

# ALZHEIMER'S TREATMENT AND RECOVERY CURRICULUM

(VOL. 1)

Alzheimer's disease and Dementia are neurodegenerative disorders that result in the deterioration and death of brain cells. Mental and Physical stimulation promote the growth of new brain cells (and connections between cells).

This curriculum is a hands-on approach for *attempting* to treating Alzheimer's Disease by inciting mental and physical stimulation in the loved one / patient. Essentially: grow new neural networks to replace (or refresh) the lost ones. **"As much as you can" is better than "nothing at all", but "as much as humanly possible" is the amount of time needed to obtain the most secure results.**

Very few of the below treatments are "passive". **The only way in which this curriculum will work is if the individual treating the patient is more tenacious than the disorder.** Alzheimer's may likely be with the patient until death – will you? Properly completing this curriculum will require numerous months or years of potentially exhaustive mental and physical work. **Every free moment needs to go into this (within responsibility) as if somebody's life depended on it – it does.** Alzheimer's is not going to just get better on its own, and it doesn't disappear just because it's not directly in front of you all of the time. If you want to reroute your patient, friend, or loved one from deterioration, YOU will have to be the determining factor.

The most important part of this entire process is to unburden tension – knowing you can and will do everything humanly possible, and to have fun. The reason you're catalyzing this person's (potential) recovery is because you care about them in the first place. **Recall the emotional foundation of your relationship with this individual, and center 100% of your interactions on the very best rapport you've ever had with the patient / loved one. Life is about fun productivity, and old age is about fun alone (earned through a lifetime of productivity). If you fail to treat the person, but you bring them joy: you have succeeded.**

The most dominant emotion/disposition is always the one that sets the standard of the entire room – if properly expressed. If you're a bundle of joy, or serenely calm – and treat everything in life as a positive thing – this will put the patient at ease. At times, Alzheimer's patients may remain quiet and follow the lead of whomever they're with (for the sake of not revealing to others that they are a bit lost). **Nothing can be more comforting than being in the presence of invincible good-nature. The presence that you're to convey is (hopefully) nothing but the honest truth: "no matter what, I still love you".**

This presence transmutes mistakes from a source of embarrassment, to a source of merriment. This presence negates, neutralizes, and ultimately, starves offensive behavior. Mental and Physical insecurities are always the source of any individual's unhappiness. The feeling of being unconditionally loved and/or respected provides mental security.

The most important principle of this entire curriculum is this:

**"Perhaps, just perhaps: you can cure your loved one of Alzheimer's through your own efforts.**

**Even if you can't cure it, you can treat it.**

**Even if you can't treat it, you can do your best – you can try to.**

**If nothing else, you positively CAN make your patient or loved one happy."**

The last one is the most important part. You are one who cares enough to try. Even if you can't commit a lot of time to it, you can commit a little bit here and there. You are one who fights for your loved ones; this fight is just in an unusual form. It requires more mental endurance than it does physical endurance. It requires patience, but you have the potential to save a life in the most literal sense.

The content below is not in any particularized regimen that needs to be followed exactly. Add and omit as you see fit according to the factors and circumstances of your situation. Color outside the lines, or create new ones (and color those). Do what works. **Do what will make the patient or loved one happy** (within morality and legality).

\*The writer of this document is not a doctor nor medical professional. This is an ongoing attempt at civilian-capable treatment of Alzheimer's and Dementia. I believe in "doing whatever I can, as best as I can" – and I think you, reader, believe that too. This document will be continually updated over time. As of now, this is the best I got. Follow or disregard the below suggestions at your own discretion. Do whatever you can – as best you can. Whether you succeed or not: you will be proud of yourself for the rest of your life. Good luck.

\*\*If you discover any new methods of treatment (through activity and/or enjoyment), please send those suggestions to [Theupwardeducation@gmail.com](mailto:Theupwardeducation@gmail.com) with a title like "ATMS - Alzheimer's Treatment Method Suggestion."

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# NEURO-REJUVENATION METHOD

THE GIST AND SCIENCE OF NJUV

**The principle idea behind this entire document is as follows:**

1. Neurogenesis is the growing of neurons. Synaptogenesis is the growing of connections between neurons. Each can happen when you learn new things and exercise.
2. All of the activities of your body, and thoughts of your mind, are biochemical reactions between cells.
3. The activities and thoughts of your day determine the physiological shape of your mind.
4. Alzheimer's and Dementia are results of neurological decay.
5. Through mental and physical stimulation (like learning and exercise), the patient / loved one can grow new neural networks to replace the deteriorated ones, and grow new synapses to replace decayed ones. \*Synapses are connections between neurons.

**Targets for Neuro-Rejuvenation (N-JUV) Method:**

**Do not expect recovery.** Alzheimer's Disease is officially classified as "incurable". Treatment will be very trying on your patience (long-term and short-term). But if you see "enjoyment" as the objective, and "recovery" as a potentially probable happy accident: **you can look at the treatment as "productive, quality time" spent with a loved one / friend / patient.**

That being said...

**Here are the potential aims / identifiers for recovery:**

1. **Halt or slow neural decay.** Neural decay is accentuated by inactivity.
2. **Introduce neurogenesis into circadian rhythms,** and increase the rate of it over time.
3. **Bring enjoyment to the patient** regardless of his/her mental state.
4. Re-establish **independence** in daily activity (through reinvigorated cognitive capacity)
5. **Re-establish lifetime chronology.** Patient can recall past, but no longer lives in it.
6. **Fluidity of thought and speech** reestablished.
7. **Improved physical range and competence.**

YOU are the instrument in this cure. If you're polluted with mental baggage, you put your patient's state of mind at risk. The patient can and will be trying at times; they can't help it – but you can. For as long as you are around the patient, you have to be the embodiment of "Relentless Positivity". That doesn't mean bouncing off the walls, but it does mean *no negativity*.

Desired results are not guaranteed (obviously). Do your best for as long as you can, and as long as you are able to. Going for it and not succeeding is better than not going for it at all. **You should know that failing to recover the patient is going to be the norm. Recoveries will be the exceptions.**

**DEALING WITH MISUNDERSTANDINGS, CONFUSION, AND/OR CONFABULATIONS**  
**CORRECTION** or **INDULGENCE & REDIRECTION** are the best possible options in all cases of misunderstanding, confusion, and confabulation.

- If correcting the patient doesn't work, indulgence would be the best option.
- Indulgence is very rarely the best first-option (unless known from experience that correction results in mental trauma). Indulgence is the contingency to correction.
  - Redirection is ensures that you will not be wasting too much time on indulgences.

Every comprehensible statement the patient makes is a key into understanding their current mindset or thought process – even if the statement may appear to be irrelevant, false, or invented.

# THE SCIENCE BEHIND NEURO-REJUVENATION

If you want to skip the science below and get straight to the Treatments, here are the terms needed to understand the rest of the document beyond pg. 13:

**Neurons:** individual units of the body's electrical system.

**Synapses:** connections between neurons.

**Neurogenesis:** growing new neurons.

**Synaptogenesis:** growing new synapses.

**Neural Networks:** Interlinking neuron chains that collectively interact to conceptualize a thought (in the brain) or action.

**Circadian Rhythms:** Your body's operational rhythm, established by daily activity.

**Mental Stimulation:** Generating activity in the brain beyond its baseline while at rest/relaxed.

**Physical Stimulation:** Generating physical activity in the body that is beyond its baseline while at rest/relaxed.

**Long-Term Potentiation:** The process of synapses growing stronger due to constant activity.

## NEUROSCIENCE

Rather than paragraphs, perhaps this information is best delivered with a few key points.

- Neurogenesis is the process of growing/creating new neurons in your brain.
- Neurons are the interlinked cells of the brain that transmit electrical signals to generate thought and action. Synapses are the connections between neurons.
- **Every single thought, idea, and action you have is a biochemical process involving the neurons in your brain (and body). Every conscious thought is a biochemical action in your brain.**
- Every moment of existence is registered as a series of neural networks communicating with each other. All of the concepts / aspects / factors that we are aware of have not only one, but several neural networks associated with them.
  - New and novel experiences are rendered through activity of existing neurons; it's just that those existing neurons are firing in a new pattern / network.
- **Certain activities and experiences trigger neurogenesis and synaptogenesis in the brain. This curriculum seeks to utilize both neurogenesis and synaptogenesis to rejuvenate the brain of the patient (through mental and physical stimulation).**
- **If lost networks cannot be recovered and revitalized (due to neural decay), perhaps they can be replaced enough to restore lucidity and independence.**

Increased activity from healthy neurons and neural networks can spread that vitality to the surrounding area. Neural activity is what promotes neurogenesis and synaptogenesis. The antennae (dendrites) and transmission tunnels (axons) of neurons are capable of branching out in all directions and forming connections with thousands (and sometimes tens of thousands) of other neurons.

### TLUVI #2 – Potential Excitement

If you're interested in learning more about neuroscience on the cellular level, here is a reference to a visual encyclopedia on the subject.

[www.theupwardeducation.com/tluvi-posters](http://www.theupwardeducation.com/tluvi-posters)

### TLUVI #2 – Medical Reference

If you think you may be interested in joining the fight against Dementia – or any neurological disease – here is a free reference that lists every neurological disorder, and explains how each manifests itself on the cellular level (referencing the TLUVI #2 poster as a visual aid). It is the first thing you need to know about the disease/disorder that you will be combating.

[www.theupwardeducation.com/teaching-content](http://www.theupwardeducation.com/teaching-content)

## CIRCADIAN RHYTHMS

Circadian rhythms are the biological patterns of your body on the daily basis. The amount of mental and physical work you do over the course of a day has a direct impact on the amount of energy that you will have on the following days. Increased mental and physical work raises the standard and provides more energy per day. Decreasing work lowers the standard, providing less energy per day.

In Alzheimer's patients you must slowly increase their mental and physical workload so that they start becoming more mentally and physically healthy. A potential sign that your efforts may be working is an increased appetite in the patient.

## EPIGENETICS

The thing that differentiates cell types from each other are the genes that they have turned on or off. Epigenetics is the subject concerning how genes are expressed in the nucleus.

The activities of daily life (such as eating, sensing, and exercise) can alter the expression of genes. Our body responds to the necessities of our life on the cellular level. This response is dictated by the your interaction with the environment. You have considerable control of your own interaction with your environment, which means you have some say in how your genes express themselves, and how your body behaves.

Neurogenesis is triggered by the appropriate genes in neural stem cells – and other brain cells – being activated. The migration of new neurons is determined by the amount of activity in that particular region of the brain that is to be the destination. The increased activity is a party that the new neuron can 'hear' from far away.

The environment influences the body, and you have direct influence over the environment of the patient. The stimulating influences in the environment could stimulate beneficial cellular processes that were previously dormant.

## AMBITION-BASED TREATMENT (ABT)

**Psychological Component:** Ambition is the fountain of youth. One is truly young when one is willfully applying mental or physical effort to accomplishing a task.

**Neurological Component:** The critical thinking required to earn any short or long-term ambition is a way to "keep alive" a manner of lucid thinking that is necessary for independence and mental health.

It is important for the patient to complete objective-based tasks in an unhurried and unimposing fashion. Start them on the task(s) and encourage them, but set no completion date. They should work on X only as they are available to do so.

**Take an inventory of the patient's interests, hobbies, and potential ambitions, and start working with them on the daily basis to make progress towards numerous checkpoint accomplishments leading to whatever the ambition is.**

If they don't seem much interested in the future, then commit your time to their fun and comfort in the present. **'Ambitions' will vary in scale from the minute to the far-fetched; most will be small scale. Consider every ambition a possibility, and begin the process of improvement/training/etc. according to the time and resources you have available to do so.**

**THE PROCESS IS THE TREATMENT, NOT THE ACHIEVEMENTS.**

## SHORT-TERM AMBITION

- Short-term ambitions can be considered those that can be completed anywhere from a few minutes, a few hours, a few days, or a few weeks.
- **Short-term goals may take significantly longer than you (or patient) anticipate.** An activity that you expect to take only a few minutes could end up taking many hours, or the entire day. So long as the patient retains cognizance of the thing that they are looking to accomplish, give them the time (and assistance) to do so.
- What can be considered an ambition?
  - Anything that the patient wants to get done (and cannot be done in less than 5 minutes) can be considered a short-term ambition.
- **Short-term Ambition ABT involves motivating the patient to exert mental and physical efforts in order to accomplish a task(s) that is not a part of their normal routine.**

## LONG-TERM AMBITION

- Long-term ambitions are ambitions that it would require a month or more to complete.
- Any American (of any status) with a working brain can build their own bridge to their desired achievements. Set up realistic checkpoints (starting small) that lead up to certain milestones, which lead up to the ideal.
- It SHOULD take forever to accomplish. It's essentially encouraging the patient: "Do everything you've always wanted to do. Starting with Step 1."
- **Long-term Ambition ABT involves taking an extensive inventory of the patient's 'bucket list', and getting them started on each achievement (one at a time) – in the same way you'd help any friend accomplish his / her goals.**
  - A 'bucket list' is a list of things that an individual wishes to do before dying.

More severe cases (of dementia) may not be applicable for Ambition-Based Treatment because the patient is uninterested in future activity(ies). In such cases, use Itinerary-Based Treatment (IBT) instead. Cognitive improvements as a result of IBT may make ABT a viable option in the future.

## ITINERARY-BASED TREATMENT (IBT)

**Psychological Component:** Many – if not most – seniors with Alzheimer's might not be too interested in 'ambitions' (regardless of the scale). Perhaps they've already done what they wish to do in life. The only thing left for them to do is enjoy themselves in every moment. IBT seeks to make such enjoyment productive. Mental and physical exhilaration is the point of IBT (whether goal-oriented or goalless).

**Neurological Component:** Muscle memory is your instinctive ability to perform actions that you have performed several times before. Whether the patient remembers the actions or not, **the actions performed during IBT – if done on a daily basis – will result in Long-term potentiation (LTP) and muscle memory.** If their mind doesn't consciously remember the activity, their body instinctively will. LTP and muscle memory are proof of neural activity.

Take an inventory of patient's interests and hobbies, and develop various single-day itineraries that are filled with the type of activities that the patient enjoys. Segment the day into sections, and plan what activities the patient will be doing on those days. Work on one itinerary at a time. The activities of Itinerary 1 can be the only one used for a month or more. This gives time for new circadian rhythms and muscle memory to develop. \*Developing such LTP may take several months.

The patient does not have to rigidly do a specific thing at a specific time (though it is probably best if each activity occurs at relatively the same time). Consider the itinerary a list of potential activities, and if they feel more inclined towards an activity (even if it is scheduled for later), let them do as they wish (seeing as the main objective is "fun", for them).

Plan the itinerary according to the wake-rest schedule of the patient. All activities should be planned for only when they are awake. Do not pressure patient to stay awake to complete an activity, but allow them to stay awake if they insist on continuing (when it is usually time for them to sleep).

A sample itinerary would look like any regular daily schedule.

24 hour Day	
Morning 6:00am – 6:30am	Music & Exercise (light)
Morning 7:00am – 8:45am+	Narrative recitals
Day 9:15am – 11:00am	Video Games
Day+ 11:00am – 4:00pm	Misc. Hobbies / Activities / Music / Exercise
Evening 4:30pm – 6:30pm	Narrative recitals
Evening 6:30pm+	Journal and Music

\*Tailor the itinerary according to the disposition, cooperation, and interests of the patient. It could feature more or less activity than the sample above.

Over time, add more light exercise here and there (between activities) to get the body used to expending more energy within the usual routine. Instigate narrative recitals (explained in Treatments section, below) as often as you can do so without being an annoyance to the patient.

[Itinerary-based treatment \(IBT\) involves inciting new LTP and muscle-memory by filling a day with activities that provoke mental and physical stimulation.](#)

[If memory is not retained on the daily basis, follow the exact same itinerary every day until noticeable familiarity comes with the activity on the “first try”.](#) After this point, introduce a new activity into the itinerary (in ADDITION TO – not replacement of the old one). **The LTP-established activity must remain part of the itinerary until the patient consciously remembers (and asks for) it without provocation.**

## DIFFERENT PEOPLE BEHAVE DIFFERENTLY

People with Alzheimer’s cannot all be classified into one type of behavioral group. Each person will act differently according to his/her character. The baseline traits of a person’s character do not go away (even if they’re not always apparent at times). These traits can be utilized in a positive way to contribute towards recovery.

# CONSIDERATIONS DEALING WITH DEMENTIA

Alzheimer's Disease is a form of dementia.

The more active your brain, the closer your brain cells (neurons) get to each other, and the more efficient they become – this is long-term potentiation (LTP). Alzheimer's is the weakening, separating, and dissipating of brain cells and their connections.

The brain of the patient is on a free-fall trajectory of neuronal decay. This has not been proven to be a permanent thing; this is possibly something that can be fought and beaten definitively.

If it were this easy, why isn't everyone doing it?

Because this information is not common knowledge; and even if it was, not everyone will have the time for what is required. **The amount of time necessary for this curriculum to work cannot be emphasized enough.** Eventually, the behaviors incited in the treatment will become habitual to the patient, but that will not be happening any time soon.

Death is inevitable for everybody. **Your goal is for the eulogy of the patient to be:**  
**“He/she died getting younger.”**

That's a eulogium anyone would be proud of. And what better feeling for *you* than to know that you had some part in it. If you're willing to give it a shot, here are some things to consider.

## KEEP IT MOVING

Seeing as you know good and well that the patient cannot control the many inconveniences that they may cause you, there is only one way to respond to such inconveniences:

**Clean it up, and keep it moving.**

The patient has caused some sort of accident – so what? It isn't the first time and it won't be the last. Give the patient appropriate comfort (through dismissive playfulness), give the patient advice on how to not do X again (if applicable), and keep a lookout for such behavior in the future.

Mentally prepare yourself for what you might have to do, and run through mental simulations on how you might do it. You may have to:

- **Clean up spills:**
  - How would you clean up spills on each room of the building? What would you use? Where do you keep it? How long would it take? What motion/movement would it involve?
  - Has it happened before? What was the cause? How can it be avoided in the future?
- **Witness and have to clean up broken items:**
  - What items are most at risk for an accident?
  - Which items in which rooms are the most susceptible? What would you use to clean it up? Can you afford another one? Can you prevent the breakage of X?
  - Has it happened before? What was the cause? How can it be avoided in the future?
- **Search for the patient because they have wandered off:**
  - Where do you think they might go?
    - Locations that they frequent may be good places to start, but remember they could also be wandering randomly, or steered by the fiction of a confabulation.
    - What means of perambulation did they use?
      - If they used a vehicle, you may want to call the police if they are not qualified to drive.

- Where were they seen last? By whom? When?
  - What direction were they going the last time they were seen?
  - Did they say anything when last seen? What did they say?
- **Have to repeat things over and over again.**
  - Set your “patience meter” to “unlimited” and hold it there with both hands.
  - At times it will seem you are talking to a brick wall. Stay polite and laugh it off.
- **Help with personal and private activities:**
  - Getting dressed / Using the restroom / Washing up / showering / bathing /etc.
  - Imagine you were in the position where *you* needed help with such activities. How might you feel about receiving aid?
    - **Always keep the dignity of the patient in mind for everything that you do.**
- **Have to clean up human waste due to incontinence.**
  - Both urine and feces, and perhaps in unusual places.
    - How would you do that? What would you use? Where do you keep it? Mentally go through the process a few times from beginning to end.
      - Doing this even ONE TIME will desensitize you to the real thing (should it occur).
  - Are there any measures you can take to prevent this in the future?

Do not allow any of the above to make you bitter, resentful, or frustrated. **In the long-term (of your life), X situation is only a minor inconvenience.** When dreading the action necessary, snap yourself back to reason with this, “...and I was never heard from again.”

“I didn’t want to do it, but I had to get the urine out of the carpet – so I tried...and was never heard from again...” Once you complete the task, raise your arms in triumph knowing nothing in the universe can hold you down. They said you weren’t gonna make it! They said you couldn’t do it! But look at you now!

## KEEP IT FUN

The ideal experience is one where both you and the patient are having a good time. The term patient is used for clarity throughout the document, but you should see all treatment methods below as something you’ll be doing with a *friend*.

Do not behave towards the patient as if he/she is actually a patient that you are nursing. They’re a loved one you’re trying to comfort – and treat, if possible.

If you are in a bad mood, it may be wise to occupy the patient with a passive treatment (instead of a cooperative one you had planned) – at least until you calm down.

Your attitude will be the defining factor in how well you handle the treatment. If you consider all inconvenient symptoms as ‘character quirks’, you will have a much easier time dealing with them. If your situation were looked at from the genre of “comedy”, than furrowed brows turn into facepalms.

## YOU ARE SPEAKING TO AN ADULT

Even if their dementia is severe, if the patient is ever lucid, it means that he/she is capable of understanding tone of speech – if not the content. Even if it seems natural (due to their behavior), try your best not to speak to your elders like children. Either talk to them like a friend, talk to them like family, or talk to them as if you were speaking to a gentleman/gentlewoman.

Do not alter from this tone unless you know for a fact (from experience) that X tone produces a better result when the patient is unresponsive – or in a contentious mood. It can be embarrassing and humiliating for an elder to be talked down to as if he/she were a child. Most cases of this are accidental. Now that you know to look out for it, you have a better chance of avoiding this mistake.



## QUESTIONING ABOUT INTERESTS

Ask open-ended questions (that must be answered with continued speech).

Do not ask questions that can be answered in one or few words. When speaking of their interests and what they like doing, try to get them talking for as long as possible. The best possible answer you can get from a patient is one in which they continue to talk on-and-on-and-on about something from the past. \*Severe cases may not be able to expound on the past at all.

All answers and all (discernible) speech from the patient is a window into their thoughts. Use follow-up questions to keep the activity (of the neural networks) alive in the brain of the patient.

**If the patient is seeming to struggle with recalling answers, begin asking “Yes or No” (or 1-word answer) questions.** Ask follow-ups to answers to ensure that the patient understood what you were asking them. If they didn’t – or seemed not to – fill them in on what you mean in a casual and conversational way with the undertone of, “I’m sure you already know this, I just like talking a lot”.

If the patient is inclined to answer (and if they do not find it too bothersome), you cannot ask this question enough times:

“What are you thinking about?”

Every answer to this question is important. The more often it’s asked, the more important the answers become. Such answers – accumulated and analyzed over time – can convey patterns of thought and ideas of the patient. Understanding of such thought patterns will only aid treatment.

## QUESTIONS ABOUT LIFE

Part of this curriculum involves you questioning the patient on many things (past, present, and future). When questioning them about the past, you are trying to stimulate them mentally by requiring the mental effort needed to recall the past (and narrate its contents). In addition to this, you are also trying to recall / revitalize any adjacent memories that may be associated with the excerpt in question.

Just because the patient normally forgets X circumstance, issue, or time period does not necessarily mean that the neurons in its neural network are totally destroyed. You know from experience that thinking about one event of the past can cue (and queue) up adjacent memories.

When you ask the patient questions, your goal is to keep them talking for as long as possible (and listen to everything they say as clues to help you tailor your NJUV treatments).

If you find that such interviewing does not come natural to you, use the classics (in reference to X conversation):

- Who?
- What?
- When?
- Where?
- Why?
- How?

If you believe that their answers are confabulations: try to reroute the conversation to different subjects until you find one where they speak realistically.

Some patient’s with dementia are conscious of it. Even patient’s that are not conscious of it can become highly stressed out from the realization that they are missing memories. **It is important to pay very close attention to the temperament and emotional state of the patient – to make sure that you don’t provoke embarrassment (or any similar emotion) with your questions.**

Do not bring more stress into their life by making them conscious of their dementia. If you see that they are forgetting something (and upset about it), tell them the honest truth: “I forget stuff all the time, too. Don’t worry about it...” (or some form of this) and reroute the conversation. **If you want to make a patient feel comfortable about his/her symptoms, let them know that they are not alone in their forgetfulness.**

## CONFABULATIONS

Confabulations are fictional thoughts or memories that are meant to replace absent or missing information. The most common causes for this are:

- **Accidental Confabulation:** Not knowing that they are fictionalizing, and doing so automatically to fill-in-the-blank of their thoughts and/or speech.
  - For the most part, all confabulations are accidental.
- **Embarrassment:** from not being able to recall X.
- **Thoughtlessness:** not feeling like spending mental effort to recall X, or not wanting to disrupt the conversational fluidity.
- **Cover Confabulation:** to hide wrongdoing – also known as lying. The difference here is that an **intentionally created confabulation can actually become something that is earnestly believed (later on) due to the mental disorientation and uncertainty of the patient.**
- **Compulsivity or Convenience:** Patient used to lie for the sake of convenience in early life, and continues to do so in latter years. You may be able to tell the difference between a lie and a confabulation by observing the demeanor of the patient.

If you want to be right all of the time, assume all confabulations are accidental rather than intentional. It is absolutely guaranteed that most confabulations WILL be accidental / innocent.

The imperative for conversational fluidity is more powerful than the imperative to tell the truth. The literal purpose of the human brain is to “make sense out of things”. If you give a human being a nonsense sentence, that human will interpret it to have meaning based on previously existing knowledge of the components of that sentence. The patient does not consciously know that the neurons along X neural network have decayed; their brain simply fills in the gap with whatever thought processes are nearby (and confirmation bias conserves the fiction).

Confabulations may often be reflections of some form of art/entertainment, or reflections of hypothetical thoughts that are perceived as real. Patients may insert events from life, fiction, or invention into their otherwise normal conceptualization of reality.

**Patients either:**

- (A) Totally believe the fiction of his/her own confabulations.
- (B) Oscillate between belief of confabulations and the truth of reality.
- (C) Acknowledge reality (after correction or reconsideration) after momentarily believing confabulations to be true.
- (D) Believe an asymmetrical mix of the truth and the fiction of the confabulations.

## DISTORTED MEMORY

**All people – not just those with dementia – have a habit of distorting memories to either suit their preferences, or to fill-in-the-blanks for missing information.** Since everybody possesses a confirmation bias, everybody likes to think that they are right about everything. Usually, the younger we are, the greater our capacity to recognize our bias, accept new info, and check our prejudices. The further back the memory, the more susceptible it is to distortion. With dementia, case of distorted memory can be minor or severe.

Depending on the nature of the confabulations or distorted memories, invented or misremembered fictions can influence the behavior of the patient. If a fictional scenario provokes a rallying conviction, the patient may feel a “call to action” based on the circumstance.

The patient may form action plans (unbeknownst to you) on how he/she will be carrying out their ideas. **A patient taking actions based on confabulations can jeopardize the safety of the patient and others.** Different people will respond differently to corrections. Some may: (1) Genuinely Accept correction (2) Partially / Temporarily Accept correction (3) Pretended / Unbelieving ‘Acceptance’ of correction (4) Outright denial of correction (5) Total Incomprehension of what’s being said.

If any difficulty arises, redirect the patient to whatever location they currently belong in. Do this by guiding them to that place / area / location one step at a time. Consider each transition of posture and transition from room to room a “step” in the process.

## FORMER FAMILY SEEKING (FFS)

FFS is when a patient begins to seek a former spouse, loved one, friend, child, or confabulated relation that is obviously not around anymore (either due to death or distance).

All experiences and memories are biochemical reactions in the brain (between neurons). The more a subject (or person) is experienced over the course of a life, the more ingrained that person becomes in the neuro-anatomy of the brain’s connections (synapses).

**The neurophysiology and synapses of our brain – and experiences of our life – are our entire character.** The more you engage in something, the more a part of you it becomes.

This is why those suffering from Alzheimer’s may seek out loved ones who have long-since (or recently) passed away. A significant portion of their neuro-architecture was dedicated to those individuals (whom are now gone). When the brain is unstable and trying to make sense of things, it reverts back to what it knows, what is safe, and what is familiar.

How you respond to FFS is entirely dependent on how the patient responds to your corrections. You may need to switch-up behaviors if the patient switches-up responses. **If the patient responds positively to correction, correction is always the best course.** If patient is unconvinced concerning correction: (A) Further correction with them (if time/opportunity allows), may prove beneficial (B) Familial backup/proof (if patient is emotionally capable of handling it), (C) Indulgence and Redirection may placate the patient for the time being (until the FFS behavior wears off).

## MEDICAL OBEDIENCE

**Individuals with Alzheimer’s do not die of the disease itself, they die of other medical complications – which can be exacerbated or worsened by Alzheimer’s.**

The treatment you are attempting is supplementary treatment, not primary. You must maintain obedience to medical diagnosis and prescription in order to keep the patient healthy.

Do not think that just because you now have a treatment plan that “you’ll take it from here”. You are not ready to. Wait until you see definitive results from NJUV before consulting the patient’s doctor about altered treatments (to accent or amplify NJUV treatment).

Occasionally, you or the patient will forget to take X medications at the right time (this happens to almost everybody). Utilize accidents in not taking medication to collect information on the patient status while ‘off’ the medication. Note down the difference in behavior both on and off medication. Is the medication doing what it is supposed to be doing? If not, write a list of all the questions you have concerning the disease and medication, and call/message/see your doctor asking about them.

**DO NOT under any circumstances interfere with the prescribed use of medication for the sake of observing the patient off medication (unless okayed by the patient’s physician).**

## MOOD-SWINGS

There are plenty of perfectly justified reasons for an individual with dementia to be in a foul mood.

- Consciousness and Disquietude concerning their condition.
- Mental Discord or Condition (as a result of condition)
- Psychological Stress (from events in life)
- Physical Pain (frequent or infrequent) that results in bitterness when manifested / felt.
- Fear, Anxiety, or Depression as a result of loneliness.
- Guilt from not being able to remember something (like a familiar face, lifetime event, etc.)

**STATES OF MIND** (that the patient can potential have):

- **Lucid** – fully conscious and capable of understanding and communicating normally.
- **Lost** – mentally scrambled in regards to time, place, purpose, people and/or surroundings.
- **Fully Confabulated** – entirely engaged in the reality of confabulations. Either coherent or incoherent. Includes hallucinations.
- **Lucidly Confabulated** – reasonable in all (or most) other things *except* the reality of confabulation.
- **Defensive** – Feels fearful, paranoid, or uneasy about the environment’s intentions towards him/her. Includes panic. Silently builds. Can be caused directly or indirectly by neurodegeneration.
- **Offensive** – provoked to attack by real or imaginary pressures of environment on him/her at any given time. Can be caused by directly or indirectly by neurodegeneration.
- **Vacant** – this would be when the patient does not seem to be “there” or “at home”. This can be the result of medicinal lethargy, it can be the result of mental inactivity, or it can be the result of totally internalized mental activity. The patient is awake, but imperceptive and unresponsive.
- **Pained** – if patient has any medical issues ensure that said issues aren’t causing them needless pain. Sometimes patient’s may be too proud to admit discomfort, and frustration builds from the suppression of the discomfort.
- **Frustration** – Frustration is always a result of some type of mental or physical helplessness. Many people are too proud to ask for help, and would rather be inconvenienced than solicit assistance. Assist such people in a manner that suggests that you know they could do it, but you might as well help while you’re there (not like they need it). Talk about something other than the situation to bypass any negative feelings associated with offended pride. The new subject can dissipate such feelings before they even have a chance to surface.

## PASSIVE IMPROVEMENTS

With dementia all new things (including fictional art/entertainment) fall into the category of “learning”. The unique experience is exciting / stimulating their brain in a way that is unfamiliar. When this is done without any (or very little) action on your part, this can qualify as “passive improvement”.

Have them watch or listen to “new” stories over and over again until remembered. Then begin an actual new one and start the process over again.

## TRAUMA AND PTSD

PTSD is Post-Traumatic Stress Disorder; it is when a traumatic event from the past (and its emotional influence) resurfaces to the forefront of your consciousness in the present. The resurfacing of the event is usually provoked by an obvious (or subtle) thought, incident, or circumstance.

Our consciousness can intentionally or accidentally repress memories if those memories are painful or traumatic. There are 2 primary ways to handle this, and each have drawbacks.

- A) **Avoid**. Note down what topic triggers the PTSD, and manage conversations so as not to ever fall upon that topic.

- a. Avoiding a topic doesn't make it go away. It may deteriorate due to neurodegeneration, but deterioration is exactly what you want to STOP (and potentially, reverse).
- B) **Address.** Talk through the topic with the patient as a therapist would do.
  - a. For detailed information and steps on how to handle PTSD therapy, visit:
    - i. [www.theupwardeducation.com/teaching-content](http://www.theupwardeducation.com/teaching-content)
      - 1. And download the "**Stressful Situations Index – Adults & Seniors**" addition.
        - a. It is a free document.
        - b. **Question #4 and Question #53** cover PTSD
        - c. The SSI might also help you solve other issues concerning seniors that are unmentioned in this document (for brevity's sake).

## MOTIVATING & REFOCUSING THE PATIENT

**It is probable that you will have a very difficult time getting the patient started with all of the suggested activities below.** Try to empathize with their mindset of "not wanting to try anything new". If someone repeatedly insisted that *you* try something that you previously had no interest in, you might be inclined to decline that offer. Why? Just because you don't feel like it, right? Since that would be an acceptable answer for you, accept it when the patient expresses this sentiment...Don't stop trying, though. Just chill for the present moment. You don't want to push or pressure the patient into activity; you want to invite them into it.

**When involved in complex or procedural tasks, you may end up having to constantly refocus the patient towards what he/he is supposing to be doing.** If you anticipate having to do this (and plan in advance how you can do so), it may be less trying on your patience. For severe cases, you may end up spending most of the activity time refocusing the patient (and trying to get him/her to maintain focus). Daily repetition of the focal activity may likely decrease the amount of redirection needed.

It is important to know that NJUV has not been proven to work. It is a suggested method of treatment created for those who are willing to "give it a try". In theory, the method is sound. Alzheimer's and Dementia are classified as incurable disorders that inevitably lead to death (through complications of other diseases/disorders more often than from the actual disorder). If you achieve results, you will be among the first people in the world to successfully have treated Alzheimer's / Dementia.

## QUARRELERS, COMPLAINERS, AND SMARTASSES

Those with a contentious disposition may challenge, instigate, or bait you on many or all issues. Anticipate and expect that they will treat you unfairly (so that it is more tolerable when it happens).

Use their past behavior to develop a foresight about their future probable behavior.

When they convey incorrect info: Correct, or Indulge & Reroute. **DO NOT mirror or return their negativity back at them.**

**Adopt the attitude "I will never believe that you are as bad as you are pretending to be"**, and/or "Ahh come on, you don't really mean that". With this approach, any continuation is more sportive than malicious.

Or, you can turn every argument into sportive raillery.

If you can create a back and forth banter that is devoid of insults (at least on your part), you may just be giving the patient what they want. Perhaps they used to be convivial with their friends in a way that is more harsh than your normal standard, and the way to get them young again is to 'speak their language'. Turn this competitive energy into a challenging attitude. **Try to manage things so that the things that you 'challenge' the patient to are activities involved in the Treatment section.**

# TREATMENTS

Tailor new enjoyments and pleasurable activities to align with the preferred concepts, principles, and behaviors of the patient. Methods can be combined (and created) according to whatever suits your situation.

**The goal is maximum mental and physical stimulation, with absolute minimal stress.**

The below are things that can be implemented into both Ambition-Based Therapy (ABT) and Itinerary-Based Therapy (IBT).

## MUSIC

MENTAL STIMULATION

PASSIVE TREATMENT

**Psychological Component:** Music connects us to our past, and brings us enjoyment. Familiar music will bring joy to the patient, mental stimulation to the patient's brain, and, potentially, recall memories that were previously dormant.

**Neurological Component:** Past recollections can reactivate / reinvigorate previously neglected neural networks. Activity in any neural networks can trigger activities in adjacent ones. Networks associated with music will be intertwined with networks associated with memories. Just how you can recall special moments in your life through the music that was involved in it (sometimes unintentionally).

Think about the shows you used to watch when growing up (or much younger). Can you still remember how the opening credits theme goes? You can probably even still remember the words to some – if not most – of them. All thoughts are biochemical reactions. In order for the thoughts to be complete, the neural networks composing them must be healthy.

The things that we spend the most time with become a part of us. Music is a symbiosis of stirring art, and empathy. Different songs make you feel different things.

- **Question the patient on his/her favorite songs and albums** (throughout their entire lifetime).
  - Interview patient several times on favorite songs. Never assume your list is complete. Continue asking and you may get new ones from time to time.
- **Find and play familiar music from the past that patient hasn't heard in a long time.**
- Provide new experiences like dancing or games (or anything active) with old/familiar music.
- Make a **Requested Favorites Playlist** for songs that the patient mentioned by name.
- Make **Related Playlists** using songs from the same albums as their favorite songs.
- Make an **Era Playlist** that has songs of a similar genre around that time period/era in music.
- If the patient has lost memory only for, between, or after a certain time period: create playlists of similar genres from that lost time period, and allow patient to listen. Perhaps music from that genre could trigger memories from that time. And if the neural networks have decayed, than the music would be considered “new” to the patient – and experiencing new things cues synaptogenesis and neurogenesis...and enjoyment.

Associate music with exercise / walking / dancing / physical activity. Pair the two activities so that both become a pleasure. Engage in whatever activity you are encouraging them to do. Do the activity together as “quality time”. If lucid, see if you can get them talking or telling a story while participating in an activity. This would provide considerable mental and physical stimulation.

Make sure they have access to and operating knowledge of whatever device they will be using to listen (when you are gone). Headphones would be better than earbuds, a radio would probably be better than headphones. Ask the patient which he/she prefers. If they don't seem to understand, bring them examples of each device, and ask them on multiple days which one they prefer. Use the one they most often pick.

Encourage singing along if the patient knows the words to the music.

## PLAYING & SINGING MUSIC

**If the patient used to play any musical instrument, get such an instrument (if you have the resources to do so) and provide the opportunity for the patient to get back in the groove of practicing music.**

If they don't remember how to play the instrument: learn yourself, and reteach them (if you have the time and will to do so).

Depending on the affinity and skill level that the patient once attained for the art, they may recall a lot more than they even knew was consciously remembered. The act of playing music (and certain songs) can be a time-capsule activity that recalls long-lost times and memories. And you better believe that's some mental stimulation.

Everything mentioned above in regards to playing an instrument goes the same for singing (if the patient used to be an amateur, enthusiast, or professional singer).

## REMIXED JINGLES

If you have the time (and interest) in doing so...

Use the themes from their favorite jingles and/or songs, create relevant lyrics to match, and bring them up to date on what it is that they're usually missing (from memory) by playing the songs. Have them listen to it every day. Through daily repetition, they may create new neural networks as the need to process "new" information in the brain starts becoming formalized in their neural-architecture. In other words, **replace the original lyrics of the song with new lyrics that are informative of the content that is usually lost from the patient's memory.**

**What if the material from the past is tragic?**

Depending on the nature of the material and the general / usual disposition of the patient, tragic material can either be: (A) Left out of the remix (B) Included but briefly (in a way that is minimally upsetting) (C) Elaborated on as much as necessary (for closure)

**The bottom line for music is to find songs that the patient likes, and let them listen to it often.**

## VIDEO GAMES

MENTAL STIMULATION & PHYSICAL STIMULATION  
PASSIVE TREATMENT

**Psychological Component:** The experience of playing a video game – especially for those whom have never played before – can be quite thrilling. Most video games are designed to be as exciting as possible, and many video games are so fun that you wish to play them more and more. Video games may be the best possible avenue for provoking mental stimulation available (seeing as they promote willful continuation of the activity in the patient).

**Neurological Component:** New neural networks will spawn, and existing neural networks will synchronize in new ways to accommodate for the novel experience. The manipulating of the controller will exercise coordination, and the attention to the game will exercise working memory and reflexes. The fictional environments of the games activate the neural networks associated with navigation, spatial discernment, and declarative and working memory.

The games are a new and novel experience, and there are plenty of elements that have never been introduced to the patient before – which will result in neurogenesis, in addition to synaptogenesis. Remember that consuming any form of art/entertainment can be categorized as “learning” (for a person with dementia). There are more games in existence than there are movies. There is a 100% chance that you can find not only one, but several video games that the patient takes a liking to (if they are willing to give it a try in the first place).

**Video games that have the patient standing up and active (either with a screen, a step-pad, or a controller) would probably be preferable.** \*Be sure to be with and by patient at all times if the game is a physical one (involving standing). [There’s no reason why you couldn’t play the game with them – if its 2 players. That would be the best thing to do in all cases](#) (sitting or standing games).

If the case of dementia is severe, start with simple games that are easy enough to play and complete – and don’t provide too much of a challenge.

If the case of dementia is mild, try games that match the patient’s interests in movies. Get games whose genres correspond with their preferred genres of movies/television. ‘Sports’ is a genre.

**Try as many different games and types of games out as you can, and if the patient takes a liking to any particular type/genre: introduce more of games of that genre/type to them.**

In the same way that you remember the favorite parts of your favorite movies when you were younger (no matter how long its been), gamers remember their favorite parts of their favorite games from the past. This is because the unique experiences of the art and entertainment that we consume leave a lasting impression on us. Just to process that video game, your brain had to think in ways that it never had until that moment (same goes for any art/entertainment). Video games add the extra element of interactivity, which allows for a greater feeling of being part of that experience.

The repetition of a gaming experience can lead to neuronal changes in the neural networks that process the game’s information.

[This type of mental stimulation will affect the circadian rhythms of the brain. More concentration will be required of the brain than “usual”, and therefore the body will start nourishing the brain more than usual.](#) In combination with other methods on this document, this may provide more “fuel” to be used during rejuvenation. In the days that the patient does not game, they can use that mental energy towards something else.

**The bottom line for video games is to try a variety of different types, and continue to supply the patient with the types and genres that he/she prefers.**

**If the patient used to game in the past, interview them in the same way you did about music to find and deliver their favorites from the good ol’ days.**

## VOCATIONAL RECALL

REINVIGORATING OLD WIRING  
MENTAL STIMULATION & PHYSICAL STIMULATION

**Reactivate the muscle-memory from most of the patient’s past work-life.**

If the patient formerly had a job that required any amount of manual dexterity and orthodox or sequential maneuvers, that skill is another time-capsule device that may wake up memories (both muscle-memories, and past ones). If possible, find identical or similar activities that the patient can do at home and provide them with that chance to get back in the swing of things. This would be a form of LTP and muscle-memory refreshing.



# NARRATIVE RECITAL

RETELLING THE STORIES OF PAST EVENTS  
MENTAL STIMULATION

The goal of NJUV is to reactivate neglected neural networks, and reinvigorate the mind (as a whole) through continual stimulation. **The act and process of recalling and verbalizing a story exercises the mind and memory of the individual telling the tale.**

Go back to one of the earliest memories that you can remember, and try to verbalize that narrative out loud – starting with days before the incident, and ending days after the incident. You will notice that as you recall one thing, you may (or may not) recall adjacent memories and associations relative that time period – whether they are relevant to the story or not.

That type of accidental recall is exactly what we are looking to activate when requesting a story from the past.

Ask as many follow up questions as you can think of AFTER the patient is finished talking. Mentally (or physically) list and tally your follow-ups, and ask them once the patient finishes speaking. **Remember that all information that comes from the patient (real or confabulated) is a useful measure of where their state of mind is at the moment.**

Have the patient tell stories. Have them tell as many as they can think of, and as many as you are willing to listen to. If possible, try to encourage progressively longer stories to make ‘sustained attention’ a habit. If the stories are confabulations, listen to them as if they were real, but do not ask as many follow-ups (as you would not want to accidentally reinforce the confabulation by prompting the creation of new material). If the patient is confabulating, try to redirect them to a different time/topic.

It might be beneficial to record these (if the patient doesn’t mind you doing so), as the recordings will gain more sentimental value the more time passes.

**If you find that the realization of forgetfulness upsets the patient, either redirect them to continue on from beyond the point that they are stalled at, or, avoid narrative recitals altogether (depending on the severity of the patient’s disappointment).**

**Consciousness of memory lost can be extremely stressful for a patient. If you see that this is the case, do everything you can to “move on” from that point (as if the loss is inconsequential).**

If the patient is not too bothered by the forgetfulness, try to lead them into the subject that they are trying to remember with adjacent information surrounding the circumstance. You can pick up such information from their previous narrative recitals, or from relatives whom remember the incidents / time in question.

# DANCING

PHYSICAL STIMULATION & MENTAL STIMULATION

If it is safe for them to do so, dancing (in any way that they can) is likely going to mentally and physically exhilarate the patient. When dancing you are usually mentally ‘free’ (of tension), and physically active (exercise). **Dancing is an excellent combination of mental and physical stimulation.** The mental stimulation is provided by the release of endorphins (feel-good molecules released during pleasurable activity and experiences). The physical stimulation is provided by the willful exercise.

Use music that the patient is familiar with to get them going / get them in the mood to dance. If the patient is willing to listen/dance to unfamiliar music, use as much of that (unfamiliar music) as is possible.

Dancing is mental stimulation because it is done with music (which stimulates the mind, mentally). If the dancing has a specific form/choreography to it, than that is also mental stimulation as it is activating (previously inactive) procedural memory and (potentially) muscle memory.

It goes without saying that **if you choose to encourage the patient to dance, there's no reason why you can't do so with them as well.** If you are shy or self-conscious about dancing: accept that you're laughably bad at it, and start the comedy show. If you are criticized for your lack of skill (for some reason): agree with your critics!

**Learning new dances yourself – and teaching new dances to your relative / patient – will benefit both of you considerably.** Even if the patient unconsciously forgets what he/she learned every day, the muscle memories (and neural networks required for producing such movements) will become more enhanced and nourished from the activity. Over time, even if they mentally forget what they're supposed to do, they will get a thrill out of how 'quickly' they pick up the dance when you teach it to them for "the first time". The reason that it is so easy is because they're already used to it (even if they forgot the original experiences).

## **EXERCISE**

### PHYSICAL STIMULATION

Let's go ahead and assume (as a sane human) that you know the importance of exercise on physical health. **If the patient is willing to engage in daily routine exercise, "reinvigoration" may need to come before "strength and cardio" training.** The patient will need to slowly get back into the groove of expending physical energy beyond the norm of daily requirements. This type of reinvigoration could be considered "warming up before the regimen".

Soft and easy stretching combined with high reps and low (or no) resistance – on the daily basis – is the key to reinvigorating. When the patient is more able, responsive, and adept in the warm-up training, you can graduate him/her to more advanced exercises.

**Remain close at all times when patient is performing any exercises.**

**Exercise with the patient and make it a team activity** (otherwise, you standing around watching them exercise may seem awkward / patronizing). The act of "having to keep an eye on" someone can accidentally seem insulting. If you exercise with the patient, it entirely changes the dynamic of the room / activity.

Your presence as a loved one / friend can keep their mind on the conversation rather than the struggle of physical activity. Perhaps you've had rough days at work that didn't seem so bad because of the company you had with you, right? In exercise, you are the patient's company. Provide companionship and the time (and physical effort) may fly by unnoticed. Do not push them past the point where they want to stop.

- Walking
- Jogging
- Aerobics
- Exercise Bike
- Sports (various)
- Boxing / Shadowboxing
- Dance

If the patient has past experience in any of the above, reintroduce them to the exercises that they are most familiar with before introducing them to new and novel ones.

**If the patient has a friend / peer of similar age that they spend most of their time with, try to get both individuals in the habit of exercising together,** so that they can serve as mutual motivation to do so in the times where you are not available to encourage / motivate / moderate.

# MISCELLANEOUS HOBBIES & ACTIVITIES

ANYTHING THAT YOU CAN THINK OF THAT PROVOKES MENTAL & PHYSICAL STIMULATION

**Anything that involves sustained or concentrated mental or physical activity can be considered mental or physical stimulation. The best activities to engage the patient will be learned through questioning them about their interests.** The below are some promising general activities.

## HYGIENE

PHYSICAL STIMULATION

One of the best habits anyone can get into is that of hygienic activity. Encourage the patient as much as you can to engage in these activities on a regular and frequent schedule that promotes the development of muscle memory. Oral hygiene (brushing one's teeth) is especially important in cases of dementia, as more scientific evidence is accumulating that show there is a correlation between poor dental hygiene and developing dementia.

## COOKING / BAKING / ETC.

MENTAL STIMULATION & PHYSICAL STIMULATION

Cooking / Baking requires an attentiveness that is beyond the baseline of our normal cognition – in other words, its mentally stimulating. The necessity to follow an orderly procedure (to achieve the desired result) can help synchronize will with action, and can help recover manual dexterity.

**Supervise cooking / baking at all times.** To spare the dignity of the patient, do not do so overtly. “Hang out/around” with the person while they are cooking and only interfere when necessary (unless patient is of a temperament that does not mind when mistakes are corrected).

**Assume that the patient will make a mess and muddle the process – plan accordingly.**

**The cooking should be seen more as an exercise in procedural and dexterous action than it should be the expectation of an essential meal.** Assume the final dish may not be edible, and if it is, that's even better.

\*This could have hazardous results due the dangerous kitchen appliances (heated and bladed). Plan accordingly and monitor the patient when in the process of cooking.

## PUZZLES / GAMES / ETC.

MENTAL STIMULATION

According to the patient's willingness to engage in the material:

- **PUZZLES** (of various types) and **PHYSICALLY INTERACTIVE GAMES** can provide new experiences and occupy the attention and mental effort of the patient.
- Puzzles and games that the patient remembers may recall old/dormant memories and experiences. Ask them of their previous experiences with such games.
  - What type of board games do they remember? What type did they enjoy when younger? Can you still get a hold of those games? If so, purchase the games and re-introduce the patient to the action of playing them.
- Such puzzles and games may be just as useful if they are on a tablet or electronic device (assuming that the patient knows how to work the device).

## CHORES+

### PHYSICAL STIMULATION

In order to restore physical competence and independence in the patient, they must have the manual skills and energetic capacity to take care of the tasks that one would take care of if living alone.

Independence is being able to do X chores and daily activities single-handedly if necessary.

**Dishes:** Most people have spent a good deal of time washing dishes. As simple of an activity as it is, the physical stimulation could end up strengthening the patient's circadian rhythms.

**Dusting:** Assuming the patient is paying attention to his/her work (and not doing it blindly), dusting requires attentiveness – to spot where dusting is needed. This adds a bit of mental stimulation to the chore as well.

**Sweeping:** This may require supervision, as it can sometimes be necessary to bend over to lift and empty the dustpan (depending on the type used). **Chores requiring any bending, climbing, or lifting should always be monitored.**

**Surface Cleaning:** Aside from the physical activity, cleaning surfaces provides a natural mental satisfaction that comes with bringing order or cleanliness to an otherwise entropic area. Any chores requiring the patient's handling of chemical (cleaning) agents should always be monitored.

**Gardening:** If the patient is not physically capable of working in a garden, than a few plants around their residency may be enough to get them back in the habit/procedure of caring for a living thing.

## ART

### MENTAL STIMULATION & PHYSICAL STIMULATION

The act of creating something is (beneficially) taxing on the brain. Every new and novel thought is energizing the brain by providing nourishment to neurons and neural networks that previously were unused (or, never existed before – if the experience is an entirely new one). Creating art is significantly more beneficial than consuming it – and everyone has the capacity to create art.

What the creation means to others is of little or no importance whatsoever. What the creation means to YOU (in this case, the patient) means everything.

When dealing with dementia, the patient may not always be able to have a comprehensive understanding of what it is they're doing or trying to accomplish, but the moments where they can rally their mental and physical resources to create something are precious and very useful for treatment. If the patient is new to any of the arts, than you should start up the same type of art as a hobby. Start X form of art at the same time as the patient, and you all can learn and grow together.

- Writing
- Drawing
- Painting
- Pottery
- Sculpture
- Singing
- Dance
- Photography
- Etc.

If the patient has past experience in any of the above, reintroduce them to what they are/were most familiar with, first (even if they've lost the skills for it). Relearning something they once knew will likely be easier than learning something entirely new.

Depending on the severity of the case, it is likely that the patient will forget what he/she has been working on at times (if not all the times). As long as they are willing to continue, or start anew, keep encouraging them to work. Remember that **THE PROCESS IS THE TREATMENT, NOT THE COMPLETION OF TASKS, OR ANY PARTICULAR ACCOMPLISHMENT.**

# PETS

## MENTAL STIMULATION & PHYSICAL STIMULATION PASSIVE TREATMENT

**Psychological Component:** I think most of us are familiar with the feeling of joy, contentment, and adoration that pets can inspire in us. Dementia is usually stressful on the mind (especially if consciously recognized). Pets are some of the best stress-relievers in existence.

**Neurological Component:** New things and experiences cue neurogenesis and synaptogenesis. A pet is a new thing, initially, and a prompt for neural networks to form and develop LTP over time. If the case of dementia is severe, than the constant new experience of the pet may at least bring psychological relief / ease. Over time, the neural networks associated with the (continually forgotten) pet may stabilize – allowing the patient to form a permanent memory of the new thing.

This is “physical” stimulation because of the physical act of petting, holding, caressing, etc. the animal.

The people and beings around us become a part of our life (and an anatomical part of our brain) the longer they are around us for. That is often why patients seek out lost loved ones when in a confused state. They feel most comfortable and pleased around what’s safe and known. If a pet is allowed into the patient’s life, that pet will – over time – become a new factor that is both safe and known; and therefore, be a source of comfort to the patient (as a family member might be).

The primary purpose of pets are: (A) An outlet for those with affection to spare. (B) Affection donors for those lacking in affection. (C) Companionship during lonely times. In cases of dementia, purposes B and C can provide indescribable security, comfort, and pleasure to patients.

# JOURNALS OR TIME CAPSULES

(NOTES TO THEMSELVES)

## MENTAL STIMULATION & PHYSICAL STIMULATION

**Used here, “journaling” is a reference to writing down any remembered excerpts from past circumstances, or current thoughts.**

**Psychological Component:** Patients are likely going to write about the memories that they cherish most. They might not be able to remember everything, but what they do remember will likely be things that they are happy to remember. The act of writing this down will be mental and physical stimulation, but ‘enjoyment’ may end of being the largest benefit of journaling.

**Neurological Component:** If the patient’s neural networks are decaying, journaling can be seen as “evacuating” important memories for safe-keeping. The act of recalling those memories reactivates the neural networks associated with them, and if the patient rereads the journal entries in the future, the reading will reactivate those networks as well.

If you can persuade them to entertain the idea, it would be beneficial for the patient to make a journal of his/her thoughts throughout the day, and write in it whenever they have the fancy to.

If they are not interested in writing out their thoughts for the day, you can **QUESTION THEM ABOUT MOMENTS IN THE PAST AND HAVE THEM WRITE OUT A CHRONOLOGY OF X EVENT(S)**.

You will be asking them to write down narratives concerning excerpts of their lives. **In the long-term, you will be asking them for their life’s story. You’re just taking it one excerpt at a time.**

The more you ask about (and listen to), the easier it might be for the patient to “continue where he/she left off” – by you leading them into the missing section. Do not expect this to happen – as it is unlikely; but “unlikely” does not mean “impossible”. The only way to know is to try it. Some memories may be gone for good; some may just be dormant.

If the patient is able to recall events, but is not physically capable of writing, than you should take dictation and transcribe their speech into text. The recall process is more important than the actual writing. The recall process is the most important part of the treatment method.

There is a chance that the patient may write nonsense or illegibly. Ask them if they can read and understand what was written. If they can understand it, take down what they say (so that the content is not lost to their illegibility). If the patient can't understand his/her own writing, do not take over and start dictating their recitals. **Even if the writing is nonsense or unreadable, as long as the patient is still willing to write things down (or try to) allow them to do so.**

If they are willing to journal, continue to encourage them to do so even if what they write is nonsense, ineligible, or confabulated.

## NEW FOOD

MENTAL STIMULATION & PHYSICAL STIMULATION

**Psychological Component:** Food is one of the simplest pleasures a person can experience. Even if the stimulation experienced from new food will likely be relatively mild, the enjoyment it can bring always has the option of swaying the balance of activity probability. Meaning, a patient in a good mood because of a good meal may be more willing to try some of the treatments suggested on this curriculum.

**Neurological Component:** The experience of trying new food will either generate new LTP consciously (if that new food is regularly served – and remembered by the patient), or accidentally (if the food is regularly served and forgotten). In the latter case, it may not provide much benefit, but it will likely provide enjoyment.

New experiences activate unique neural networks. The more primitive / essential the experience, the more likely it will leave an impression on us. Food is a pleasure that can set the tone for several (subsequent) hours of our day. This curriculum is about making the patient happy. Who *wouldn't* be happy with a delicious new meal every now and then?

Be sure that you are aware of any allergies that the patient may have, and always use discretion when preparing spicy food for the patient. \*If unsure, omit all spicy foods from consideration.

## NOSTALGIC FOOD & SMELLS

MENTAL STIMULATION & PHYSICAL STIMULATION

For the same reasons as music, art/entertainment, hobbies, and vocational activities, nostalgic foods and smells have the potential to reawaken memories and time-periods long since forgotten.

Eating food that one hasn't had in a long time always has the potential to bring back memories from that long time ago (when the food was last had). This goes the same for certain smells. Smells that may recall memories are: laundry detergent, deodorant, cologne, candles, candy, flowers, lawn/grass-shavings, woodchips/shavings/lumber, hot metal, food (obviously), hay, alfalfa, alcoholic beverages, soap, shampoo, etc. Anything with a familiar scent has the potential for memory recall.

This is classified as physical stimulation because the act of mastication is combined with the sensation of smell; and, the sense of taste is a physical sensation.

# QUESTION POSTERS

## MENTAL STIMULATION

Make large posters that will have a question on them meant to prompt the patient to reflect on a moment in the past.

- “What are you most proud of?”
- “What have you always wanted to do?”
  - Use answer to outline methods of ABT.
- “What is your favorite song/movie/book?” etc.
- “What are all the jobs you’ve had over the course of your life?”
- What was your favorite job?
- “What are some of your favorite memories?”
- What is your favorite food?
  - Do you remember the last few times you had it?

Needless to say, anything associated with their answers should be acquired and given to them as part of this curriculum (music, movies, books, commemorative photos/video, etc.).

Do not ask these questions in rapid-fire succession, and do not move on to the next poster until you’ve exhausted all follow-up questions concerning the current one.

If you can find pictures relative to the answers that the patient usually gives, print them out and attach them to the poster/board to see if the visual cues prompt additional memories. Even if they don’t, the patient will likely enjoy the photos+ for the same reason that we all enjoy such things.

As usual, if the patient becomes confused, uncomfortable, or stressed because of the ability to recall the past, quickly move on to something else.

# ADDITIONAL CONSIDERATIONS

## ENCOURAGEMENT

Speak to the patient as you would speak to a peer that is a good friend of yours, but perhaps emotionally unstable. Encouragement should be much more about enthusiasm than it should be about pushing the patient forward.

**Laugh WITH the patient at mistakes, and let them know that X mistake happens to you all the time** (it probably does, just in a different context – or with a different activity). **Do not laugh AT the patient for making a mistake.**

**If you know that the patient can be hard on him/herself for clumsiness or making mistakes, willfully make mistakes and become clumsy (when in their presence) to put them at their ease, and to remind them “nobody’s perfect”.** Let them know “we’re both off today, huh?” \*If you choose to do this, make sure not to let them know that you are doing it on purpose (as it can seem patronizing/insulting). Do not jeopardize your own safety for the sake of doing this (obviously).

## CARETAKER’S JOURNAL

If you are successful at Neuro-Rejuvenation, the process you used could be of tremendous benefit to the world. If you are up for it: **journal as much about the process you’re using as you’re willing to.** It could be just a couple of lines on what was done that day/week/month. What part of the NJUV process did you attempt, and what were the results? **The more detailed the better, but any details that you document (successful or not) have the potential to be of use to the ongoing study of dementia.**

