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**How Caregivers View Their
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Fall 2014/
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care *AD*vantage® is published quarterly by AFA.

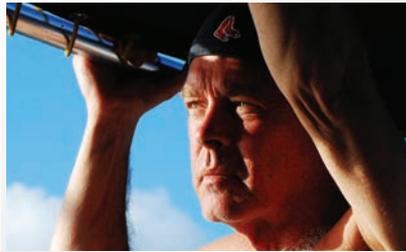
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FALL 2014/WINTER 2015 VOL. 10 NO. 2
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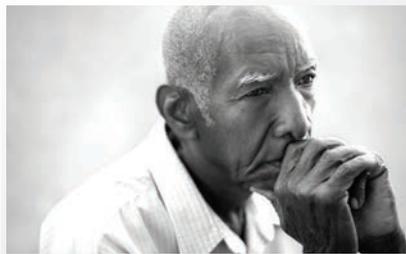
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How caregivers view their situation really does matter.



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A MESSAGE FROM
OUR PRESIDENT & CEO

Last issue, I introduced you to our social services team, in the first of a series of columns designed to give you a glimpse of what happens behind the scenes here at the Alzheimer's Foundation of America (AFA) each and every day. Now, it's time to meet our development team. Headed by Kristin, a 35-year nonprofit fundraising veteran and Cecilia, who has a background in online giving and e-mail messaging, our development team prides themselves on customer service.

A given day will find them on the phones with donors and potential donors, listening to our community members' personal stories of how Alzheimer's disease has touched their lives, answering questions and providing information on where their dollars go. Did you know, for example, that 85 cents of every dollar donated to AFA is invested in programs and services?

That, along with the team's efforts in maintaining open lines of communication, transparency and accountability, helped AFA earn a four-star rating from Charity Navigator, a "Best in America" seal of excellence from Independent Charities of America, and the Better Business Bureau's Wise Giving Alliance National Charity Seal, among other distinctions.

From helping individuals set up memorial donations or tribute gifts to cultivating a robust annual fund community, our development team consistently goes above and beyond. An example of this is our volunteer community, which stands hundreds strong, from coast to coast. From school bake sales, to teen fundraisers, workplace challenges to fun runs and triathlons, Cecilia provides community fundraisers the tools they need to host successful events, including educational materials and giveaways.

This quarter, Kristin and Cecilia are spearheading two initiatives that merit mention in this column. From November 5-December 31, thanks to a group of anonymous major donors, every donation made to AFA's special fall appeal will be matched.

In addition, people braving door-buster sales on Black Friday and scouring online deals Cyber Monday, also will have a chance to give back during this season of thanksgiving. Tuesday, December 2 is Giving Tuesday. Be sure to check AFA's website, Facebook and Twitter pages for more information on how to participate.

If you have a question about giving, please don't hesitate to reach out to us at 866.232.8484 or info@alzfdn.org. Our team is here and ready to help.

Sincerely,



Charles J. Fuschillo, Jr.
 President & CEO
 Alzheimer's Foundation of America



This heart supports
 the greatest act of love —

Caregiving!

Caregivers of individuals with Alzheimer's disease or related illnesses give from the deepest recesses of their hearts, inspiring the world with their courage, dedication and hope. Embrace the spirit. Share this inspirational heart. Show you care — about caregivers, loved ones and the cause.

Proceeds benefit the **Alzheimer's Foundation of America (AFA)**. AFA provides optimal care and services to individuals confronting dementia, and to their caregivers and families, through member organizations dedicated to improving quality of life.

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IN TOUCH

READERS' NOTES

Our support group greatly appreciates care *ADvantage* magazine and all the work that you do to support caregivers and their loved ones with Alzheimer's disease and other dementia-related illnesses. Our group discusses articles in the magazine each time that we meet. Their expression is, "Thank God someone out there cares about caregivers and understands the journey." Thank you so much for all that you do.

NANCY COLEMAN-ZACHARIAS
DALLAS, TEXAS

I just read one of your issues. I am impressed with the quality and valuable information it offers.

NORMA SEERLEY
SUN CITY WEST, ARIZ.



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*"Even if something is left undone,
everyone must take time to sit
still and watch the leaves turn."*

- Author Elizabeth Lawrence

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WRITE TO US

Please send your letters, questions and "Heart and Soul" submissions to: careadvantage@alzfdn.org or care *ADvantage*, Alzheimer's Foundation of America, 322 Eighth Ave., 7th Floor, New York, NY 10001.

Published contributions may be edited for length and clarity.



Feeling More Forgetful?

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CONNECT

Connecting Your **QUESTIONS** and Our **ANSWERS**

A Q&A WITH **HEATHER SAPOSNICK, LMSW, QDCS**, A SOCIAL WORKER AND PROJECT COORDINATOR AT THE ALZHEIMER'S FOUNDATION OF AMERICA



© Jill Lehmann, Dreamstime.com

QUESTION: My mother always took great care in her appearance. She loved getting her hair and nails done, especially when friends accompanied her to the salon. Now, I am having a hard time with her personal hygiene. Any suggestions?

ANSWER: Since your mother liked to pamper herself and enjoyed the social aspect of the salon, try recreating that environment in her own home—complete with nail and hair stations that stimulate her senses of sight, smell and touch.

For nail care, set up a table with the necessary equipment like nail clippers and nail polish in her favorite colors. Massage your mom's hands with fragrant lotions like lavender or rose, and then drape them with a warm towel.

For hair care, you can utilize the bathroom or kitchen sinks for shampooing. Gently massage her scalp with scented shampoos and conditioners.

While these activities are going on, play soft music or tranquil sounds like that of the ocean. And, to further recreate a salon atmosphere and encourage socialization, consider inviting one or two of her family members or friends for the "spa day."

While your services won't earn a tip, as a caregiver, you will gain the priceless reward of having your mom well cared for.

QUESTION: I am a 50-year-old primary caregiver for my mom, who has the early signs of Alzheimer's disease. I have three siblings, including two who live nearby and do nothing to help out. They show up on Christmas only. I have such anger inside of me because I feel that I am stuck caring for my mom daily when there are four of us who should be pitching in. How do I deal with this anger? It's eating me alive.

ANSWER: Alzheimer's disease is not only the individual's disease, but one that affects the whole family. Some families pull together, with each member taking on a role that utilizes his or her strengths and time availability. However, other families do not have it that easy. Often, the daily responsibility is left to one person—in this case, you.

While it is understandable that this situation has left you feeling angry and probably resentful, it is essential to find positive ways to manage these emotions. Venting to trusted friends or a counselor, attending a support group, journaling, or exercising may help.

Concerning your siblings, there are several possible reasons why they may not be pitching in. First, they may not realize how much work is involved in caregiving and may need more education about the disease. Second, your mother's illness may trigger many emotions among family members, including denial and frustration. Ideally, it would be advisable for your siblings to first process their emotions and get educated about Alzheimer's disease, so they might be open to taking on caregiving responsibilities.

It is also important to realize that all families have a history of relationships and established roles, which can influence current and future situations. If you were always the "helper," this could explain why your siblings have left you with all responsibility. Whatever the case, revisiting the past is not helpful.

One of the best interventions is to have a family meeting to address the circumstances. You can hold the meeting in your home or a neutral setting, and conference in by phone or computer others who join from afar. Arrange an agenda. Consider hiring a professional—e.g., social worker, geriatric care manager—to lead the meeting and help develop a care plan.

If it ends up that your siblings are unable or unwilling to physically help with your mother, try assigning them other responsibilities, such as handling financial matters or scheduling doctors' visits. Ultimately, your siblings may or may not "step up" and be involved to your satisfaction, and conflict may arise. Keep in mind this is not about you or your siblings; rather, it is about coming together to provide the very best care for your mother.

Editor's note: See page 11.

For immediate assistance, contact the Alzheimer's Foundation of America's social work team.

Call 866.232.8484, or SKYPE or chat live at www.carecrossroads.org during regular business hours; or e-mail info@alzfdn.org.

RESEARCH CLIPS

The Lancet Neurology • August 2014

New research suggests that about one-third of Alzheimer's disease cases worldwide might be linked to potentially-modifiable risk factors: diabetes, midlife hypertension, midlife obesity, physical inactivity, depression, smoking, and lower levels of education. Therefore, researchers said, improved access to education and use of effective methods targeted at lowering these risk factors might reduce the incidence.

JAMA Neurology • August 2014

A lifetime of learning and mental stimulation may be linked to better cognition later in life, according to a new study. In evaluating 2,000 people, aged 70 to 89 at the study's onset, either without dementia or with mild cognitive impairment, researchers found that higher education/occupation scores, and greater mental stimulation in mid-to late-life were protective factors. The participants' self-reported activities included crafts, reading, working on computers, or playing music.

PLOS One • July 14, 2014

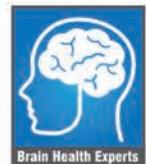
After analyzing data from 417 individuals with mild cognitive impairment (MCI), researchers concluded that memory concerns exhibited during the early stages of MCI are reliable in predicting future dementia, while their predictive value in the more advanced stages is reduced.

Neurology (online) • June 25, 2014

Veterans who sustained a traumatic brain injury (TBI) during service were 60 percent more likely later to develop dementia than veterans who did not, according to a study that examined medical records of more than 188,000 U.S. veterans ages 55 and older. Among other findings, veterans with a history of TBI developed dementia about two years earlier than those without TBI who had dementia; and veterans with TBI who also had depression, post-traumatic stress disorder, or blood vessel disease had a higher risk of dementia than those with either TBI or these other conditions alone.



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OSTEOPOROSIS: Bone Disease and Broken Bones

THE SITUATION

Fear of falling is common among aging adults. Fear of falling is even more common among older adults with osteoporosis. And for good reason. Osteoporosis is a disease—related to the loss and/or reduced formation of bone—that causes bones to thin, weaken and stiffen, turning even the slightest wrong move and, worse, a tumble into the potential for a broken bone or bones. Post-menopausal women are especially at risk due to their smaller bone structure as well as increased tissue loss that results from decreased production of estrogen, a bone-protecting hormone, after menopause. Men also face this condition, since a decrease in testosterone can cause bone loss.

THE SOLUTION

> **Know the risks.** Middle age (50+), genes, family history, menopause, certain medications or illnesses, and previous broken bones are some of the risk factors for osteoporosis that fall outside of your control. In your power: healthy lifestyle choices.

> **Get an exam.** Speak to your healthcare professional about risks, steps to prevent osteoporosis, and the state of your bones. A bone mineral density test is one of the ways clinicians determine bone health. For Medicare beneficiaries, Medicare's preventive services cover the cost of a bone mass measurement if someone is at risk for osteoporosis or has other specific medical conditions. In general, the lower your bone density, the higher the risk for a fracture; the spine, hip and wrists are common targets.

> **Discuss medications.** Clinicians may prescribe medications for low bone density, osteoporosis, or pain management resulting from bone fractures. To prevent and/or treat osteoporosis, the U.S. Food and Drug Administration has approved multiple medicines in various forms (e.g., tablet, nasal spray, skin patch) and frequency (e.g., daily, weekly, monthly). Like with any medication, it's important to understand the risks and rewards.

> **Adjust living space.**

With the goal of helping to prevent falls, take stock of your indoor and outdoor living environment. Then, get to work! De-clutter, fix broken or uneven walkways and steps, install handrails, use night lights or motion-sensitive lights, and remove throw

rugs, for example. For safety tips throughout the home, visit the "House of Care" on www.carecrossroads.org, a website of the Alzheimer's Foundation of America.

> **Be strong.** Consult with a healthcare professional about an appropriate regular exercise program based on your bone health and other medical conditions. To lessen the chances of a fracture, think weight-bearing exercises, like walking and aerobics; muscle-boosting exercises, such as weight lifting; and balance exercises, like tai chi and yoga.

> **Eat well.** Starting at a young age, what's good for your heart is good for your brain—and also good for your bones. This includes a well-balanced diet, rich in rainbow-colored fruits and vegetables, and plenty of water. Talk with a healthcare professional about proper nutrition and dietary supplements (e.g., calcium, vitamin D) based on your bones and overall health. Research shows vitamin D may help reduce the risk of Alzheimer's disease as well as osteoporosis. Nix smoking and limit alcohol consumption.

> **Manage mental health.** If osteoporosis—caused broken bones and physical changes, such as a curved upper spine—get you down, speak to a mental health counselor or join a support group. The National Osteoporosis Foundation hosts an online community at www.inspire.com and lists support groups on its website, www.nof.org.

—CAROL STEINBERG



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What's Your Opinion?



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Has the American Dream been overrated? Should the U.S. step in to stop a foreign government from abusing its own citizens? Should community service and voting be mandatory?

Residents at several assisted living facilities in the New York area can give you an earful on these topics—and sometimes quite heatedly. They are participants in a debate program for older adults run by the Debate School of New Jersey, LLC, Mahwah, N.J.

The school's founder, Ralph Cohen, introduced the program for older adults this year, and now about two dozen clients in New York, New Jersey and Connecticut host the formal discussions, including 10 Atria Senior Living residences. It is an outgrowth of a similar program he started for elementary school students, originally as a winter debate club at his son's elementary school, with the goals of building critical thinking, listening and speaking skills.

In expanding the program to older adults, Cohen suggested, "In my opinion, there are few if any activities that are as intellectually stimulating as debate. The debate sessions work because they are uniquely stimulating, challenging, entertaining and educational."

He said he "makes sure that as many attendees as possible participate, and as fully as they are able to." Attendees include some people in the early stages of dementia.

Cohen, a former telecommunications analyst and product/business development manager, serves as the moderator-coach for each of the 50-minute sessions. First, he divides the 10 to 20 participants into two teams – one affirmative, one negative. Next, he writes several propositions on the board and gives background on each, and then prompts the debaters to put forth opposing arguments with statements like, "What if we..."

Compared to the debates for elementary school students—that focus on topics like voting age and the safety of video games—the voices of the older adults reflect years of life history.

"Seniors become embroiled in heated discussions and become excited far more often, and with considerably greater intensity than the students," Cohen observed.

Debates about the government's role as an international peacekeeper, and whether the practice of medicine is a violation of natural law have generated some of the liveliest bouts.

At Atria Rye Brook, a senior living community in Rye Brook, N.Y., about 20 residents have been participating each month in the debate club since it started there last spring.

"Residents benefit from this by having stimulating conversations and engaging in issues that are timely. [They] need to 'think outside the box' to solve a problem," said Caren Kern, the community's engage life director.

Kern also noted an extra bonus: Residents continue to discuss the topics over dinner—"a springboard for continued intellectual conversations here at Atria Rye Brook."

With the success of these programs, Cohen is considering hosting debates between older adults and students in the future.

"My work at the debate school provides me with great satisfaction because I believe I am contributing to the quality of life of senior citizens by providing the opportunity for them to engage their intellect," Cohen said. "Moreover, the residents of these facilities were the bedrock of our society for many years, and I am honored to be able to give something back."

-CAROL STEINBERG

DETAILS: www.debateschoolusa.com

Heading Out to Pluto

Written by GREG O'BRIEN

My wife [Mary Catherine] finally broke the silence.

"Do you know where you are going?" she asked.

I wasn't sure on a number of fronts. So, I just kept driving ...

I had to call several times to the office of neurologist Donald Marks, M.D., to get the directions straight. I was a bit on edge, awaiting results of a SPECT scan brain image test.

On the third floor of a boxy red brick building, Marks' office had all the ambiance and accoutrements of a hospital waiting room. Opening the door, I felt as though I were slipping into Lewis Carroll's "Alice in Wonderland" where "nothing would be what it is, because everything would be what it isn't."

I was dizzy with delusions of what could lie ahead. The office was filled with decent individuals, mostly in their 80s, all with cognitive impairments picking their way through the perplexities of age and a maze of cruel games the mind can play.

At 61, I was the only "young" man in the room (yikes!), and saw myself outside the box of dementia, yet felt trapped within it. I glanced at my wife. Like most couples, we've had our ups and downs in marriage, more ups, hopefully, than downs. I felt badly for her. Today was a trip down.

I was told earlier that Marks, an expert in the study of the mind, gets right to the point ...

Marks lived up to the billing. Knowledgeable, cerebral and caring in a clinical way, he put me through the paces of more clinical tests: word recall, various supplementary checks on short-term and long-term memory, category naming, visuospatial skills, and other evaluations. I flunked them all. Bottom line: the clinical tests reinforced Elovitz's forthright assessments, and the SPECT scan identified a brain in progressive decline. His formal diagnosis: "EOAD," as he wrote in his report. I glanced at it quickly, inverting the first letter, dealing with some related dys-

lexia, and thought for a moment that he had written, "TOAD."

"No," he said, "Early-Onset Alzheimer's Disease."

The words cut into me like a drill press.

"I can deal with this," I said defensively. "This is not a surprise. I can fight it."

My reporter instincts kicked in. I showed little emotion, just digested the diagnosis on a self-imposed deadline. Facts, get the facts straight. I first thought about my mom, about my grandfather; I knew the deal. I wanted more facts. This was no time for emotion ... I was afraid now to look at my wife, so I stared at Marks, trying to remain in a state of control that I had just realized was beyond me. After all, I'm a baby boomer, and we're all in control. At least, we suppose.

Finally, I gave into the emotion.

I felt Mary Catherine staring at me. I think she must have known all along.

"What do we tell the kids?" I asked her. My voice splintered.

When you're married to someone for close to four decades—when you've been through all the "for better and for worse" throes of marriage, when you have a partner who knows you almost as well as you know yourself ... then at a time like this, little needs to be said. We both knew what the future held.

No one had to sky write. We were all about the kids.

Mary Catherine grabbed my hand, we nodded, and then listened to the doctor. The moment is embedded in my mind in a freeze frame.

Marks, a man of great compassion and incredible intellect, offered support, but got right to the point.

"You need to take the diagnosis seriously," he counseled me in front of my wife, having been prepped in advance on my aversion to reality. "You have a battle ahead of you. I'm speaking to you as if you were terminal. Are you getting this?"

I was. There was hardly a tone of political correctness in his voice; I needed the reality check. You must know your enemy—study with military precision—to fight your enemy.

Alzheimer's [disease] is a death sentence. The words resonated throughout my mind ... I felt the tears running down the sides of my face. My eyes didn't blink.

"A most unusual situation of a bright man who had the opportunity to witness dementia in a parent ... with self-awareness of early symptoms within himself," Marks wrote in his initial report, dictated on voice recognition software as if the report were being written in slow motion before me. Marks also observed that a previous brain MRI revealed some "frontal Flair/ T2 changes, consistent with a previous head injury."

"This may have 'unmasked' Alzheimer's pathology," he added, "but his genetic loading is striking ... The brain SPECT scan is most compelling in clinical context for Alzheimer's."

Marks encouraged me to remain as physically fit as possible "as he is to keep his cerebral blood flow out ... I suspect he is exhibiting the phenomenon of 'cognitive reserve' in which case he may tolerate on a functional basis impairments further into the baseline underlying pathophysiology of the disease longer than one who does not have the same cognitive reserve."

"The diagnosis has been made, in my opinion," he concluded in his report, "... I am not sure how much longer he has in terms of being able to reliably and meaningfully provide the quality of work he has put out in the past. The general point is there needs to be balance between a healthy desire to overcome obstacles and yet acknowledge fundamental reality."

A final word of advice, Marks urged me to meet as quickly as possible with an estate attorney to protect family assets, given the statutory five-year

"look back" during which a nursing home can attach personal properties and bank accounts. He also recommended that I designate a healthcare proxy and future caregivers, and assign power of attorney.

In the space of a bleak afternoon, my identity in the real world—my mind, along with the cherished red cedar shingle home that I had built for the family about 30 years ago, the one with the high-pitched, red cedar wood roof on about two acres of farmland off a winding country road that was now a part of a National Register of Historic Places—was on hold.

There wasn't much more to hear or to say. We left the office and drove home in silence most of the way. The stillness spoke legions. I couldn't wait to get back over the bridge, my Linus security blanket. Lots to digest quietly in a 45-minute ride home. The assimilation of urgency was choking—bucket lists of cleaning up relationships, end-time planning that we all like to put off, and the strategies of surviving financially, physically and emotionally. Many before me and many today, I thought, have been captive in such a contorting state of affairs with a range of disabilities, health issues, and timelines. I wasn't alone. Yet, I felt so isolated.

I felt sad for my Mary Catherine. This wasn't fair to her. And I couldn't fix it.

Dammit, I couldn't fix it!

The tool box was empty. I couldn't repair my brain. Ever. Not even with duct tape. All my adult life, I had relied on duct tape to fix leaks from the upstairs

bathroom in the kitchen ceiling, "repair" broken appliances, hang posters, fix a tail light, repair a garden hose ... and once, as a last resort, as an ace bandage for a pulled groin to get through the 5K Brew Run one hot August day in Brewster.

"How are you doing," I finally asked, as if from Mars.

My wife, as author John Gray might put it, is from Venus. I love Mary Catherine, but often she doesn't want to be confused with the facts; she seeks a safe harbor, as any good sailor does. I fly by the seat of



The author, Greg O'Brien

GREG O'BRIEN, of West Brewster, Mass., has more than 40 years of experience as a writer, editor, investigative reporter, and publisher, and is the editor/author of several books. He has contributed to, among other publications, the Associated Press, UPI, USA Today, and Huffington Post. He is the former editor and publisher of the Cape Codder and Register newspapers, and former editor of Cape Cod Life. This guest column is an excerpt from O'Brien's new book, "On Pluto: Inside the Mind of Alzheimer's" (Codfish Press, 2014), and is reprinted with permission.

my pants. I find reality far below the surface, bottom fishing for answers ...

"Well, we have a lot to consider," she said; it was an understatement that could fill the Grand Canyon.

I knew. Like me, she felt alone.

Then we came upon the Sagamore Bridge. That's when the faith kicked in—a bridge to a new reality, a new hope for me. I was going home, sanguine about the fact that I had some answers in hand. But for MC, it was new isolation this side of the Mississippi. Maybe her father was right. As we coasted to the crest of the Sagamore, "the seventh bridge of Dublin," as it's called Eire, given the number of emerald transplants on the Cape, I thought of John Belushi in the classic movie "Animal House."

"What? Over? Did you say 'over'?" the unrelenting Bluto Blukarsky declared at the Delta House, urging his brothers to fight on. "Nothing is over until we decide it is! Was it over when the Germans bombed Pearl Harbor? Hell no!"

Germans?

Hey, I was on a roll. So I charged over the Sagamore Bridge with a satchel of denial.

Life goes on, doesn't it?

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How Caregivers View Their Situation Really Does Matter

Written by
KEREN ROSENBAUM-COOKS, LCSW, QDCS



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Every caregiver can relate to the frustrations and heartbreak that come along with watching a loved one go through Alzheimer's disease or a related dementia.

While the challenges of this disease are very real, the ways we choose—whether knowingly or not—to view and feel about our life circumstances can greatly influence our actions and behaviors.

This cycle is at the core of Cognitive-Behavioral Therapy (CBT), an evidence-based treatment for anxiety and depression. And the results can be powerful. For example, a study of family caregivers of people with Alzheimer's disease who participated in a nine-week CBT group displayed lower levels of anxiety and improved sleep compared to a control group that did not receive the therapy.

According to CBT theory, when a person's thoughts become "distorted"—meaning that their thoughts are different from the reality of the situation—this process can cause a person to have upsetting feelings like sadness, worry and self-doubt. These emotions can trigger unhelpful or even harmful behaviors. Thought distortions can take many forms, and most people aren't even aware that they are experiencing them.

Below are some common thought distortions and strategies you can take to change this mental pattern and help prevent negative feelings and behaviors.

Overgeneralization or "All or Nothing" Thinking

What is it?

Overgeneralization is when you tell yourself that a single situation applies to all circumstances. For example, after hearing that a friend had a negative experience at a nursing home, you tell yourself, "All nursing homes are bad."

What's wrong with it?

This statement is not based in reality. While, unfortunately, there are some "bad" nursing homes, there are also many nursing homes that provide excellent care. By telling yourself that "all nursing homes are bad," you reject the possibility of obtaining a potentially-helpful resource before you even begin to consider it.

What can you do about it?

Be careful about using the words "always" or "never," and thinking, "it's all or nothing." Instead, try "some" or "sometimes." For example, instead of telling yourself, "All nursing home are bad," try saying, "While some nursing homes may provide a poor level of care, there may be others that provide a high quality of care."

Mental Filter

What is it? Mental filter is focusing only on the negative aspects of the situation while ignoring anything positive. A common example of mental filter in caring for people with dementia is, "My husband can't do anything."

What's wrong with it? While your spouse can't do some things, and can't do all of the things he used to be able to do, telling yourself he can't do anything may lead to your doing things that he, in fact, still can do for himself. This can result in more work and stress, and possibly also anger and resentment, for you; and boredom and a sense of uselessness for him—a recipe for behavior issues such as wandering or hoarding.

What can you do about it? Try saying to yourself, "While my husband can't do a lot of the things he used to do, let me see how I can involve him in something he still can do." By focusing on his remaining abilities, rather than his losses, you set the stage for a positive interaction. This may free up time for you, and help boost his confidence and self-esteem, while also preventing his development of challenging behaviors.

Discounting the Positive

What is it? Discounting the positive is when you tell yourself that good things "don't count." For example, you are your father's primary caregiver and you would like your sister to be more involved. When she offers to take him out for lunch, you think, "That doesn't really count as help."

What's wrong with it? By writing off your sister's actions, you don't allow yourself to appreciate what she is doing. She may then feel unappreciated, which can cause her to choose not to help at all next time. This can lead to more frustration, anger, resentment and disconnect all around.

What can you do about it? The goal is to shift the way you think, looking at situations as partial successes rather than complete failures. Try telling yourself, "I may feel disappointment that my sister didn't stay with my father for the whole day, but taking him out for lunch is a good start. It frees up some time for me, and is better than nothing." This acknowledges the reality that your sister is helping, even if her actions fall short in your mind. Focusing on what she is doing will make it easier to have a calm and respectful conversation with her about increasing her help, and may up the likelihood for her to agree. It's human nature for people to be more likely to offer to do more if they feel their current efforts are being acknowledged and appreciated.

Magnification or Minimization

What is it? Magnification is blowing things way out of proportion. Minimization is playing down the importance of something, by saying that it doesn't really matter. For example, if your grandmother is showing signs that it may no longer be safe for her to drive, telling yourself, "My grandma is going to die if we take the car away from her" is an example of magnification; thinking, "It won't really matter what I say about my grandmother's driving because it won't change anything anyway" is an example of minimization.

What's wrong with it?

By magnifying or minimizing the situation you are unable to act on addressing a real safety risk to your grandmother and others.

What can you do about it?

Instead of convincing yourself that your grandmother will die, try saying, "Grandma may be angry or even get depressed about handing over her keys, but I know that as a family we can work together to help her get through this transition." Instead of thinking that nothing you say or do will matter, try telling yourself, "While it may be hard to find a way to address my grandmother's driving, maybe there is some creative way to make this work." By thinking in a positive but realistic way, you will be better able to put plans in place. It also will give you a sense of hopefulness that what you do matters and that you can be successful.

Personalization

What is it?

Personalization is when someone (falsely) sees himself or herself as the sole cause of something that happens, or an external situation. For example, you have been caring for your mother for five years, and now your spouse wants to take you on a vacation. You say to yourself, "I'm such a bad daughter for even thinking about a vacation. If I go away and something happens to Mom, I wouldn't be able to live with myself. Besides, nobody can take care of my mother the way I can. What is she going to do without me?"

What's wrong with it?

The main distortion here is the belief that you are the only one who can provide good care for your mother. This is coupled with the false belief that by taking time to attend to yourself and your marriage something will go wrong and that it will be your fault.

What can you do about it?

Try saying to yourself, "Thinking about taking a vacation is really hard. While it's true that I know how to best take care of my mother, maybe I can share my techniques with others. If I set up a solid care team to fill in, chances are she will be OK, and if I allow myself to relax on vacation I will have more patience when I return." By shifting your thinking, you make it possible for others to step in and care for your mother—and give yourself space to relax with your spouse.

OBSERVE, ANALYZE, MODIFY

In order to better understand if you are automatically thinking distorted thoughts without being aware of them, try the following approach. It can either be used in the moment or after the fact by journaling, speaking with a trusted friend, family member or counselor, or simply reflecting on it in your own mind.

- **Observe** – What thoughts are going through my mind? What "story" am I telling myself about the situation? How do I feel about what is happening when I think these thoughts?
- **Analyze** – Am I jumping to the worst-case scenario? Am I using "either or thinking?" Is there something I can tell myself to help ease my distress in the moment? What evidence do I have that this thought is accurate/inaccurate?
- **Modify** – Is there another way that I can look at the situation? What might I advise a close friend if he or she were in my shoes? Are there any positive aspects of the situation that I might be overlooking?

KEREN ROSENBAUM-COOKS, LCSW, QDCS, is a licensed clinical social worker and project coordinator at the Alzheimer's Foundation of America.

Preventing the Unthinkable:

Get rid of guns and other deadly weapons in your home

Written by **DONNA COHEN, PH.D.**

This article may be a tough one for many of you to read. It deals with the real potential dangers associated with having guns or other deadly weapons in the home of a person with Alzheimer's disease or a related dementia, regardless of whether the person lives alone or with family members or others. A body of research over the past 10 years indicates two disturbing facts. First, there is a small subgroup of people with dementia who are capable of killing themselves or killing a family member or other person, sometimes killing themselves after killing someone else. Second, some caregivers, especially depressed spouses and adult children, may be at risk to kill their cognitively-impaired family member and sometimes also kill themselves afterward. Although these fatal events are uncommon, they have devastating effects on family members and the communities where they occur. And as the incidence of dementia increases, primarily in line with the aging population, only time will tell if the number of violent acts also increases.

Homicide and Homicide-Suicide in People With Dementia

JT, a 63-year-old woman with Alzheimer's disease and vascular dementia, shot and killed her healthy 93-year-old mother. JT had been upset and anxious, and was persuaded to take a nap by her own daughter. JT awoke about an hour later and came out of the bedroom with a shotgun, upset that she had not eaten lunch (although she had). After shooting her mother she then shot herself in the chest. Although JT was not expected to live, she did recover. She was charged with second-degree murder and released to her family on \$50,000 bail. Taking into consideration JT's declining health, including multiple strokes that worsened the dementia, the judge sentenced her to probation for one year so her family could continue to care for her.

FK, an 86-year-old resident in an assisted living facility, took out his firearm, and shot and killed another male resident, 89-year-old JB, in a common area. FK then walked to the room he shared with his 86-year-old wife, and shot her before turning the gun on himself. FK died at the scene, and his wife and JB died later in the hospital. FK had become increasingly upset and angry with JB for spending so much time with his wife. The evening of the killing followed a dance where JB danced almost every number with her. The tragic homicide-suicide was the result of an ongoing dispute among the three individuals, all of whom had dementia.

There are no national or state data sources to determine how often people with dementia kill. Since homicide and homicide-suicide rates for persons age 50 and older are very low, dementia offenders are probably rare. Studies

using newspaper sources by the Violence and Injury Prevention Program at the University of South Florida suggest that the occurrence of killings by a person with dementia range from one or two, to seven or eight nationwide each year. Ninety percent of offenders are men who kill a spouse or other family member (the other 10 percent are women who kill a spouse or other family member); 80 percent use a firearm; and 90 percent of these incidents occur in the home. When these killings occur in a long-term care facility, the victim is usually another resident. The acts are often violent—whether committed with a firearm or other available weapon. A 69-year-old man with dementia stabs his wife in the head with a pickax. An 80-year-old man beats his wife to death with an oxygen canister. An 85-year-old man stuffs a plastic garbage bag in the mouth of a bedridden girlfriend and smothers her with a pillow.

Although anger and aggressive behaviors occur in some individuals with dementia, it is difficult to predict when deadly violence will occur. The following factors are associated with increased risk for homicidal behavior in people with dementia: history of assaultive or physically-violent actions; history of serious alcohol abuse; a diagnosis of vascular dementia or Wernicke-Korsakoff's dementia (associated with alcohol abuse); active paranoia and psychotic symptoms, especially when the person reports hearing voices telling him or her to hurt someone; low tolerance for frustration; having access to firearms in the home; and having experience with guns in law enforcement or the military.

Regarding the military, the U.S. Department of Veterans Affairs (VA) recently began a public

awareness campaign about gun access and individuals with dementia in hopes of preventing suicides and other violence. A downloadable VA brochure recommends various safety tips (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2731).

Any number of factors can trigger homicide and homicide-suicides. In virtually all cases, these are not willful, intentional actions to injure and kill. Rather, they are the tragic outcomes of a combination of circumstances and problems: the person's sensory, cognitive and/or emotional impairments; the individual's fearfulness, anxiety, and difficulty communicating; the awareness of the risk of violence and preparedness of family members and others who interact with the person; environmental stressors, such as conflict or threats to harm; and the availability of firearms, knives, heavy objects, and other lethal means. Random circumstances such as sudden arguments, fights with a family member, losing or forgetting a favorite object, or jealousy or anger may intensify rapidly at home or in a long-term care setting when someone with dementia is frightened, angered, or has catastrophic reactions to other persons, events or situations (e.g., the person overreacts and misinterprets the actions of others).

Homicides and attempted homicides present challenges for law enforcement, lawyers, judges, mental health professionals, and government officials to balance the needs and civil rights of individuals with dementia and the need to protect the public. Law enforcement may be untrained and lacking policies and procedures to deal with these situations. Individuals with dementia are usually arrested, questioned and jailed for months because non-jail alternatives do not exist, and the jail envi-

ronment often leads to or worsens serious behavioral problems. A few communities have created programs in which prisoners are reviewed weekly to identify persons with dementia, screened for dangerousness, and relocated to another environment, such as a geriatric unit. Once a person with dementia enters the criminal justice system, attorneys and judges have to deal with considerations about the nature of the killing, the severity of the dementia, and the person's ability to stand trial (Cohen & Krajewski, submitted; Cohen, 2004).

Family Members Who Kill

*CS shot and killed his wife, AS, who had been diagnosed with Alzheimer's disease six years earlier, and then killed himself. Both of them were 81, and they had been married for more than 60 years. Several months before the homicide-suicide CS had contributed an essay to *The New York Times* describing their years together, and the last section focused on his wife's disease and his role as a caregiver.*

CC, killed her 82-year-old mother, ED, who had Alzheimer's disease, by beating and stomping her to death. Prior to this, CC had been a devoted caregiver for her mother for several years. CC was tried and found guilty of second-degree murder and was later sentenced to 30 years in prison, to be suspended after serving 14 years.

Family caregivers who kill violate ethical, moral and legal standards, and these occurrences have long-term consequences for families and society. More research is needed to develop a better understanding of the characteristics of these homicides in order to develop effective intervention and prevention strategies.

Over the past several decades, a number of homicides and homicide-suicides prominently featured in the media have stimulated time-limited discussion about the practice, morality, and legal disposition of family caregivers who kill a relative with dementia when there has been a history of a devoted, caring and responsible relationship between the parties. The case that marked the beginning of significant public interest in the U.S. was the trial of 75-year-old Roswell Gilbert (Gilbert v. State, 487 So. 2d 1185-Florida District Court of Appeals), who was convicted of first-degree murder in 1985 for killing his wife of 51 years, Emily, who had Alzheimer's disease. Gilbert was pardoned by then Florida Governor Bob Martinez because of ill health and released in 1992. He lived with his daughter until his death in 1994.

A review of newspaper articles, recently conducted in the Violence and Injury Prevention Program, of family caregivers who killed a medically-dependent relative in the U.S. from 2010 to 2013, showed that of 122 such acts—77 percent of which were homicide-suicides—25 percent of the victims were individuals with Alzheimer's disease or a related disorder, and

most of the offenders were male spouses or male and female adult children. Further, a study of U.S. newspaper articles from 2001 to 2004 revealed 13 cases in which a family member killed a relative with dementia, and all but one occurred in the home. Among the offenders, 54 percent were married men aged 71 to 88 who killed their wives aged 71 to 89; 46 percent were adult children, who were men with one exception, ranged in age from 41 to 60, and killed loved ones aged 65 to 85 (Cohen, 2004). Guns were the most common method used by spouses, and suffocation was the most common method used by adult children. In all cases the offenders had been long-time caregivers devoted to a loved one with dementia with no evidence of previous violence or maltreatment toward that person.

The available literature suggests that a significant proportion of caregiver homicides and homicide-suicides are the result of a coming together of factors that overwhelm devoted caregivers who have no history of violence or criminal offenses. Their decision-making becomes impaired by overwhelming stress, depression and other mental health problems, physical exhaustion, extreme frustration



A POINT

How common is it to find guns in the homes of people with dementia? In a recently-released study, researchers who conducted a chart review of 495 individuals who underwent initial evaluation for cognitive impairment at the Cleveland (Ohio) Clinic found that 89 of them had a gun in the home. Among them, 71 percent had dementia, 37 percent had delusions, and 17 percent had hallucinations, half of which were hostile hallucinations.

The researchers found no significant difference in the presence of dementia, delusions or other measures between the groups with and without guns—underscoring the fact, they said, that diagnosed individuals, their families and caregivers do not consistently remove guns from the households of people with dementia.

with the lack of knowledgeable physicians and other health professionals, the absence of available and affordable home-based services to support their efforts, and isolation from family and friends (Cohen & Grabert 2000). These multiple stressors fuel hopelessness and helplessness about the circumstances, which compromise rational thinking and consideration of other options, and prompt actions leading to homicides.



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There are indications that caring for someone with Alzheimer's disease or a related dementia heightens the risk of deadly violence by depressed older spouses and adult children (Cohen, 2004a; 2004b). Violence-producing factors may stem from the chronic burden of losing the battle to maintain the individual's functioning and manage distressing psychological and behavioral symptoms.

These experiences do not excuse killing, but they are a different set of circumstances and motivations relative to other killings by caregivers, such as homicide by neglect and/or abuse that may be motivated by a desire for financial gain as well as mental health and substance abuse problems; and intentional homicide and or homicide-suicide motivated by domestic violence, custody conflicts, severe

mental illness and substance abuse, and deliberate intent to commit a brutal homicide.

The way state prosecutors and judges deal with these killings varies. Only a few cases go to trial, and most offenders plead guilty to a lesser charge and are sentenced by a judge who may depart from sentencing guidelines. The punishment may range from second-degree murder to time served with community service. Adult children appear to receive harsher sentences than older spouse offenders (Cohen & Grabert, 2000).

There are several factors that suggest the possibility of an increased risk for a caregiver of a loved one with dementia to commit a violent act:

- An older couple has been married a long time, or the adult child is the primary caregiver, and frequently living with the person with dementia.
- Both the person with dementia and the family member have multiple medical problems, and the health status of one or both is changing.
- A move to a nursing home or assisted living facility is pending or under discussion.
- The older couple or adult child and parent are withdrawing from family, friends, and social activities.
- The caregiver and person with dementia have been arguing or there is talk of divorce or a history of estrangement.
- The caregiver is depressed and shows signs of the following: changes in eating or sleeping; crying for no apparent reason; inability to feel good about the future; talk of feeling helpless or hopeless, that the future is bleak or that there is nothing that can be done;

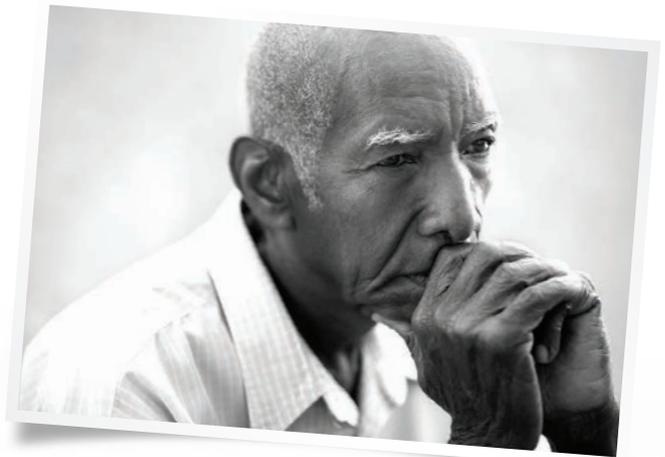
threats to harm the spouse; loss of interest in activities that used to give pleasure; anxiety and agitation; giving things away that are important to the caregiver; and making plans to give someone a key to the home.

Recommendations for Intervening If You Suspect a Caregiver Has Lethal Intent

If you have concerns that a family caregiver is thinking about killing the individual with dementia and/or possibly themselves, it is essential for the person to seek help from a medical professional to screen for depression and homicidal intent.

- **Do not be afraid to ask if the caregiver has thought about homicide or homicide-suicide.** You will not be giving the person new ideas.
- **Do not act surprised or shocked, or sound judgmental or critical.** This may make the caregiver withdraw from you—or even lash out at you. Continue talking and ask how you can help.
- **Offer hope that alternatives are available,** including help from physicians or hospitalization, as well as respite care and supportive services to relieve some of the stress of caregiving. Do not offer casual reassurance. It may make the person believe that you do not understand.
- **Get involved.** Be available to speak to the caregiver and assist in finding help. Show interest and support.
- **Ask whether there are guns in the house.** Ask the person what plans are in place to commit murder and/or suicide. The more detailed the plan, the higher the risk.

- **Remove guns, and ammunition, and other methods to kill.** As a first step toward disposal of weapons, contact a local law enforcement office to find out about a gun return program. Also work with law enforcement and healthcare professionals on ways to safely remove weapons without incident.



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- **Do not be sworn to secrecy.** Get help from persons or agencies that specialize in mental health counseling or crisis intervention, such as the National Suicide Prevention Lifeline.
- **Call for help in an emergency.** If you ever feel that your immediate safety or that of the person with dementia or the caregiver is at risk, call 911.

Advice for Family Members on Developing a Safety Plan

Deadly violence by individuals with dementia may be rare at this time, but these killings happen. There are a number of practical steps caregivers can take to help minimize or prevent violence:

- **After reading this article, do not think this cannot happen in your family.** Living with

dementia affects all aspects of life, and the possibility of a killing may not have entered your mind. However, it is important for family members to discuss the possibility, think about the warning signs and risks, and make a plan to prevent such an incident.

- **Remove firearms, and ammunition, and other lethal weapons from the home where a person with dementia lives.** Family members may need to meet together to figure out how many guns are in the home. The person with dementia may not want to provide the information or may not remember, and an older spouse may not know where they are. If a caregiver has personal firearms, they should be secured in a locked gun safe.



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- **Confide in your loved one's friends.** If your loved one was an avid hunter prior to the onset of dementia, it would be important for you to educate social contacts such as hunting buddies on the risks of individuals with dementia having access to firearms. Someone may sell, trade or lend a gun to your loved one, with the intention of helping out a friend, unaware of the potentially-disastrous consequences of this action. If you believe that your loved one may attempt to purchase additional guns, try to restrict access to large sums of money.
- **Learn about legal requirements.** Federal and state laws and policies regulate firearms. State laws vary widely on a number

of issues pertaining to gun safety, including reporting laws and limiting the ability of a person with mental health conditions to obtain firearms and ammunition. To learn more about gun-related laws, contact an attorney; the U.S. Department of Justice Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF); state and local law enforcement offices (e.g., police department, sheriff's office); or the Law Center to Prevent Gun Violence. If the individual has an illegal or unlicensed gun, inquire about gun amnesty or gun buyback programs in your community.

- **Get creative.** For many individuals who have been responsible gun owners throughout their lives, having access to a gun has

been a symbol of safety, security, power or independence. Introduce or increase activities that may boost similar feelings, such as a rummage bag or box filled with items like yarn, soft sports balls, or fishing gear that spark reminiscence and tactile stimulation, or a household "fix-it" task. If your loved one demands an explanation for the removal of a firearm, utilize a "therapeutic fib" or white lie (e.g., the firearm needs to be fixed, an adult relative wants to borrow it to go hunting). This may help reduce the individual's distress and help to preserve a positive relationship between you and your loved one. If hunting was an important social and recreational aspect of your loved one's life, consider other ways for the individual to stay connected, such as nature walks, hikes

or bird watching with hunting buddies. If the person is a former police officer or member of the military, it may help to join related social groups, such as the Policemen's Benevolent Society or Veterans of Foreign Wars.

- **Talk with trusted professionals and friends to get assistance.** There are a number of people you can contact to help you remove guns and other lethal instruments. Call your local law enforcement agency; many police and sheriff's agencies have special programs with officers trained in older adults and dementia, such as Crimes Against the Elderly Units. Seek assistance from staff at an Alzheimer's agency, Area Agency on Aging, Adult Protective Services office, hospital-based memory disorder center, or university memory disorder program in your area. Other contacts include the facilitator and members of a dementia support group, or a member of the clergy.
- **Talk with your doctor.** Do not hesitate to tell your doctor if you notice risk factors or if the person with dementia has threatened or hurt you. This is not something to be embarrassed about and hide from others. Indeed, it may save your life.
- **Call for help in an emergency.** If you ever feel that your immediate safety or the safety of your loved one or others is at risk, call 911 to have your loved one taken to the nearest emergency room for a psychiatric evaluation.

Conclusion

As the incidence of dementia skyrockets, it is all the more important for family caregivers and healthcare professionals to be aware of the risks that guns and other weapons pose and to put plans in place to prevent tragedies. Healthcare providers, law enforcement, and community agency professionals need to be proactive in screening people with dementia and their caregivers for depression and lethal violence. As well, family members, friends and neighbors need to be better informed about the risks of violent death and not be afraid to get involved and seek help.

Predicting violence is as difficult as predicting the weather. However, while no guarantees exist, it is possible to be prepared, know the possible warning signs, and be proactive. It can be the difference between life and death.

HELP

Law Center to Prevent Gun Violence

www.smartgunlaws.org | 415.433.2062

National Adult Protective Services Association

www.napsa-now.org | 217.523.4431

National Suicide Prevention Lifeline

www.suicidepreventionlifeline.org | 800.273.8255

U.S. Department of Justice Bureau of Alcohol, Tobacco, Firearms and Explosives

www.atf.gov | 800.800.3855

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A PERSONAL WALK ON THE DARK SIDE

Written by **MARILYN K. LABAKI**



Give me a description of what you know about Alzheimer's disease. Nine out of 10 people will tell you they visualize an elderly person, sitting quietly, with a blank stare of non-recognition.

What a majority of people are not aware of is the dark side of Alzheimer's disease—the potential for people with the brain disorder to turn violent at any stage of the disease. It happened with my husband. After several years of living with Alzheimer's disease, he didn't want me in his world: He couldn't recognize me. I was an intruder.

The psychologist thought my husband could be having flashbacks due to his Korean War service. Whether it was his makeup as a person who needed to be in control or a result of Parkinson's plus Alzheimer's disease that triggered the violence, I don't know.

I do know how hard the situation is to cope with. Without a lot of family support, I could not have kept him at home as long as I did.

I ultimately found it easier to go along with my husband's wishes than to try to make him understand reality. Distraction was my main recourse. When he would frequently wake up at night, he would want me to help him unload a truck, find something he lost, or address any number of things his troubled mind told him to do. At these times, I would suggest a warm drink or a snack. On many nights, we also had breakfast at 3 a.m. Usually, he would be distracted until the situation in his mind changed.

It was harder to distract him when he stood over me, and ordered me out of his home or "I would be sorry." Sometimes he held a book, a long-handled shoe horn, or whatever weapon he could find. After he passed away, I found a tire iron and two guns hidden in his closet.

It was against my nature to be afraid of my husband; I know now it was foolish to believe this.

My husband's mother and a brother both had Alzheimer's disease. Neither was violent. I didn't expect this to happen to my spouse. Some family members had a hard time believing what was going on. It didn't happen a lot when someone was here.

Our five children are all very supportive, but I was trying to do it all myself. My body finally caved in. I was hospitalized with shingles and blood clots that moved from my legs to my lungs. The family took turns staying with Dad. Now they knew.

When I got home from the hospital, I hung in there for a few months until one December day when my husband left the house while I was in the shower. I was panicking, and then one of our sons called to say Dad was there. I felt relief until I heard later how upset my son was over the things his father said about that "strange woman" in his home. It was the same day it all came to a head.

The boys knew I could not manage Dad alone any longer so they planned to be here. One son was here when my husband stood over me threatening me with his long-handled shoe horn. I do believe, for the first time, I was afraid. My poor husband didn't have a clue who I was.

Ultimately, after taking him to a hospital to undergo a mental evaluation, the physicians decided—and the family agreed—that he needed confined care and medication to control his violence so he could be managed in a nursing home. My husband was in a nursing home about one month when he started to decline. He had a peaceful passing. He had accepted his rest.

Now, I try to remember the good years. In time, maybe I will.

MARILYN K. LABAKI, of South Zaneville, Ohio, was married to her husband for 58 years. She was a hospice volunteer for 28 years before giving up that role to care for her husband full time. "Volunteering could have been preparing me to take care of him," she said, "but I found how different it was when it was my husband and my life."



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TASKS

Written by **MARGARET GIBSON**

The task of a human being is to transform suffering to joy.

- Sufi teacher

And along the way, there's housework.

Forget the computer, the checkbook, the inscrutable repair of whatever overheats or squeaks or ices over.

Never mind the wooden lamp post, rotten, fallen on its face like a corpse in the wet grass,

which needs to be cut. Your allotted

jobs are to dust, fold the laundry, tasks in which you take such unsung pleasure

I'm abashed. I'm sorting cutlery; I'm Job

in a bathrobe, wondering where oh where

in the wrong drawer you put it. "We'll make a good wife of you yet," I nearly joke.

But look at you: so happy, I bite my tongue.

MARGARET GIBSON of Preston, Conn. is the author of "Broken Cup," a book-length collection of poetry about "traveling the way of Alzheimer's" with her husband. She is the author of 10 books, including "Vigil," a National Book Award finalist, and is professor emerita at the University of Connecticut.

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STEP BACK IN TIME

It's only fitting that as we look ahead to the new year, we also step back in time—and engage people with dementia in activities from days gone by. Games, hobbies or even routines that speak to someone's younger years can help evoke familiarity, recall long-term memories, and enrich lives.

Here are some blasts from the past:

- 1. A CLOSE SHAVE:** Bring back a traditional brush and shaving soap that was part of a person's morning routine, rather than use a can of shaving foam and disposable razor. Some habits of a lifetime are well worth keeping alive!
- 2. DRESS FOR THE OCCASION:** Outfit the grandchildren in some vintage clothes and hats from a second-hand shop or the attic, and use these outdated fashions to start all sorts of conversations and memories about everyday clothes and special occasions.
- 3. A SPORTING CHANCE:** Try searching for vintage football or other sports programs, shirts or caps to relive the golden days of a favorite team. Some collectors' favorites can be very expensive, but others can be found for just a dollar or two, and libraries may stock books about teams' histories.
- 4. WOMEN'S WEAR:** Search online auction websites for vintage copies of women's magazines. While the latest publications may not be of much interest, copies that transport ladies back to times gone by with recipes, stories and fashion articles could be just the thing for an afternoon's reading.
- 5. PIECE IT TOGETHER:** Tackle a jigsaw puzzle—a very traditional pastime to do alone or with youngsters. Always consider the age appropriateness of the puzzles.
- 6. ON THE ROAD:** Reminisce about learning to drive, a first set of wheels, or day trips in the car by looking at books about cars from over the years.



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- 7. STAMP COLLECTING:** Dig out the stamp album in the attic and put this old hobby to work in a different way, as a reminiscence tool. Or create a new album. For example, soak stamps from envelopes and place facedown to dry; then, stick them onto a piece of plain paper and store in a binder.
- 8. PEN TO PAPER:** Take the time to write a traditional letter. If your loved one is not able to write, perhaps the person can dictate the contents, or just listen aloud while you share your ideas for a letter to a family member or far-away friend. Make an occasion of walking to the mailbox together, and always ask recipients to reply via the old-fashioned way so there is a response to look forward to.

This column is based on "As Easy as ABC: Care UK's Top 100 Hints and Tips for Activity Based Care," and is reprinted with permission.

DETAILS: <http://www.careuk.com/dementia-care/activity-based-care>



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