



When evaluating risk perceptions, defined as one's "subjective judgment about the likelihood of negative occurrences" (Kim & Choi, 2017, p. 773), of individuals, physicians must take into consideration statistics, emotions, individual circumstances, and quality of information (Spencer, 2017). Alzheimer (a form of Dementia) patients experience debilitating symptoms effecting behavior, memory, and thinking (Spencer, 2017) and Alzheimer patients must be treated thoughtfully and with care by physicians when receiving information regarding themselves and associated risks.

Survival Rates

When communicating with Dementia patients, physicians should communicate with percentiles and ranks, related to survival, to effectively convey the options and/or solutions decision-makers (the patients) are presented with (Harris, Lowenkamp, & Hilton, 2015). Since Dementia patients, specifically Alzheimer patients, are more than likely going to be accompanied to doctor visits by a loved one or caregiver, the risks of treatments, alternate living options, and life expectancy should be relayed in a rate, or percentage form, accompanied by temporary solutions/treatment options, as Alzheimer's is not a curable disease (Spencer, 2017). By communicating survival rates to caregiver/patient duos, physicians can be sure that accurate information has been received, and presented in a positive light, as "survival rates" are much easier to fathom when discussing a loved one than "death rates" and this relative risk reduction, framed encouragingly, can create hope and confidence among family members/caregivers (Hoffrage & Koller, 2015).

Emotional Appeals

When perceiving risks, emotional appeals are important to consider as well (Kim & Choi, 2017). According to Kim and Choi (2017) "Feelings of dread, perceived lack of control, and the extent to which a hazard is judged to be unknown are used as cues for the estimation of risks, influencing people's risk perception and subsequent decisions". These perceived feelings, whether reflective of the actual gravity of the situation, or not, are important to consider in patients, because however a patient perceives a situation reflects their reality, and a physician cannot argue how someone else perceives any given situation. When assessing one's emotional appeal in a doctor/patient scenario, logic is not always the correct solution. Because Alzheimer's patients present such a unique communication situation, as a physician, one *must* genuinely take into consideration the patients feelings at all times, even when the patient's feelings do not seem to make sense or match the current tone of the message being conveyed.

Validation Therapy Implication

An extension to emotional appeals (Kim & Choi, 2017), would be introducing validation therapy (Spencer, 2017) into physician/patient situations. Because in most situations physicians will be communicating with a caregiver, defined as "the act of providing physical, psychological, and *emotional* support to another individual" (Spencer, 2017, p. 177), validating the feelings and perceptions of the patient with Alzheimer's is vital to productive communication. While a Dementia patient may not be able to effectively translate the thoughts from their brains into sentences which accurately convey the information they would like to, physicians cannot underestimate the level of comprehension which may or may not be apparent. When communicating risk, validating any and all emotions of the patient is necessary in order to maintain a calm patient.

Individual Differences

Physicians also need to consider the individual differences of patients (Kim & Choi, 2017). Patients with Alzheimer's are particularly unique because more likely than not, patients are accompanied by a family member or caregiver, so as a physician, one must be able to communicate with each unique duo in order to best communicate the risks of the patient. All individuals cope differently, and the physician must be able to determine the coping styles of both the patient and the caregiver. Coping styles can range from "monitors", who worry about risks, to "blunters" who do not seek detailed information regarding risk and prefer blunt, short statements (Kim & Choi, 2017). If the Alzheimer's patient and the caregiver cope differently, as a physician, one must take into consideration both styles and be able to accommodate both.

Interpersonal Deception Theory

The interpersonal deception theory, or IDT, is also unique to Alzheimer's patients (Spencer, 2017). In most cases, telling the whole truth is always the best practice for a physician, however, in many cases with Dementia patients, masking the truth, or leaving out complicated details is required to maintain any understanding from the patient. Although deception seems unethical, reminding a patient of reality when they are in a world of their own can create "emotional and psychological trauma" (Spencer, 2017, p. 178). When communicating risk to patients, it is wise for the physician to join the patient in whatever reality they are experiencing in order to best accommodate for potential distress and unnecessary damage. Communicating risk through the IDT is a required skill for Dementia physicians to acquire to best care for patients.

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