37 Communication with Elderly Patients

Inga Meyer-Kühling, Britta Wendelstein

> We tend to overprotect people in old age in particular, to regulate them and thus to take away their freedom. And in doing so, we are guided by the - often implicit - equation of physical ageing processes with mental and spiritual ageing processes [...].
>
> cited from Kruse 2017: 418

Abstract: With increasing age communication can be changed by health impairments (e.g. impaired hearing). In addition, cognitive impairments - such as those that occur with dementia, which is clearly age-related - can have a strong impact on communication. Therefore, adapted conversational behavior is often necessary when communicating with elderly patients. However, over-adaptation of the conversational style can also have negative effects. This chapter therefore presents formal aspects as well as aspects of a relationship dimension in communication with elderly patients and patients with dementia-related diseases. Furthermore, it provides recommendations for communication based on a self-reflective conversational style.

37.1 Introduction: Communication in old age

Communication with elderly patients, in particular patients who are suffering from dementia, is characterized by stereotypical perceptions. These relate to a conversation partner who is limited and incompetent.
Age-associated changes of perception (e.g. of vision and hearing) can influence ways of communication. Furthermore, cognitive deficits as in dementia, are eventually able to limit communicative competence. Additionally, comorbid symptoms such as apathy or depression are supposed to limit ways of conversation.
For all kinds of patient-physician situations it is inevitable to secure understanding - in particular regarding medical information or therapies with obligation to give consent. For better understanding it might be necessary to adapt own ways of communication.

In consequence, a patronizing way of communication is used, if an excessive adaption is utilized with the assumption of a limited conversation partner. This results in negative influence of patient-physician communication, moreover of a trusting relationship and the relationship influences compliance, satisfaction and health status of the patient (Adelman 1991).

This chapter enlightens the relevance of reflection regarding one's own ways of communication. On the one hand, formal aspects of age-associated changes of communication as well as phenomena of language reduction (such as in Alzheimer's disease) are discussed. On the other hand, it will be illustrated that relationship dimensions play an important role in patient-physician communication, which should not be underestimated. Consequences of an excessive adaption of communication are illustrated in a model. In conclusion, recommendations for communication are given, which help to balance supportive adaption and counterproductive overadaption.

37.2 Age-associated conditions of communication

Age-associated physiological changes are caused mainly by formal difficulties of communication with elderly patients. They relate to the sensory system, cognitive impairments, and the symptoms of age-associated diseases such as strokes or Parkinson's disease (e.g. Cummings 2020).

Dementia of the Alzheimer's type (AD) is a disease in which symptoms have a particular impact on communication with elderly patients.

In addition to these age-associated physiological changes that can influence verbal communication, communication also takes place on a relationship level. Speakers are often strongly influenced by preconceptions about the person they are talking to. Therefore, a distinction must be made between formal communication problems on the one hand and communication difficulties at the relationship level on the other, which are described in the following sections.

37.2.1 Formal aspects

In this chapter communication in old age will mainly be considered from a formal perspective. Physiological changes of ageing in the patient's communicative abilities will be described. The question of the extent to which sensory and cognitive deficits occurring in old age affect the elderly persons' speech comprehension and production abilities – in short, their ability to understand and be understood – will be examined. Subsequently, the cognitive changes in the course of mild cognitive impairment (MCI) and AD are shown and speech degradation phenomena occurring in the context of AD are described.

Sensory und cognitive changes in old age

Various sensory and cognitive changes as part of the natural ageing process pose challenges for communication with elderly patients.

On a sensory level, for example, communication difficulties due to hearing impairments offer major difficulties in communication with elderly people. Even without hearing loss, elderly persons have more difficulties in distinction from speech and background noises (Rajan, Cainer 2008). In addition, a decrease in the ability to concentrate, faster fatigue and a reduced ability to adapt to the other person's pace of speech can be described as hurdles in conversation. These factors influence the patient's cognitive and physiological endurance (Knäuper et al. 2002) and can therefore impair their attention and make it more difficult to comprehend complex medical conversation content.

Difficulties in speech production, word-finding, and naming difficulties, as well as speech comprehension can also have a negative impact

on the flow of communication and social interaction in general (Thornton, Light 2011). As a result, the elderly patient may only be able to describe their physical complaints in a superficial and concise manner when talking to the physician.

Another age-related physiological change affects the capacity of the working memory. This manifests itself in reduced processing and storage of new information (Knäuper et al. 2002). A possible consequence may be that the patient has difficulties in remembering the physician's questions (which are building on one another) and is therefore unable to answer them adequately.

The feeling of not being able to understand the person you are talking to and not being able to articulate your own concerns can affect the elderly person's motivation and therefore have a significant impact on the further course of the conversation. Communication content is not understood, questions are not asked and important information may not be recognized by either the patient or the physician.

The symptoms of age-related diseases such as Parkinson's or aphasia due to an apoplectic stroke also make it more difficult to communicate, for example by affecting articulation, volume of speech, speech comprehension and word fluency (Sachweh 2012). Dementia poses a particular challenge for communication with elderly patients. In the following, the symptoms of AD, the most common of the dementia-related diseases, are examined with regard to the obstacles and opportunities to communication.

Cognitive changes in LKB and Alzheimer's dementia

In addition to sensory and common age-related cognitive changes in old age, the development of dementia can lead to further changes in communicative abilities, which have their origins in declining mental abilities that underlie speech production and reception processes. Mild cognitive impairment (MCI)[1], which can be seen as a preliminary stage of AD in which there is still no remarkable impairment in everyday life, is accompanied by a decline in cognitive performance (Petersen et al. 1999). This can have a major impact on everyday communication. Conversion to a

1 Mild cognitive impairment is associated with cognitive deficits that do not, however, reach the severity of dementia and do not affect everyday abilities. With MCI, there is an increased risk for Alzheimer's disease. However, there are also forms in which there is no progressive deterioration with conversion to dementia (Petersen et al. 1999).

manifest dementia and thus a further decline in cognitive performance is also associated with an increasing impairment of speech and communication skills.

The most prominent symptom of dementia is a decline in memory performance. In the early stages, episodic memory content is primarily affected, such as autobiographical memory. In addition, there are deficits in processing speed - which is particularly important for time-sensitive oral communication - and the ability to adapt. Patients need more and more time to process information and find it increasingly difficult to adapt to different demands, such as listening to a conversation that is interrupted by a ringing telephone.

Further deficits occur at the level of short-term and working memory, which can cause considerable difficulties in spoken communication regarding maintaining conversational topics or assessing listener information.

These changes in cognitive abilities often lead to speech and communication disorders (previously described in Bayles, Kaszniak 1987). Even in the early stages of AD or MCI, speech skills are impaired (e.g. Wendelstein 2015, 2016, McCullough et al. 2019). Speech deficits are also used in diagnostics. They are integrated into common test batteries such as the CERAD-NP test battery (Morris et al. 1989), and considered a criterion in DSM-V diagnostics as well (American Psychiatric Association 2022). It is likely that they can be used to discriminate normal ageing from dementia in preclinical stages in the future with further development of automated speech analysis (Wendelstein 2016: 177, Ivanova 2023).

Speech loss phenomena can often be compensated for very well in everyday life. The most conspicuous symptom is probably word-finding disorders as described by a patient in Box 37.1.

Box 37.1	Word-finding disorders[2]

P: […] Sometimes …er… when you are looking for a word and it is not there, and I had a conversation with my wife and, um [clears his throat],

2 Free translation by the authors. This transcript excerpt is taken from the biographical interviews of the 'Interdisciplinary Longitudinal Study on Adult Development and Aging' (ILSE), financed by Dietmar Hopp Foundation, formerly from funds of Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, Germany. Thanks to all who had been involved in that project.

then, um, then I got all (inaudible) tongue-tied, then bang, boom. It is like a barrier, very unpleasant. Sometimes, when I think away from it, then it comes back [...].

However, the range of speech degradation phenomena extends far beyond mere word-finding disorders. At the word level, there is also a reduction in active vocabulary. AD patients tend to use umbrella terms rather than concrete terms, or resort to phrases with little content such as "thing" or pronouns (e.g. he, she, it) and have difficulties in understanding pronouns (Almor et al. 1999). Changes also occur at the sentence level during the course of AD. AD patients form increasingly shorter sentences and - as a result of the disease-related working memory disorder - have increasing difficulties with long sentences. From moderate stages at the latest, AD patients have difficulties in understanding and producing complex sentences (Bickel et al. 2000, Kemper et al. 2001). Frequent breaks in sentences also lead to AD patients' speech appearing halting and incoherent. As the disease progresses, so do the difficulties in understanding figurative speech such as metaphors or idioms (Papagno 2001). The patients themselves tend to make more frequent use of empty phrases (Bridges, Van Lancker Sidtis 2013). The use of phrases and highly overlearned multi-word combinations shows that the ability to compensate is still preserved in the early stages. Fluent speech can be perceived as relatively undisturbed at first glance, but often lacks a "common thread" and is increasingly characterized by a lack of content and detail (cf. Wendelstein 2016, Ahmed et al. 2013). Box 37.2 provides an overview of the speech deterioration phenomena in early to moderate AD.

Box 37.2 Speech deterioration phenomena in early to moderate AD

- Word-finding disorders
- Decrease in active vocabulary
- Accumulation of contentless words
- Difficulties in understanding complex and long sentences
- Production of shorter sentences and more aborted sentences
- Difficulties in understanding figurative speech
- Frequent repetitions
- Speech lacking in content, often lacking a "common thread"

In the later stages of AD, the language deterioration phenomena intensify towards the use of fewer, repetitive expressions and even mutism. In these stages, AD patients are increasingly restricted to communication that takes place on an emotional and relationship level rather than a factual level and are pre-dominantly receptive on this level (Sachweh 2019, Meier zu Verl 2023).

In many cases, the cognitive and linguistic symptoms of dementia are accompanied by psychopathological symptoms that can make communication even more difficult. Apathy or depressive symptoms often occur (Petersen et al. 1999). These can lead to a reduced drive to communicate and can also lead to misinterpretations due to reduced facial expressions and gestures (Sachweh 2019).

37.2.2 Relationship dimension

Besides the formal dimension of communication, a relationship aspect must always be taken into account (e.g. Meyer-Kühling, in press). According to Paul Watzlawick's much quoted axiom it is impossible *not* to communicate (Watzlawick et al. 1967/2017) (cf. § 7.4). Communication is not explained by *what* a person says, but *how*. Many aspects influence verbal communication – such as nonverbal actions like an effusive use of gestures and facial expression. Furthermore, paraverbal aspects, which make the speaker's voice sound annoyed even if they are formulating a content-neutral sentence.

For the conversation between patient and physician it is essential, that not only formal aspects take influence, as physician's speaking volume and speed or their ability of explaining complex issues. Communication rather means to enter a relationship with each other. This is of high significance if physicians find themselves in a conversational situation - in particular with elderly patients. On the one hand, the meaning of the medical information, which is supposed to be mediated, is important. Especially in case of patients suffering from multimorbidity this information can be very complex. On the other hand, the way of communication in itself is substantial, see E 37.1:

E 37.1		Meaning of conversations at eye level for the patient-physician communication[3]
01	I*	How …er… satisfied are you with your medical treatment at the moment
02	P	Fine
03	I	Yes but
04	P	however
05	I	Can you rely on it
06	P	I can rely on it. Especially when …er… I mean …er… all those years with Doc Miller [anonymized] internal medicine but …er… [2.5] I had …er… the preventive check-up …er… there and he had so little …er…
07	I	Time
08	P	time and he never …er… [clears the throat] asked on his own initiative do you have pain or where do you have pain
09	I	[laughs] (incomprehensible) otherwise he tells
10	P	Somewhere that bothered me. My my uncle the brother of my father j/just didn't go there anymore and he told if you can`t even talk to the physician that`s too one-track form …er… I don`t go there anymore
11	I	and then you changed [1] physicians
12	P	Yes, then I switched to …er… Doctor Meier [anonymized] and …er…

*Interviewer

If physicians want to consider the relationship level within conversations with patients, they must realize that from the outset the situation is an asymmetrical one. The various characteristics of asymmetrical conversations include for example (according to Matolycz 2009):

3 Free translation by the authors. This transcript excerpt is taken from the biographical interviews of the 'Interdisciplinary Longitudinal Study on Adult Development and Aging' (ILSE), financed by Dietmar Hopp Foundation, formerly from funds of Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, Germany. Thanks to all who had been involved in that project.

- The physician's professional role
- Work clothing in contrast to patients who are possibly not fully dressed or in sleepwear
- The body posture, e.g. if the physician is acting and speaking standing and the patient is lying in bed or sitting in the wheelchair
- The leading edge of information the physician has got
- The possibly intimate information patients have to give about their physical condition (for example regarding excretions)
- The time slot which is available for the whole examination and is only known by the physician

The conditions mentioned above become more acute if the patient is cognitive and/or sensory impaired and the physician does not adapt their way of communication.
In order to adapt adequately to sensory or cognitive impairments a pronounced sensitivity of the physician is required. An adaption to age-associated changes can be successful if it is individualized as well as based on mutual understanding and appreciation.

However, if an adaptation to possible impairments of the elderly person is carried out without reflection and based on stereotypes, in the worst case this can not only lead to failed communication but may even be met with withdrawal by the elderly patient. This happens when the patient does not feel taken seriously and feels belittled. As a result, a sustainable patient-physician relationship, in which medical concerns are articulated in a trusting, appropriate and sufficient manner on both sides, is at risk. According to a 'self-fulfilling prophecy' (Lehr 1987, see also Rothermund 2024) age attributes assumed by the physician can be reinforced in the patient, so that the communicative relationship becomes increasingly aggravated, like a vicious circle. To do justice to the relationship dimension the physician's ability of observing and assessing the patient's communication skills is of high significance.

If the patient suffers from dementia the relationship dimension plays an important role. Firstly, this can be explained by the fact that an interlocutor often tends to adapt their language behavior excessively due to the assumed and actually existing cognitive impairment. The commonly cited idea that patients suffering from dementia revert to 'childlike behaviour' also stands in the way of adequate interaction with an adult. The perception of non-verbal signals (e.g. gestures, facial expressions, intonation, volume), which convey emotional content (e.g. impatience, patronization), is usually preserved longer and better in patients with

dementia than the purely content-related verbal level (e.g. Degen et al. 2021). Even severely impaired patients, who can barely understand the verbal content of a conversation, are often able to perceive the emotions and feelings that determine a conversation (Sachweh 2019). The relationship aspect can be seen as a resource of communication. Dementia patients can benefit from this, for example through an attentive, calm attitude. It must be taken into account that patients suffering from dementia often are not sole interlocutors but accompanied by their relatives. On the one hand, patients can feel supported by the presence of familiar people. In a successful communication situation relatives can contribute to explaining information regarding medical appointments, diagnosis and therapy.

On the other hand, the presence of the relative also poses risks for successful communication with the patient: In order to communicate information effectively due to time pressure and also because of the important content, in the worst-case scenario, accompanying relatives are often approached instead of directing the conversation to the patients themselves. Talking *about* rather than *with* the patient is perceived as belittling even by more severely impaired dementia patients. In addition, there is a risk of overlooking the patient's verbal and nonverbal signals, when it is constantly tried to act and talk on their behalf (Kojer 2022, Sachweh 2019).

37.2.3 Age-associated changes and expectations: risks and chances of communication situations

It is common that very old people are described as difficult to make contact with and unwilling to cooperate (Kojer 2022, Adelman 1991). Such age stereotypes and even worse ageism can lead to significantly poorer health (Chang et al. 2020). Age stereotypes can be aggravated by misinterpreted communication problems. Therefore, the heterogeneity of cognitive and sensory changes in old age must be considered (Lamnek 1995/2010) but in addition adaptations to the age-related physiological conditions of the patient (elder speech) must be used with consideration.

The model shown in Fig. 37.1 illustrates how communication with an elderly patient can proceed if it is influenced by unreflected, stereotypical expectations and behaviors of the physician. The model refers to the presentation by Ryan and Kwong See (2003: 61, cf. also Sachweh 2019: 187 ff., Ryan et al. 1995: 147) and initially depicts the perception of age

characteristics (such as wrinkles, gray hair, etc.) by the interlocutor - in the case of patient-physician communication, the physician. The perceived age characteristics can give rise to culturally influenced stereotypical expectations of the competencies of the elderly patient - and thus also of their communication style.

Such age stereotypes relate, for example, to the assumption that elderly people have reduced hearing (expectation of sensory limitations) or are mentally unable to follow the patient-physician conversation (expectation of cognitive impairments). A negative consequence of these assumptions can be that the physician, as a conversation partner, adapts his communicative behavior excessively. On the one hand, such over-adaptation often leads to the reinforcement of age-associated communication styles on the part of the elderly interlocutor, and, on the other hand, such over-adaptation can be perceived as belittling. This leads to an exacerbation of the existing asymmetry in the communication situation and can sometimes have considerable consequences for further communication. In the sense of a 'self-fulfilling prophecy' (Lehr 1987, see also Rothermund 2024) the age characteristics assumed by the interlocutor can become more pronounced, so that the communicative worsening continues to aggravate like a 'vicious circle'. Such a development is depicted as a cycle in the model below in Fig. 37.1, as the behaviors can replicate or even intensify further (see also in Hoefert 2008).

Such exaggerated adaptation occurs on a formal level, for example, through extremely loud, slow and/or simplified speech (adaptation to expected sensory and cognitive signs of ageing).

However, communicative adaptation to age stereotypes can also have a major impact on the relationship between physician and patient. This happens, for example, when the physician uses a patronizing style of speech - i.e. expresses his or her supposed superiority verbally and non-verbally - or displays exaggerated gestures and facial expressions (see § 12). As a result, the patient may feel belittled, which can subsequently lead to a negative attitude, or the patient may conform to their age-stereotypical role and behave accordingly.

The relationship between patient and physician, which is asymmetrical from the outset, is exacerbated by stereotypical expectations and adjustments. This can lead to the patient withdrawing because they do not feel taken seriously. Medical concerns are not articulated and trust for a sustainable patient-physician relationship is thus jeopardized.

The consequences of a pattern of events as shown in Fig. 37.1 are, on the one hand, the endangerment of a trusting patient-physician

relationship, which can have negative consequences for further treatment and for compliance with proposed therapies. On the other hand, the physician's over-adaptation to age stereotypes and the patient's subsequent adaptation to negative expectations can lead to an incorrect assessment of actual cognitive abilities.

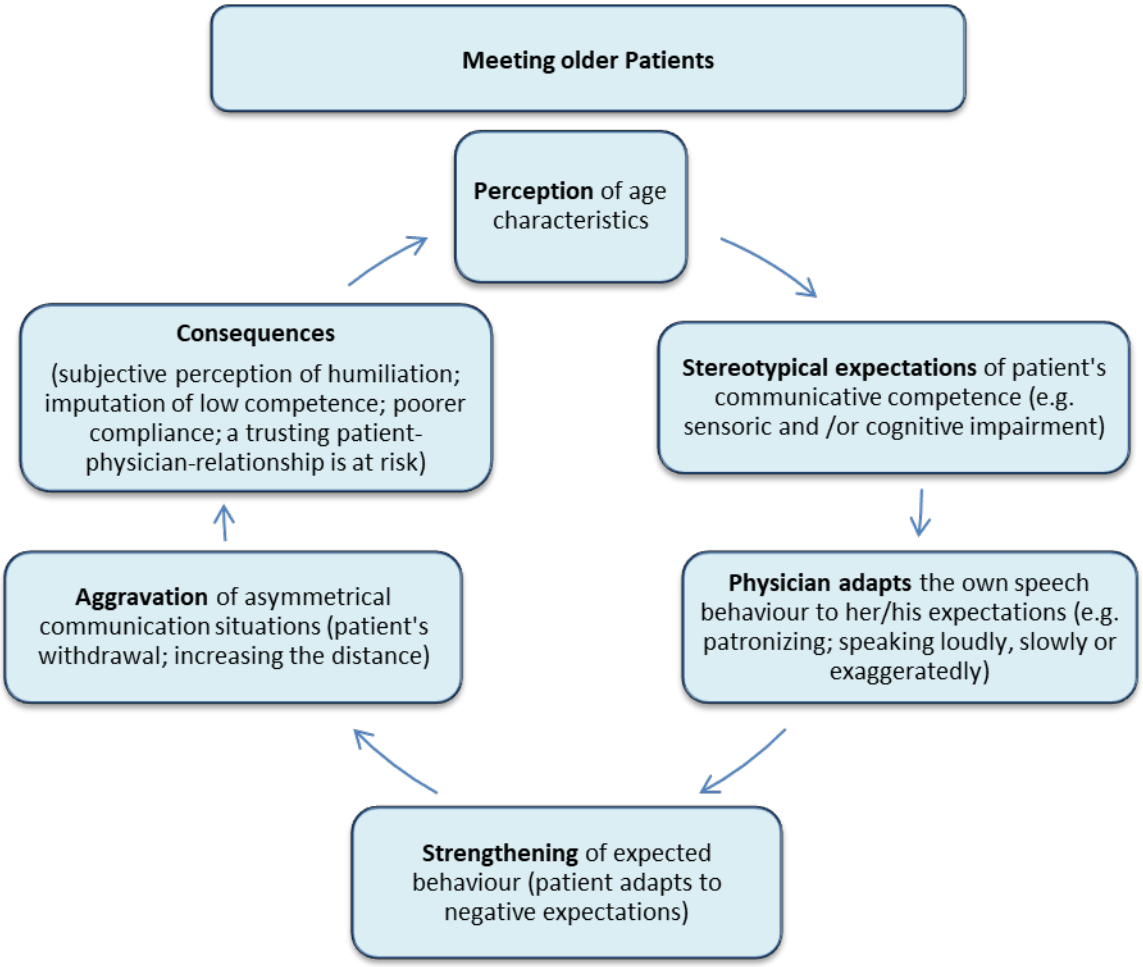

Abb. 37.1: Communication model, modified after Sachweh 2019: 187ff, Ryan et al. 1995: 147 and Kwong See, Ryan 2003: 61.

Successful communication situations are particularly important in patient-physician discussions to enable a realistic assessment of the symptoms and, in the case of elderly patients, their abilities and skills. A good basis for communication increases the patient's willingness to cooperate and their compliance with therapy offers. Particularly in the case of cognitively or sensory impaired patients, it is necessary to adapt one's own communication behavior, but to avoid over-adaptation under close

observation of the patient and self-reflection. A trusting communication situation can lead to a reduction in anxiety and uncertainty, especially in patients with dementia.

37.3 Recommendations for communication

Hereafter, various recommendations for communication will be given to facilitate verbal and non-verbal communication with elderly people. With the help of these recommendations, a patient-physician conversation should be possible on an appreciative relationship level.

At this point, it is important to mention that the inter-individual differences of elderly patients - especially about character traits and communication styles - must be considered. There is no magic formula for dealing with elderly people. The recommendations for communication given here serve as a guide. Intensive observation of the person and a self-reflective examination of the communication model shown in Fig. 37.1 are essential prerequisites.

The communicative approach in the course of a patient's dementia is a special condition that is considered separately at this point. The recommendations for dealing with patients with dementia are to be understood regarding the different stages or degrees of severity of this disease. To find an appropriate approach to elderly patients, different conditions of communication must be considered on both the formal and the relationship level.

As far as communication on a formal level is concerned, it is important to be aware of the extent to which sensory and cognitive changes affect the communicative abilities of elderly patients. When communicating, it is essential to be patient, to reduce the speed of speech and to use gestures and facial expressions consciously and with emphasis (Rodero et al. 2023). Also seen from the other side, for a better understanding the patients, their emotional expression should be considered as an important resource of communication (Kojer 2022, Degen et al. 2021, Kruse et al. 2019).

The aim of the physician-patient conversation is to present medical content in a way that is easy for the elderly patient to understand. Conditions that could disturb the patient's attention (such as noise levels, restlessness, numerous interruptions) should be avoided from the outset so as not to make communication unnecessarily difficult. The use of short, non-nested sentences and the avoidance of an accumulation of

medical terms or a detailed explanation of these is recommended. To make it easier to understand and retain the content of the conversation, important points should be repeated and can also be visualized if necessary (e.g. Gießelmann, 2017).

Box 37.4	Recommendations for communicating with elderly patients

External framework conditions

- Quiet room
- Avoid disruptive factors (interruptions, background noise, parallel activities...)

Nonverbal behavior

- Eye contact
- Open, facing posture
- Matching facial expressions, gestures and conveyed factual content
- Adjusted volume (do not start too loud)

Shaping verbal expressions

- Verbalize the time frame and content of the conversation beforehand
- Avoid long, convoluted sentences
- Avoid unnecessary technical terms
- Repeat important content if necessary

This is preceded by precise observation of the other person's communicative skills and orientation towards their verbal and non-verbal resources to avoid over-adaptation and linguistic action based on stereotypes. The communication model shown in Fig. 37.1 makes it clear how important it is to assess the patient's communicative and cognitive abilities to find a conversational style that is appropriate for an adult. In this context, it should be noted that the situation in which communication with the elderly patient takes place is asymmetrical from the outset (Matolycz 2009). In addition to their possible impairments during the ageing process, patients are in a much weaker position. For example, they are dependent on the physician's specialist information and recommendations, but have no overview of the time frame available to them for the discussion. An appreciative relationship in the patient-physician discussion therefore essentially starts from the physician.

Successful communication with elderly patients therefore starts not only on a formal level, but also on a relationship level. The physician must

ensure that a trusting framework is created for the conversation with the patient by allaying their fears and giving them security and time to formulate their concerns.

Box 37.5 Recommendations for the relationship level

Communication between elderly patients and physicians that is respectful on a relationship level is favored by several factors:

- Critically rethink your own stereotypical expectations of the other person
- Avoiding a depersonalizing style of conversation (talking *to* the patient, not *about* them)
- Open, facing posture
- Choose a conversational style appropriate for an adult
- Create a trusting and respectful environment and allay the patient's fears

Without in-depth self-awareness and reflection on one's own communication skills, such a personal approach to elderly patients is not possible (cf. Meyer-Kühling, in press; Meyer-Kühling et al. 2015). Awareness of the extent to which patronizing language elements (such as the use of a telegram style or baby talk) are used in communication with elderly patients is a first step towards making communication more respectful. Such an attitude towards elderly patients is underlined by appropriate nonverbal behavior: this is facilitated by an open and attentive posture, frequent eye contact and matching behavior such as matching gestures, facial expressions, and factual content (Sachweh 2019; Bowlby Sifton 2008). In any case, depersonalization of patients must be avoided at all costs. This means that in their presence, relatives should not be spoken to about the person, but care must be taken to always include them in the conversation, not to act on their behalf and to disregard their wishes (e.g. Kojer 2022).

The ways of behavior described above also apply when communicating with patients suffering from dementia. In addition, the cognitive impairments associated with dementia must be considered. Here, there is a particular balancing act between avoiding over-adaptation on the one hand and adapting speech to ensure understanding on the other hand. Dementia patients are highly distractable by external influences, which is why particular attention must be paid to a low-distraction environment.

The asymmetry of communication mentioned above is even more pronounced in conversations with these patients and the physician often encounters an insecure patient. Care must be taken not to embarrass the patient and not to reinforce frequently present depressive thoughts (Lämmler et al. 2007).

Due to the deficits in understanding figurative speech, it is recommended to avoid these as well as ambiguous words or technical terms. Short-term memory deficits can be considered by choosing sentences that are rather short and not convoluted and by repeating what has already been said using the same words. If possible, only one important piece of information should be included in a sentence (Kurz et al. 2004). Reduced expressions such as pronouns (he, she, it) also cause difficulties for dementia patients (Almor et al. 1999, Wendelstein 2016); the corresponding nouns can be used instead. Frequently occurring word-finding disorders can also make communication with dementia patients more difficult. An understanding and cautious approach is advisable here and behavior that puts the patient under pressure should be avoided. It is therefore important to give the patient time to formulate their wishes. It may be helpful to encourage the patient to paraphrase the missing word or to use a word with similar content (cf. Sachweh 2019/2008: 38ff).

Even if it is often recommended to support communication with aids such as pictures, sketches and written summaries, the use of such aids could also be critical. On the one hand, the choice of aids which are used must be weighed up - pictures that seem too childish, texts that are too long and complex - on the other hand, these elements intended as support can be distracting or confusing. In addition, reading and writing are often impaired even before oral communication. When using such aids, it must be considered on an individual basis whether patients will benefit from them (cf. Knebel 2015: 86f).

Box 37.6	Additional recommendations for communicating with dementia patients

External conditions

- Pay even more attention to avoid distracting factors
- Give the patient time (to understand but also to formulate, e.g. in the case of word-finding disorders)

Nonverbal behavior

- Note: the facial expressions and gestures of AD patients can be impaired by comorbid conditions such as apathy or apraxia
- Choose a calming voice pitch

Shaping verbal expressions

- Use short, simple sentences
- Avoid idioms and metaphors
- Avoid ambiguous expressions
- Repeat nouns more often instead of pronouns (he, she, it)
- Repeating what has been said with the same words

In the later stages of dementia, the difficulties to communicate on a verbal level can lead to complete mutism. In this case, communication on an emotional or relationship level should be seen as a resource, as it is often retained for longer (Knebel 2015, Sachweh 2019, Meier zu Verl 2023).

37.4 Conclusion

Communication with elderly patients is linked to various challenges. On a formal level, age-related physiological changes about sensory functions (e.g. age-related hearing loss) must be considered in the conversation, as must the elderly patient's declining ability to concentrate and faster fatigability. Possible cognitive impairments, including dementia, make it necessary to create appropriate conditions for the patient-physician consultation, to use non-verbal communication (gestures, facial expressions) in a targeted manner, to adapt the content of the conversation and to convey it on an appreciative level.

Both in terms of age-related physiological changes in general and cognitive performance in particular, the high inter-individuality and thus variability of elderly patients must be emphasized (e.g. Schaie, Baltes 1996). This means ageing processes can also present themselves very differently within the same target group. Age stereotypes, which focus on the presumed sensory and cognitive limitations of elderly patients, do not reflect reality and should be viewed with caution. They are linked to ageism and are likely to negatively influence the patient-physician relationship. To avoid ageism, incorrect assessment of the cognitive abilities of

an elderly patient and inappropriate over-adaptation when communicating with elderly patients, it is necessary to observe not only their communicative limitations in advance, but also their resources.

For this reason, the recommendations above are intended to provide guidance for rethinking stereotypical ideas and to sensitize the physician to what they can do to have an appreciative and targeted conversation with the patient. This is particularly important when dealing with patients suffering from dementia. The key is to reduce patronizing and depersonalizing behaviors in the patient-physician conversation and to ensure that the person with dementia is carefully involved in the conversation and not only talked about with their relatives, even though they are present in the room.

Adequate communication with elderly patients helps to recognize their complaints, avoid treatment errors and helps to counteract a disregard for the patient's needs and thus a coercion of medical measures (Kojer 2022). Communication that focuses on the patient's communicative resources, far from stereotypical assumptions, gives the patient a sense of security and thus helps to build a long-term, sustainable patient-physician relationship which is crucial for compliance, patient satisfaction and health status of the patient (Adelman et al. 1991).

37.5 Further information

A basic overview about communication between elderly patients and physicians is given in Adelman et al. (1991).

An overview of formal aspects of language loss in different dementia types can be found in Cummings (2020) and more detailed for Alzheimer's dementia including preclinical stages, in Wendelstein (2016).

Sachweh (2019) describes conditions and characteristics of communication by and with people suffering from dementia including relationship and emotional aspects. The importance of the relationship level in dealing with persons suffering from dementia is also impressively described by Kojer (2022).

Lately, a training program for professional caregivers has been developed, which focuses on meeting needs especially of people who are suffering

from dementia and whose verbal communication skills are already limited (see Meyer-Kühling, in press). After evaluation of this training, it may be possible to adapt it to the target group of physicians.

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

Adelman RD, Grene MG, Charon R (1991): Issues in Physician—Elderly Patient Interaction. In: Ageing & Society 11(2), 127-148.

Ahmed S, Haigh AF, De Jager CA, Garrard P (2013): Connected speech as a marker of disease progression in autopsy-proven Alzheimer's disease. In: Brain 136(12), 3727-37 .

Almor A, Kempler D, Macdonald MC, Andersen ES, Tyler LK (1999): Why Do Alzheimer Patients Have Difficulty with Pronouns? Working Memory, Semantics, and Reference in Comprehension and Production in Alzheimer's Disease. Brain and Language 67(3), 202-227.

American Psychiatric Association (2022): Diagnostic and statistical manual of mental disorders. 5th edition.

Bayles KA, Kaszniak AW (1987): Communication and cognition in normal aging and dementia. London: Taylor and Francis

Bickel C, Pantel J, Eysenbach K, Schröder J (2000): Comprehension Deficits in Alzheimer's Disease. Brain and Language 71 (3), 432-48.

Bowlby Sifton C (2008): Das Demenz-Buch. Ein 'Wegbegleiter' für Angehörige, Pflegende und Aktivierungstherapeuten. Bern: Huber.

Bridges KA, Van Lancker Sidtis D (2013): Formualic language in Alzheimer's disease. Aphasiology 27 (7), 799-810.

Chang ES, Kannoth S, Levy S, Wang S-Y, Lee JE, Levy BR (2020): Global reach of ageism on older persons' health: A systematic review. PLoS ONE 15(1): e0220857.

Cummings L (2020): Language in Dementia. Cambridge: Cambridge University Press.

Degen C, Frankenberg C, Meyer-Kühling I, Wendelstein B, Knebel M, Pantel J, Zenthöfer A, Rammelsberg P, Andrejeva N, Schröder J (2021): Communication skills in nursing home residents with dementia: Results of a

prospective intervention study over 21 months. Z Gerontol Geriatr, 55 (1), 27-31.

Gießelmann K (2017): Kommunikation mit Demenzerkrankten: Eintauchen in eine andere Welt. Dtsch Arztebl 114(14), A-704 / B-600 / C-586.

Hoefert HW (2008): Kommunikation mit alten und dementen Patienten. In: Hoefert HW, Hellmann W (Hg.): Kommunikation als Erfolgsfaktor im Krankenhaus. Heidelberg: Economia, 79-104.

Ivanova O, Martínez-Nicolás I, García Meilán JJ (2023): Speech changes in old age: Methodological considerations for speech-based discrimination of healthy ageing and Alzheimer's disease. In: International Journal of Language & Communication Disorders 59(1), 13-37.

Kemper S, Thompson M, Marquis J (2001): Longitudinal change in language production: Effects of aging and dementia on grammatical complexity and propositional content. Psychology and Aging 16 (4), 600-14.

Knäuper B, Schwarz N, Park D (2002): Selbstberichte im Alter. In Motel-Klingebiel A, Kelle U (Hg.): Perspektiven der empirischen Alter(n)ssoziologie. Opladen: Leske & Budrich.

Knebel M (2015): Kommunikation bei Demenz. Validierung eines Instruments zur Erfassung kommunikativer Verhaltensweisen bei Demenzen. Berlin: Logos.

Kojer M (2022): Kommunikation – Kernkompetenz der palliativen Geriatrie. In: Kojer M, Schmidl M, Heimerl K (Ed.): Demenz und palliative Geriatrie in der Praxis: Heilsame Betreuung unheilbar demenzkranker Menschen. 3d edition. Wien: Springer.

Kruse A (2017): Lebensphase hohes Alter. Verletzlichkeit und Reife. Berlin, Heidelberg: Springer.

Kruse A, Wiloth S, Schmidt J, Pick P, Fleer B, Kötter H, Kimmel A (2019): Erfassung von Lebensqualität gerontopsychiatrisch Erkrankter im Rahmen der pflegeheiminternen Qualitätssicherung. Abschlussbericht Projektphase 2.

Kurz A, Gertz HJ, Monsch A, Adler G (2004): Demenzerkrankungen: Kommunikation zwischen Arzt, Patient und Angehörigen [Dementias: communication between doctor, patient and relatives]. Dtsch Med Wochenschr.;129(5):199-203. doi:10.1055/s-2004-817662

Lämmler G, Stechl E, Steinhagen-Thiessen E (2007): Die Patientenaufklärung bei Demenz. Zeitschrift für Gerontologie und Geriatrie 40, 81-7.

Lamnek S (1995/2010): Qualitative Sozialforschung. Lehrbuch. 5th Edition. Weinheim, etc.: Beltz.

Lehr U (1987): Kompetenz im Alter: Ist die Bundesrepublik ein Land der Hilfsbedürftigen? Universitas 9, 879-90.

Matolycz E (2009): Kommunikation in der Pflege. Wien: Springer.

McCullough KC, Bayles KA, Bouldin ED (2019): Language Performance of Individuals at Risk for Mild Cognitive Impairment. In: Journal of Speech, Language, and Hearing Research 62 (3), 706-722.

Meier zu Verl C (2023): Affizierung und Responsivität als Arbeit: Interaktionssoziologische Untersuchungen zur reflexiven Praxis der Demenzpflege. In: Mollenhauer R, Meier zu Verl C (Ed.) Interaktion und Kommunikation im Alter. Interdisziplinäre Forschungsperspektiven. Velbrück Wissenschaft, Weilerswist, 169-201.

Meyer-Kühling I (in press): Meeting psychosocial needs in inpatient nursing care - Development of a training programme for professional caregivers. Apollon Discussion Papers. Apollon University for Health Care Management, Bremen.

Meyer-Kühling I, Wendelstein B, Pantel J, Specht-Leible N, Zenthöfer A, Schröder J (2015): Kommunikationstraining MultiTANDEM*plus*. Ein Beitrag zur Verbesserung der Kommunikation zwischen Pflegenden und Ärzten. Pflege 28, 277-85.

Morris JC, Heyman A, Mohs RC, et al. (1989): The Consortium to Establish a Registry for Alzheimer's Disease (CERAD). Part I. Clinical and neuropsychological assessment of Alzheimer's disease. Neurology 39(9):1159-1165.

Papagno C (2001): Comprehension of metaphors and idioms in patients with Alzheimer's disease: A longitudinal study. Brain 124 (7), 1450-60.

Petersen RC, Smith GE, Waring SC, Ivnik RJ, Tangalos EG, Kokmen E (1999): Mild cognitive impairment: Clinical characterization and outcome. In: Archives of Neurology 56(3), S. 303-308.

Rajan R, Cainer KE (2008): Ageing without hearing loss or cognitive impairment causes a decrease in speech intelligibility only in informational maskers. Neuroscience 154(2), 784-95.

Rodero E, Mas L, Larrea O, Rodríguez-de-Dios I (2023): The Relevance of Communication Between Alzheimer's Patients and Their Caregivers. Effective Prosody Strategies to Improve Communication. In: Health Communication 39(12), 2906-2919.

Rothermund, K (2024). Wie Altersbilder das Leben im Alter prägen. Psychotherapie im Alter 21 (1), 51-70.

Ryan EB, Hummert ML, Boich LH (1995): Communication predicament of aging. Journal of Language and Social Psychology 14 (1-2), 144-66.

Ryan EB, Kwong See ST (2003): Sprache, Kommunikation, Altern. In: Fiehler R, Thimm C (Hg.): Sprache und Kommunikation im Alter. Radolfzell: Verlag für Gesprächsforschung, 57-71.

Sachweh S (2012): „Noch ein Löffelchen?“ Effektive Kommunikation in der Altenpflege. 3d edition. Bern: Huber.

Sachweh S (2019): Spurenlesen im Sprachdschungel - Kommunikation und Verständigung mit demenzkranken Menschen. 2nd edition. Bern: Hogrefe.

Schaie KW, Baltes PB (1996): Intellectual Development in Adulthood. The Seattle Longitudinal Study. Cambridge: Cambridge University Press.

Thornton R, Light LL (2011): Language comprehension and production in normal aging. In: Birren JE, Schaie KW (eds.): Handbook of the Psychology of Aging. Amsterdam: Elsevier Academic Press.

Watzlawick P, Beavin JH, Jackson DD (1967/2017): Menschliche Kommunikation. Formen, Störungen, Paradoxien. 13th ed. Bern: Hogrefe. (engl. orig. 1967).

Wendelstein B (2016): Gesprochene Sprache im Vorfeld der Alzheimer-Demenz: Linguistische Analysen im Verlauf von präklinischen Stadien bis zur leichten Demenz. Heidelberg: Universitätsverlag Winter.

Wendelstein B, Schröder J (2015): Veränderung verbaler Kommunikation bei Alzheimer-Demenz: Zwischen Früherkennung und Ressourcenorientierung. In: Busch A, Spranz-Fogasy T (Hg.): Handbuch „Sprache und Medizin“. Berlin, etc.: De Gruyter, 317-32.

Citation note

Wendelstein B, Meyer-Kühling I (2025): Communication with Elderly Patients. In: Koerfer A, Albus C (eds.): Medical Communication Competence. Göttingen (Germany): Verlag für Gesprächsforschung