

# Alzheimer`s disease persuasive essay

[Health & Medicine](#), [Disease](#)



Alzheimer's Disease does not kill instantly; it destroys the individual bit by bit, tearing away at their person-hood and self-identity. Most victims suffer for 9 to 15 years after onset of the illness. It is the most common type of dementia in the United States and Canada and after age 40, the risk of developing it doubles with aging every 5. 1 years during adults' life.

A form of dementia, the DSM-IV-R's (Diagnostic and Statistical Manual) criteria for diagnosing dementia include: impairment in short- and long-term memory, at least one of the following: impairment in abstract thinking, impaired judgement, other disturbances of higher cortical functioning, personality change, significant interference with work, social activities, or relationships, in addition, symptoms do not occur exclusively during the course of delirium; and specific etiologic organic factor is evidenced or can be presumed. For an individual with this terrible disease, living with memory loss and its associated disabilities are very frightening.

Alzheimer's includes behavioral characteristics that extend beyond its cognitive explanations. These behaviors require study because of the influence on both the patient and caregiver. Treatment often looks to drugs for relief of symptoms and to slow the course of progressive decline, rather than on assisting the individual with coping mechanisms. It has been termed a " family disease", not only because of possible genetic relation between victims, but because family members provide 80 percent or more of the care giving. Chronic and progressive mental and physical deterioration decrease the victim's capacity for independence and increase the need for support from family members caring for the victim at home.

The victim attempts to make sense of a seemingly new and hostile world, and this leads to dubious and uncharacteristic changes in behavior, personality, decision-making, function, and mood. Certain symptoms that are often associated with depression may be observed in patients who are cognitively impaired but not depressed. Professionals must be aware of all the symptoms the patient is experiencing, and reports from family members must also be taken into account. The patient usually reports fewer negative feelings or mood problems than are identified by caregivers.

Patients often attempt to cover up their disease by modifying the behaviors of others, rather than identifying their own inevitable retrogression. Fears of the unknown, fears of abandonment, lowered frustration tolerance, and loss of impulse control may result in problematic behavior. Also, appropriate behavior may simply be forgotten, and faces of family members and friends unfamiliar. However, the victim of Alzheimer's often denies these symptoms. More obvious, even to themselves are the expression of emotions such as panic and deprivation. Experiences such as early retirement and anticipated changes in the responsibilities of daily life are never realized. The inability to drive a car is especially painful and frustrating for some. Self-esteem and sense of worth plummet. Individuals with Alzheimer's lose their capability to plan, postpone, wait, or predict the outcomes of their actions. Family members very often fail to attribute losses similar to those previously mentioned to a disease. They tend to deny the existence of the disease.

Family members may go through a period of denial in which they make excuses for the patient, attributing the problems they encounter to normal

aging, stress, etc. Alzheimer's disease creates new demands on the family, who have to adopt numerous roles. The parent, once the primary caregiver to their children, is now like a child receiving care. Each family member defines the situation differently, but display common management behaviors that will be discussed further. Within these similar stages of management, reflection of individual attitudes is obvious due to unique interpretations of the stages.

The spouse is usually the primary caregiver of the patient, but when unable to provide the care necessary, an adult child is the most likely candidate.

These adult children fear that the disease terrorizing their family and destroying a loved one will be hereditary. Negative behavior changes that are undergone by the victim have major effects on the caregiver.

Mental health and life satisfaction of the caregiver seem to decrease rapidly, but according to Lisa Gwyther (1994), the key to minimizing these effects is to strategically change responses by the human and physical environment.

Changing the responses of the outside world, rather than attempting to change the responses of the individual with the disease helps to organize difficult changes.

Experienced spouses and wise families learn to distract the patient rather than confront them on their shortcomings. They should learn to enrich the victims' pleasure in each moment, spurring preserved memories and skills to maintain the victims' positive feelings of competence, belonging, productivity, and self-esteem. Consistent reassurance and unconditional love are vital to peace and harmony within the family.

The patient experiences degeneration of short-term memory, which often results in misplacement of objects and forgetting the names of familiar people. They have irrational or imaginary fears that make them suspicious of those closest to them, and they may accuse others of theft and/or infidelity. This is a source of increased frustration, confusion, distress, and irritability on the part of both the patient and the family. As a result, those involved may rely on alcohol and drugs to alleviate the stresses of coming to terms with the disease.

Many families of victims either fail to seek, or do not receive a correct medical diagnosis. They tend to become over-involved and angry, stages necessary in the process of adjustment. The family members attempt to counterweigh the losses experienced by the patient, because the deterioration is beginning to become obvious. Their anger, not necessarily with the patient, stems from the burden, embarrassment, and frustrations caused by the patient's behavior. Burden is reported to be highest in this phase of mild dementia.

When the spouse is the primary caregiver (in comparison with adult children or others), care is more complete, and less stress, conflict, and ambivalence are observed. Spouses tend to look for activities, or ways of interpreting the patients behavior, that allow for a continuing adult relationship, rather than a parent- child one, which may belittle the patient. Psychological stress results from conflict between resentment, anger, ambivalence, and guilt, self-blame, and the pain of watching a loved one deteriorate. Caregivers also report physical fatigue from providing care to their regressing loved one. Of all of

these, the most difficult is performing the basic daily activities for the patient, and coping with upsetting behavior.

Proactive approaches towards treatment of the disease involve the conscious decision that success is possible, both for the patient and family- unfortunately this is something that most afflicted individuals realize too late. In addition, the victims of Alzheimer's may or may not respond to certain types of intervention. A patient may react to one type of treatment one minute and not the next. Immediate, observable changes in patient and family behavior, function, and mood were noted when caregivers learned to separate the resolution of the problem from the intention of the patient. For example, rather than confronting a patient or assigning blame when an object is lost, the caregiver replaces the item the patient claimed "stolen". In this way, unnecessary stress and tension are eliminated for both patient and caregiver.

Each family member experiences a similar process of coming to terms with the changes. This process includes three stages: describing how the victim is the same, and/or different, prior to disease onset, rewriting the individuality of the victim, and redefining the relationship with the victim. During the first stage, family members look for behaviors that still represent the victims' "true" self, and those that the person with Alzheimer's no longer has. In the second stage, the disease and individual with the disease must be seen as two in one. Part of the struggle in this stage is to maintain the adult identity of the victim while managing their child-like needs.

Still, in the third stage of the adapting process, major problems continue to present themselves. These may include: family and social disruptions, increased marital conflicts, and employment-related difficulties. Family members are usually not aware of one-another's viewpoints; they do not understand that they are not all seeing the victim the same way. Due to the fact that they are not all having the same type of relationship with the victim, paths towards the common goal of attaining highest level of function for the victim may be divided. As a result, the more effort individual family members put into achieving this goal, the more conflict is created. However, if individuals voice their different perspectives and encourage discussion, this may allow the family to function as a complete whole. Understanding between family members can be coupled with social support groups' ideas about the disease.

A social network may be effective in protecting individuals with terminal diseases from some of the negative effects. An active organization, The Alzheimer's Disease and Related Disorders Association (ADRDA) established a network of individuals and families affected with dementia. The speed at which this network is growing is clear evidence of the need for more groups like it. Information sharing, encouragement, and provision of social support are among the top objectives of such groups.

A committee at the St. Louis Chapter of the Alzheimer's Association developed Project Esteem to provide emotional intervention for people with Alzheimer's in the Forgetful phase. Its purpose is to provide opportunities to

share thoughts and feelings with peers and professionals, and to have some fun.

It came about as two separate groups, one being individuals with Alzheimer's and the other, caregivers. Reported feelings related to dementia from both groups include: anger, anxiety, stress, acceptance, and frustration. The number of individuals who report negative feelings greatly outweigh those of acceptance.

At initial meetings, bonding is established through the sharing of early memory experiences. Gradually, comfort comes from knowing that the victims are not alone; there are others with the same limitations. The realization that the victims are ordinary people with a chronic illness, rather than an uncontrollable mental illness, is comforting. Overall, the most effective coping occurs when the individual recognizes their own mental change, realizes the diagnosis, and deals with the unexpected attitudes of others. Benefits of group support in this early stage of Alzheimer's are considerable. Individuals sharing similar situations gain insight and encouragement through verbal exchange; when real world suggestions were needed, and non-verbally; when words were simply not accessible. However, as word comprehension and creation becomes increasingly difficult, the individual enters a new stage of disease development.

Short-term memory, orientation, and concentration are now severely impaired. Throughout this stage, remote memory, intellectual functioning, comprehension, and judgement decline steadily. Ability to care for one's self also declines, and sleep patterns are altered; this is a severe blow to the



patient's independence and self-esteem. The patient then becomes suspicious and paranoid, even of those closest to them. Likelihood of involvement in accidents at home and abuse of medication increase. Behaviors may include night wandering, night shouting, and nocturnal micturition (night- time urination). Obviously, traditional family behaviors and interactive patterns realize drastic alteration.

Family members begin to feel guilty for their impatience and intolerance of the patient, even though many of the demands of the patient are unrealistic and illogical. A major problem for those closest to the patient is readjusting expectations of the patient and themselves. Changes and problematic behavior become a source of stress during this phase, but overall limitation and conflict is reported to decrease, which may simply be the result of institutionalization of the victim. Use of drugs is found to be twice as high in care-givers as in community subjects, and care-givers often let their own health deteriorate.

Particularly for the spouse's caregivers, social isolation becomes an issue of psychological well being. Lack of time, energy, and interest in social activities becomes prominent as the deterioration of the patient increases. In one study, spouses of patients exhibited higher levels of stress, in comparison to adult children caregivers; but husbands, in comparison to wives, report fewer burdens, and are more willing to admit the difficulty of the tasks at hand and seek out professional help. Adult male children are as likely as women are to assist their parents, but the men appeared to have the ability to distance themselves from the aging parent. This physical and

emotional separation seemed to lower the amount of guilt felt by the men. Possibly because of these differing abilities to deal with the disease, there is often conflict between family members as to how to care for the victim.

Two broad coping techniques of family members of Alzheimer victims are: (1) Distancing techniques and (2) Enmeshing techniques. Distancing techniques (as discussed earlier) involve establishing distance between the patient and caregiver both emotionally and physically. Enmeshing techniques involve the intensification of the relationship, and often the exclusion of others. This option is usually observed in cases where the spouse is the primary caregiver. Apparently, it is very difficult for spouses who use the Enmeshing technique to become involved in social support groups.

Social support is a proven mediator and alleviator of family stress and patient dejection. Adult day care programs provide respite for family members, and allow the patient to interact with individuals with similar conditions. Generally, the patients see the support group as being most helpful in the areas of information sharing and peer support. This information and assistance may help determine the strength of the individual in last stages of the disease.

This phase is the final stage of Alzheimer's disease. Mental deterioration is complete; many patients are completely unaware of, or unable to respond to their surroundings. The patients are totally dependent on others for all aspects of daily living.

The patient will, most likely, not identify family and friends, and may not communicate at all. Paranoia, agitation, and combativeness increase significantly, if the patient is able to display these emotions at all. He/she eventually becomes extremely weak, incontinent, non-ambulatory and bedridden. It has been hypothesized that at least some of the premorbid changes in strength and weakness may be predicted from changes observed in the earlier stages. Descriptions by caregivers of premorbid personality traits of the victim are similar to symptoms of depression, hallucinations, and delusions. It is during this stage that most victims are admitted to an institution for professional care. Several behavioral problems such as aggression and wandering appear to increase as individuals are moved from the community to nursing homes.

Acceptance of this disturbing disease comes very slowly to the family members. The disease's sly onset and the original appearance by the victim of retention of regular physical vigor make acceptance increasingly difficult. As the disease progresses further and further, the changes that occur for the victim become increasingly obvious and family members tend to define the situation more similarly than in previous, seemingly inconspicuous stages.

The grieving process is lengthy, because the death of the person is long before the death of the physical body. Although the loved one is long gone, their shell lives on.

At some point during this stage, the spouse must undergo the final challenge of marital evaluation. Because the patient does not recognize anyone, the spouse is totally alone, but not single. Obtaining a divorce often creates many

difficult legal issues. Many caregivers need assistance coping with the guilt of " abandoning" their spouse when placing them in a nursing home. Thus, financial problems come into the picture. Paying for nursing home services is difficult, as all effort in previous years has been put into caring for the patient.

Relatives of deceased victims can be compared to those whose family member is still living. Wives and husbands display similar feelings of burden, but the husbands report more social limitations. On the contrary, sons and daughters are different in their descriptions of burden. Sons report less social limitations than daughters do, and less affective limitation when the demented parents had died. The sons of the deceased elderly also report less conflict with others than the daughters do.

The need for individual support for the caregiver and family of the deceased is important, especially at this stage of sorrow. There may also be a sense of relief and release, as the extensive suffering of a loved one has finally ended. The empty body, which once contained a loved one, can finally be put to rest. Help and support from the staff at institutions with dealing with the grief of the final loss of a loved one is valuable and most definitely appreciated.

Alzheimer's Disease is a ceaseless debilitating disease without known cause or cure. Deterioration of mental and physical processes is inevitable, but varies between individuals- the cause for this variance has only been looked at hypothetically. It is a terrifying disease for the victim, who is constantly aware of the losses that are occurring, but can do nothing to prevent the

disease from proceeding on its deadly course. Family members respond to the disease within certain guidelines, but the attitude towards the different stages differs for all involved. Social support systems have proven extremely effective for both the victim and caregiver in the Forgetful phase of the illness. From that point on, influence on patients decreases significantly, but personal gain for caregivers continues.

There is an evident need for publicly funded support for Alzheimer's disease victims and their families. The obvious lack of information concerning the symptoms and results of the disease show the necessity for incorporation of education and support into intervention strategies for caregivers.

Evaluation of a patient with possible dementia requires a complete medical history, neurologic evaluation, and physical examination. At the present time, no diagnostic tests for Alzheimer's are available in laboratories.

It is simply a diagnosis based on elimination of other diseases. There is great need for a biological marker that would confirm the diagnosis of Alzheimer's in a living patient. Rapid progress has been made in identifying a potential genetic marker that could be used to diagnose the disease without autopsy, biopsy, or extended evaluations. Potential disadvantages of this approach would be the reluctance of both patients and physicians to have lumbar punctures done, and the potential overlap of normal patients and Alzheimer sufferers. These potential markers are a glimpse of light at the end of a dark tunnel.

Metaphorically, Alzheimer's can be seen as a house that is constantly being eaten by termites, from the inside out. Although the house may look the

same on the outside, the very foundation of the house, the part that makes it a home, deteriorates. Attempts to stop the decay are futile and, at best, temporary. Eventually, one will not feel comfortable at home, and will most likely leave the home- possibly for someone else to deal with. This relief is also temporary. The eating away of the house continues, until it eventually topples into an unrecognizable heap of what used to be a home. This feeling was best described by one individual in the middle stages of the disease: "... (J)ust a wild lost world. I'm here but I don't know where I am".