Communication: Communicating with Clients with Neurocognitive Disorders

What Is Involved in Communicating with Clients with Neurocognitive Disorders?

› Communicating with clients may involve the social worker providing information to the client (e.g., education, support, counseling), determining what information is most crucial for the client, and offering the information in a way that is easy for the client to understand. Neurocognitive disorders (previously known as dementia, delirium, amnestic, and other cognitive disorders in the DSM-IV) all have an acquired cognitive deficit in common, even if the presentation or cognitive domains (i.e., knowledge, comprehension, application, analysis, synthesis, and evaluation) that are affected are different. Common neurocognitive disorders include delirium, a substance- or medication-induced neurocognitive disorder, and major or mild neurocognitive disorder with etiological subtypes (e.g., due to Alzheimer’s, due to Parkinson’s, due to traumatic brain injury). These disorders can result in an altered mental status that can affect communication between the client and the social worker.

› The social worker needs to have an understanding of the DSM-5 diagnostic criteria for major and mild neurocognitive disorders (American Psychiatric Association, 2013)

• Major neurocognitive disorder has four diagnostic criteria:
  – Evidence must be present of major cognitive decline from a previous level of functioning in one or more areas of cognitive domain (e.g., complex attention, executive functioning, learning and memory, language, perceptual-motor, social cognition)
    - The decline is measured by the concern of the client, a knowledgeable informant, or the clinician
    - Clinical assessment or neuropsychological testing shows impaired cognitive performance
  – The cognitive deficits are having an impact on independence in daily activities
  – The deficits are not present only during delirium
  – A different mental disorder does not better explain the deficits

• Mild neurocognitive disorder also has four diagnostic criteria:
  – There is evidence of a modest cognitive decline from previous performance in the same domains as major neurocognitive disorder
    - There is a concern by the individual, a knowledgeable informant, or the clinician that there is a mild decline in cognitive functioning
    - Modest cognitive impairment is documented through clinical assessment or neuropsychological testing
  – The client is not incapable of independence in everyday activities but requires compensatory strategies, increased effort, or accommodations
  – The deficits are not present only during delirium
  – A different mental disorder does not better explain the deficits

• What: The social worker needs to assess which cognitive domains are affected and adjust the communication for the clients with a diagnosed neurocognitive disorder. Neurocognitive disorders may include issues with complex attention (e.g., difficulty concentrating when there are multiple stimuli, trouble retaining new information),
executive function (e.g., planning, decision-making, working memory, responding to feedback), learning and immediate memory, language, perceptual-motor skills, and social cognition (i.e., recognition of emotions).

**How:** The social worker must use active-listening skills, acknowledge the client’s feelings, provide reassurance and emotional support, and utilize therapeutic communication techniques to best communicate with a client with a neurocognitive disorder. Communication style, written materials, and informed consents may need to be adapted for a client with a neurocognitive disorder.

**Where:** Communicating with clients who have an altered mental status due to a neurocognitive disorder may take place in any inpatient or outpatient setting, the client’s home, or any location in which the client is receiving services.

**Who:** All social workers, clinicians, licensed staff, and non-licensed staff need to recognize cognitive limitations and be able to communicate effectively with a client who has a cognitive deficit.

### What Is the Desired Outcome of Communicating with Clients with a Neurocognitive Disorder?

- Effective communication between clients and social workers is fundamental to the delivery of quality care. The desired outcome when communicating with clients with neurocognitive disorders is for the social worker to establish a supportive, therapeutic environment and relationship with the client while ensuring that the client’s needs are met.

### Why Is Communicating with Clients with a Neurocognitive Disorder Important?

- Effective communication between a social worker and a client with a neurocognitive disorder will result in:
  - Improved quality of interaction, because the social worker understands the needs and limitations of the client who is exhibiting signs and symptoms of cognitive deficits.
  - Greater likelihood that the client and/or family will adhere to the treatment plan.
  - More effective education of client and family.
  - The client developing an increased trust and confidence in the social worker’s ability to help.

### Facts and Figures

Prevalence rates vary among different categories of neurocognitive disorders and can vary widely by age. Delirium in the overall community is between 1% and 2% (APA, 2013). In the population of adults who are over 85, this increases to 10% (de Lange et al., 2013). Living in a care facility, receiving medical care at home, being an older adult with dementia, or being older than 85 all increase the risk for delirium (de Lange et al., 2013). In 2015 approximately 46.8 million persons worldwide were living with dementia (Alzheimer’s Disease International, 2015). In adults over 65 years-old, the prevalence of dementia doubles every five years of age (Hugo & Ganguli, 2014). There are no documented prevalence estimates for substance/medication-induced neurocognitive disorders, but older individuals who have a history of longer substance or medication use are at increased risk (APA, 2013). Twenty-five percent of individuals with human immunodeficiency virus (HIV) will show signs and symptoms of mild neurocognitive disorder, and 5% will meet the criteria for major neurocognitive disorder (APA, 2013). Individuals with Parkinson’s disease are also at risk for neurocognitive disorders; up to 75% will develop a major neurocognitive disorder at some point in the course of the disease (APA, 2013).

### What You Need to Know Before Communicating with Clients with Neurocognitive Disorders

- The social worker needs to know how to evaluate the client’s mental functioning using a mental status examination. The most common is the mini-mental status examination (MMSE); if the client is demonstrating anxiety that may affect the results, the social worker can perform less formal testing. The protocol for this testing is relevant to social work responsibilities and is detailed in that section below.
- The social worker should use therapeutic communication techniques and strategies to foster a therapeutic relationship with the client to the best of the client’s mental ability. Therapeutic communication techniques include:
  - Making oneself physically available to the client.
  - Using open-ended, neutral questions.
  - Restating to the client the main content of the client’s communication.
  - Reflecting back to the client the emotional themes of the communication.
  - Helping the client to focus by asking questions that are goal-directed.
  - Seeking clarification of anything the client says that is not clear.
• Providing relevant information and education to the client that is related to his or her health, mental health, or general well-being
• Being comfortable with silence. If the client is not talking, the social worker should not speak just to end the silence
• Mirroring the client’s communication by repeating verbatim to the client what he or she has said
• Speaking slowly in short sentences and avoiding the use of professional terminology and jargon
• Maintaining eye contact with the client if this is congruent with the client’s cultural practices
• Summarizing the key points of the conversation
• Enhancing engagement through rapport, warmth, humor, optimism, and a commitment to the client as a person
• Tailoring communication to be as specific and relevant to the client as possible

There are specific steps the social worker should take to address and accommodate the client’s altered mental status due to a neurocognitive disorder. These include
• respecting the client’s personal space
• establishing privacy
• providing a calm, positive presence
• verbally acknowledging the client’s emotions and desires
• providing a quiet environment
• listening without arguing
• acknowledging and validating the client’s distress or concerns, especially since distress can be more evident when there is a neurocognitive disorder present

Preliminary steps before communicating with clients with a neurocognitive disorder should include
• reviewing the unit-/facility-/agency-specific protocol for communicating with cognitively impaired clients
• reviewing any orders from a treating physician
• reviewing the client’s medical history/medical record/mental health history to see if he or she has a documented medical condition, psychiatric condition, or is taking any medication that could contribute to or exacerbate his or her altered mental status

Social Work Responsibilities for Communicating with Clients with Neurocognitive Disorders

The social worker should complete a thorough biopsychosocial-spiritual assessment, including psychosocial functioning, coping strategies, strengths, and potential vulnerabilities

As part of this assessment, if any altered mental status is suspected the social worker may need to perform an MMSE, which is a questionnaire that quickly tests orientation, attention, immediate and short-term recall, language, and the ability to follow simple written and verbal commands. The most commonly used MMSE is referred to as the Folstein test named after its developer. The Folstein test is a 30-point test: 10 points are devoted to orientation, 3 to registration, 5 to calculation, 3 to short-term memory, 8 to language function, and 1 to constructional ability. Results of this test alone may not provide enough information for determining a neurocognitive disorder diagnosis; they may better be used in determining if a client is capable of signing consents or making treatment decisions

A more detailed or lengthy mental status examination may be warranted if more information is needed to determine a neurocognitive disorder diagnosis. A full mental status examination that is interview-based will examine the following areas for signs of cognitive deficits
• Appearance, attitude, social interaction, and behavior
  – Dress
  – Posture
  – Facial expressions
  – Rapport with interviewer and others
• Motor activity
  – Orderly versus agitated
  – Restless or hypoactive
  – Tics, tremors, convulsions
  – Involuntary movement of muscles
  – Inability to sit still
• Mood
  – Client’s sustained emotional state and overall general mood
• Affect or outward expression of mood
  – Normal, elevated, blunted, elated, flat, bewildered, anxious
• Self-concept
• Speech
  – Slurred, mumbled, spontaneous, mute, talkative, articulate, aphasic, repetitive
• Thought processes
  – Stream of thought, talk, and mental activity including form of thought processes, rate, and language
• Thought content
  – Is there selective attention, distortion of reality (e.g., hallucinations or delusions), or preoccupation?
• Intellectual functioning
  – Orientation
  – Memory, including recent, remote, retention, and recall
  – Intellectual capabilities
• Judgment and impulse control
• Insight
  For the specific determination of delirium, another option is the Confusion Assessment Method, which includes an interview, a modified mini cognitive test, and a digit span test
  • The mini-cognitive test first measures the orientation to time and place; then asks the client to name three objects and repeat them immediately; then has the client perform a clock drawing task; and finally asks the client to recall the three objects
  • The digit span test measures the working memory by listing digits and asking the client to repeat them. If the client can repeat four numbers without an error, he or she has a four-digit span
  • The social worker needs to ensure that he or she is not erecting counterproductive verbal barriers when communicating with the client. The following may be perceived negatively by the client and may escalate his or her fear and distress
    • Giving premature advice or suggestions can seem patronizing to a client with a neurocognitive disorder
    • Reassuring clients prematurely or without a genuine basis for hope when a neurocognitive disorder is progressive
    • Using sarcasm or humor that is distracting to the client or that minimizes the client’s situation
    • Judging, blaming, or criticizing the client
    • Lecturing or arguing with the client to try to convince the client that the social worker’s point of view is correct. Clients with a neurocognitive disorder can be sensitive to the feeling that they are without control of their situation
    • Using dogmatic statements (e.g., I know what is wrong with you; I know how you feel) or using jargon
    • Stacking too many questions together or using leading questions (e.g., You’ve been feeling confused, haven’t you?). Stacking may confuse clients who have an altered mental status
    • Interrupting the client excessively or at inappropriate times
    • Talking too much or dominating the conversation
    • Threatening the client
  When communicating with a confused client, the social worker should use the following techniques
    • Address the client directly even if his or her cognitive capacity is diminished
    • Try to gain and keep the client’s attention. Maintain eye contact
    • Orient the client by explaining who you are and what your role is
    • Consider meeting the client in familiar surroundings
    • Encourage the client to have a personal item with them for comfort
    • Acknowledge correct responses and provide support and reassurance
    • Use simple wording that is direct and do not layer questions or instructions upon one another
    • Open-ended questions may be difficult for a client with cognitive impairment, so carefully consider when to use them
    • Assess for any hearing and vision impairments that may be adding to the confusion
    • Use visual aids (e.g., diagrams, pictures) when appropriate during the discussion to reinforce verbal information
    • Consider utilizing direct physical contact (e.g., holding clients hand)
  • Social workers should practice with awareness of and adherence to the NASW Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. Become knowledgeable of and practice the NASW ethical standards as they apply to communicating with the clients with neurocognitive disorders (NASW, 2015)
Other Interventions That May Be Necessary Before, During, or After Communicating with Clients with Neurocognitive Disorders

› Note in the client’s record any successful communication, so that the information is available to other clinicians or team members participating in the client’s plan of care
› Alert any other clinicians or team members if cognitive deficits are suspected
› If the client’s cognitive impairment is chronic, short-term interventions for a presenting problem may not be effective. Considered long-term interventions

What Social Work Models Are Used for Communicating with the Clients with Neurocognitive Disorders?

› Communication with the clients with neurocognitive disorders will follow the therapeutic communication model outlined above

Red Flags

› If there is a suicidal threat made by the client, this must be considered an emergency. The treating physician or clinician needs to be informed, and the client may need to be evaluated for psychiatric inpatient observation or treatment and/or a mandatory psychiatric hold
› Be aware that formal cognitive testing can cause high anxiety to older clients. The social worker may want to save any formal testing for later in the assessment, present the testing to the client as being relevant to the client’s concerns, and provide support and encouragement to decrease the stress
› Ensure that medications and/or substances have been ruled out as being responsible for any altered mental status
› Lewy body dementia is a type of dementia in which psychiatric symptoms may be present before the motor or cognitive deficits. Social workers need to be aware that there may be physical causes for cognitive deficits in addition to the more common causes such as Alzheimer’s; any client who is experiencing changes in mood, behavior, etc., should have both mental and physical exams
› Head nodding and smiling does not necessarily indicate the client is understanding
› When attempting to communicate with a client who has a neurocognitive disorder, assess for the following signs that may indicate lack of effective communication:
  • Efforts made by the client to change the subject
  • Lack of questions after receiving information
  • A blank or confused expression and/or avoidance of eye contact

What Do I Need to Teach the Client/Client's Family?

› Use the therapeutic communication techniques outlined above to improve the quality of communication even if the client has an altered mental status due to a neurocognitive disorder
› Establish trust and rapport with client and family
› Educate the client and family on the utility of mental status examinations, especially with chronic conditions, to help track any changes in cognitive impairment
› If there is an etiological subtype of the neurocognitive disorder, ensure that client and family have the correct information about the condition and help them to locate the relevant supports
› Provide online resources such as HealthinAging.org at http://www.healthinaging.org/resources/resource:eldercare-at-home-communication-problems/ Dementia care Central at https://www.dementiacarecentral.com/caregiverinfo/barriers-to-communication/ Alzheimer’s Association at https://www.alz.org/help-support/caregiving/daily-care/communications

References


