challenge to recreational therapists. Most annoying behaviors (e.g., repetitive questions, wandering, rummaging) are not improved with antipsychotic medications. These bored, confused, disoriented, fearful individuals need many hours of structured reassuring activities that maintain existing cognitive functions. Recreational therapists must work around cognitive deficits and the psychiatric symptoms that terrify or distract dementia patients. Recreational therapists must be flexible in daily planning because patients fluctuate on a day-by-day and hour-to-hour basis. Nursing assistants and other staff should propagate recreational activity as the structured time is complete. A skillful recreational program for dementia patients provide great assistance in allowing patients to live with some dignity and respect while limiting the need for psychotropic medications and restraints.