Swallowing Therapy and Dementia

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One of most common questions I am asked when I teach the VitalStim Therapy course is about how to do swallowing therapy with patients who have dementia or cognitive impairments. I think the answer is not what most people expect. But first a little background about the dilemma of swallowing therapy with patients who have dementia and why this question is so frequently asked.

Swallowing therapy has advanced significantly in the last decade, and dysphagia clinicians have many options for swallowing exercises and compensatory techniques to help patients improve their swallowing function. However, with all the advancements in swallowing therapy, it is difficult to improve the swallowing function with patients who have cognitive deficits for several reasons.

Patients with dementia are often unable to complete swallowing exercises which can have rather abstract directions, such as “swallow hard”. Even if the patient can follow guided directions, it can be difficult for a person with dementia to remember why they are being asked to do seemingly strange exercises, such as “stick your tongue out and swallow” and as a result they may understandably refuse to do the exercises.

Unfortunately patients with dementia are often the very patients that need swallowing therapy the most. Memory problems can make it impossible to consistently remember to use compensatory strategies, such as a chin tuck, to improve swallowing safety. Without exercises or strategies, the only safe swallowing option for many patients with dementia is a distasteful diet modification, like thickened liquids or pureed food. But diet changes are often not a viable solution since many confused patients won’t consume food and drinks that “just don’t seem natural”. This can lead to dehydration, malnutrition, and decreased quality of life for the patients and frustration for the dysphagia clinician that wants to help the patients get better.

So, how do you improve swallowing function with a patient that can’t do swallowing exercises, is unable to use compensatory strategies, and refuses modified diets? I have found that if a patient has a weak swallow and is cognitively intact enough to eat or drink, then they may benefit from the addition of VitalStim (electrical stimulation therapy) during oral intake. The rationale is simple. The best exercise for swallowing is swallowing which occurs repeatedly during eating/drinking. If electrical stimulation is applied during oral intake, it can help to exercise the muscles during the natural activity of swallowing. The patient is then receiving swallowing therapy without having to do anything but eat or drink.

If you are familiar with electrical stimulation and the buzzing/prickly sensation that accompanies it when it is first turned on, you may be thinking: how is a patient with dementia going to tolerate the sensation of this therapy? Below are some tips for VitalStim with patients who have dementia:

1. Turn up the intensity of the electrical stimulation as tolerated. This means that you may at first get to an intensity level that is sensory only. After about 5 minutes the prickly sensation will decrease, and you can then increase the intensity a little more. Keep going until you get signs of therapeutic intensity as taught in the VitalStim course (audible swallow, better swallow with electrical stimulation, etc.)

2. Don't talk about the electrical stimulation during the application as this will likely be confusing to the patient. While increasing the intensity, talk about the food that the patient is going to eat or some other topic of interest. A patient with cognitive deficits is not going to be able to tell you if they "feel the grab" with the stimulation, and they will probably not understand if you ask if the stimulation level is "OK". If the patient cannot verbally communicate, consider body language and facial expressions and use the non-verbal signs of therapeutic intensity.

3. Follow other well-known strategies for working with patients who have dementia such as eating in a natural dining setting, such as the dining room, with real plates and silverware. This can help get your patient cognitively into the task of eating. You may want to consider getting something for yourself to eat during the session too, as it can be pretty unnatural for many patients to eat if you're not eating as well.

4. Remember, applying electrical stimulation with no concurrent swallowing or pharyngeal muscle activity is unlikely to result in any change in functioning. So you can't just apply the electrical stimulation and have the patient sit there as this will not exercise the swallowing muscles.

5. Above all else, use your clinical judgement. If a patient is not cognitively intact enough to attend to a bolus placed in his or her mouth, then this treatment is not for them. If a patient is not safe for PO intake due to aspiration or aspiration risk, you may want to limit oral intake to tiny ice chips during therapy. The use of VitalStim does NOT prevent aspiration, so consider the results of the swallowing evaluation in deciding if oral trials are right for your patient.

Of course, not all patients who have cognitive deficits tolerate the application of electrical stimulation during a meal. Some patients will be too distracted by the stimulation to participate in this therapy. But I have found more times than not, I have been able to improve swallowing function with patients who would have been otherwise unable to participate in swallowing therapy due to cognitive deficits with the use of this therapy. The bottom line is just because someone has dementia does not mean that they are not a candidate for swallowing therapy.

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