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OLIVEIRA**

**V^{AL}IDA: A validation therapy-training programme for
staff of a residential care facility**

**V^{AL}IDA: Programa de formação em terapia de
validação para staff de uma estrutura residencial
para idosos**



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Dissertação apresentada à Universidade de Aveiro para cumprimento dos requisitos necessários à obtenção do grau de Mestre em Psicologia da Saúde e Reabilitação Psicológica, realizada sob a orientação científica da Prof^a Doutora Liliana Xavier Marques de Sousa, Professora Associada com Agregação do Departamento de Educação e Psicologia da Universidade de Aveiro.

o júri

presidente

Professor Doutor Carlos Fernandes da Silva
Professor Catedrático, Universidade de Aveiro

Doutora Lia João de Pinho Araújo
Professora Adjunta, Instituto Politécnico de Viseu - Escola Superior de Educação

Professora Doutora Liliana Xavier Marques de Sousa
Professora Associada com Agregação, Universidade de Aveiro

palavras-chave

Terapia de validação, demência, estrutura residencial para idosos, formação, staff, qualidade do cuidado.

resumo

A terapia de validação envolve um conjunto de técnicas humanistas, que focam competências de comunicação para melhor interagir com pessoas com demência, aceitando as suas realidades e validando os seus sentimentos. O objetivo deste estudo foi desenhar, implementar e avaliar um programa de formação em terapia de validação (V^{AL}IDA) para o staff de uma estrutura residencial para idosos em Aveiro, Portugal. O V^{AL}IDA envolveu duas componentes: sessões de formação voluntária em grupo e acompanhamento individual entre sessões. Nesta formação estiveram envolvidos 22 elementos do staff. A avaliação compreendeu duas modalidades: questionário pós-sessão de formação; e entrevistas em grupo focal seis meses após o término do programa. Os resultados indicam que as sessões foram bem estruturadas; e o contexto do grupo foi considerado relevante, pois permitiu a normalização das experiências e a cooperação entre participantes. Além disso, o acompanhamento individual foi considerado importante, pois permitiu esclarecer dúvidas e estabelecer uma relação mais próxima com o facilitador do programa. No global, o programa foi bem aceite pelos participantes, que reportaram bem-estar pessoal e profissional. Estes resultados sugerem que o V^{AL}IDA pode reduzir as dúvidas relativas à demência e melhorar a qualidade do cuidado, e até reduzir as intervenções farmacológicas; diminuir os níveis de stresse do staff; e promover bom ambiente de trabalho em equipa.

keywords

Validation therapy, dementia, residential care facility, training, staff, quality of care.

abstract

The validation therapy comprises the use of humanistic techniques that help to better communicate and interact with persons with dementia, by accepting their reality and by validating their feelings. The aim of this study was to design, implement and evaluate a validation therapy-training programme (V^{AL}IDA) for staff members of a residential care facility in Aveiro, Portugal. V^{AL}IDA comprised two components: voluntary training sessions in group, and individual monitoring between sessions. This training enrolled 22 staff members. The programme evaluation comprised two modalities: a post-session questionnaire; and focus group interviews six months after the end of the programme. The results indicate that the sessions were well structured; and the group context was considered of value, since it allowed for the normalization of experiences and cooperation between participants. In addition, the individual monitoring was important, as it allowed for clarifying doubts and building a close relationship with the facilitator. Overall, the programme was well accepted by the participants, with reported well-being on both personal and professional levels. These results suggest that V^{AL}IDA may lessen doubts related to dementia and consequently improve care quality, and, even reduce pharmacological interventions; diminish stress levels of staff; and promote a good work climate and team work among staff members.

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List of abbreviations

BPSD	Behavioural and psychological symptoms of dementia
DCW	Direct care worker
EOC	Emotion-oriented care
NPI	Nonpharmacological intervention
RCF	Residential care facility
RM	Repetitive movements of Resolution
RO	Reality orientation
RT	Reminiscence therapy
SC	Social contact
TC	Time confusion of Resolution
UC	Usual care
VT	Validation therapy

Introduction

The number of people surviving to an old age has increased worldwide (World Health Organization [WHO], 2006). Also, in Portugal this trend is confirmed with people with at least 65 years old representing 21.5% of the resident population (INE, 2018). The WHO (2006) predicted that by the year 2050, there will be two billion people over the age of 60 years worldwide. As the population ages, the number of people suffering from dementia is expected to increase as well (WHO, 2012). The number of people living with dementia worldwide in 2013 is estimated at 44.35 million and it will continue to rise over the coming years (Alzheimer's Disease International, 2013). In Portugal there were estimated 19.9 cases per 1000 population in 2017 (Organization for Economic Cooperation and Development, 2017).

Dementia stands for severe and life-altering impacts on the person and family (Legere, 2018). It is the broad term that encompasses many other diseases, such as Alzheimer's disease, vascular dementia, mixed dementia, dementia with Lewy Body disease, frontotemporal dementia, and other less common forms such as Parkinson's Dementia (Chang, Patel & Schulz, 2015). In the DSM-5 (American Psychiatric Association, 2013) dementia is incorporated into the newly named entity major neurocognitive disorder. To meet the criteria for a major neurocognitive disorder, a person must present significant cognitive decline in one or more cognitive domains (attention, executive abilities, learning and memory, language, visuo-constructional and perceptual motor ability, and social cognition), and the decline must interfere with activities of daily living. DSM-5 also recognizes a less severe level of cognitive impairment: mild neurocognitive disorder. To meet the criteria for mild neurocognitive impairment, a person must present modest cognitive decline in one or more cognitive domains, but it should not interfere with independence in daily life activities. Given the historical legacy and wide recognition, the term dementia will be used in the current paper.

However, cognitive decline may not be sufficient to explain the functional disability in people with dementia. During the course of the disease, a heterogeneous array of psychological and behavioral symptoms is experienced by the patient and/or visible by the caregiver. These Behavioral and Psychological Symptoms of Dementia (BPSD), as designated by the International Psychogeriatrics Association (Finkel, 2000), have a high prevalence in dementia and nearly all people with dementia have at least one of these symptoms during the course of the disease (Savva et al., 2009). The most prevalent symptoms are depression, anxiety, irritability, apathy, agitation, aggression, psychosis and sleep changes (Petrovic et al., 2007; McKeith & Cummings, 2005). Available evidence suggests that BPSD are associated with increased patient and family caregiver distress, diminished quality of life, and increased costs of care (Brodaty 1997; Cerejeira, Lagarto, & Mukaetova-Ladinska, 2012; McKeith & Cummings, 2005; Ryu et al., 2005). Also, BPSD are among the most often mentioned reasons for institutionalization (Afram et al., 2014; Finkel, 2000).

According to Alzheimer's Society (2013), among institutionalized old adults, at least 80% have dementia; and consequently, BPSD are highly prevalent in these facilities, which may impose major demands on formal caregivers.

BPSD interventions for people with dementia

Many people with dementia (institutionalized or living at their homes), most of them are old adults, receive some sort of pharmacological intervention to control BPSD. However, no medication has proven to be effective on the management of these symptoms (Casey, 2015); many do not respond to medication trials, responses are sometimes idiosyncratic, and the risks associated with treatment are considerable (e.g., exacerbation of behaviors, add to mortality) (Bierman, 2007; Casey, 2015; Kar, 2009; Schneider, Dagerman, & Insel, 2005). In fact, most medication make people withdraw inward like living dead people, reducing their ability to communicate and express emotions (Feil, 2012). In addition, old adults tend to prefer nonpharmacological interventions (NPIs) to medication, mostly because they already take medication for various physical conditions and are more prone to the adverse effects (Ordem dos Psicólogos Portugueses, 2015).

NPIs are becoming an alternative or a complement. These interventions are not aimed to influence the underlying pathophysiological mechanisms but to maintain and/or promote function and participation, by managing symptoms and retarding the disease progress (Zucchella et al., 2018). The terms “nonpharmacological” and “psychosocial” are commonly used interchangeably to describe interventions used to address BPSD (Ayalon, Gum, Feliciano & Areán, 2006; O’Connor, Ames, Gardner, & King, 2009). In this paper, we use “nonpharmacological”, which includes interventions addressing aspects of social and psychological behaviors and symptoms of dementia. To date, a number of reviews have studied the use of NPIs to address BPSD. However, the results about these interventions are controversial, mainly due to methodological parameters of the studies and the complexity of the issue per se (Finnema et al., 2000; Deponte & Missan, 2006). On a systematic review from 2015, NPIs are showed to have important and significant efficacy reducing BPSD (Oliveira, 2015). Nonetheless, there are some other overviews of systematic reviews arguing that the evidence base is weak, and limited by poor quality studies, inconsistency across studies, small sample sizes, or little evidence available (Dickson et al., 2012; O’Neil et al., 2011; Seitz et al., 2012).

The American Psychiatric Association distinguishes NPIs into four approaches: i) cognition-oriented; ii) behavior-oriented; iii) stimulation-oriented; and iv) emotion-oriented (APA, 2007). It should be noted that there are several areas of overlap between these approaches and each is hardly used exclusively (Ballard, O’Brien, James, & Swann, 2001). In addition, the management of BPSD may benefit from NPIs that should be chosen in each specific case based on medical condition,

individual's resilience and compliance to treatment, available health and social services, professional resources, and caregiver care commitment and support (Cammissuli et al., 2016).

Cognition-oriented approaches include reality orientation (RO), cognitive retraining, and skills training. These approaches aim to restore (or preserve) cognitive deficits (Rabins et al., 2007). RO operates through the presentation of orientation information (e.g., time, place, location, weather, and person-related), which is thought to provide the person with a greater understanding of her/his surrounding (Folsom, 1968). It can be used both with individuals and groups (Douglas, James, & Ballard, 2004). Although RO is the most widely used management strategy for dealing with people with dementia, it has been overtaken by other approaches such as Validation therapy ([VT] Dietch, Hewett, & Jones, 1989; Douglas et al., 2004), where the emotional content of what is being said is more important than the person's orientation to the present (Feil, 1985; Douglas et al., 2004). RO is criticized in terms of its appropriateness to the people and the settings for which it is used (Burton, 1982); and caregivers may experience extra frustration at using this technique and at having repeatedly to try to orient the person, with little noticeable long-term effect (Hitch, 1994).

Behavior-oriented approaches focus on creating a safe and positive environment (e.g., adequate space, low noise and commotion, special care units) for people with dementia. (Kverno, Black, Nolan, & Rabins, 2009). These interventions aim to reduce people's depressive symptoms, lessen or eliminate specific problem behaviors, and be beneficial for improving mood and disruptive behavior (Cohen-Mansfield, 2001; Opie, Rosewarne, & O'Connor, 1999; Proctor et al., 1999; Rabins et al., 2007). Still, with some exceptions, the limited available follow-up data have suggested that the benefits do not persist beyond the duration of interventions (Rabins et al., 2007). An example of behavior-oriented treatments is behavior therapy, which aims to reduce or improve behavior by analyzing the situations in which the behavior occurs and anticipate these situations (Verkaik, van Weert, & Francke, 2005). A few studies showed its efficacy in the context of dementia (Burgio & Fisher, 2000; Douglas et al., 2004). Behavior therapy is based on principles of conditioning and learning theory, using strategies aimed at suppressing or eliminating challenging behaviors. It requires a period of detailed assessment in which the triggers, behaviors and reinforces are observed, and their relationships made clear to the person (D'Onofrio et al., 2016).

Stimulation-oriented approaches include recreational activities or therapies (for example, crafts, games, pets), art therapy (e.g. music, dance, drama), exercise, multisensory stimulation/Snoezelen, simulated presence therapy, and aromatherapy, some of which overlap with emotion-oriented care treatments in their content. They are intended to mobilize the person's available cognitive resources by providing stimulation and enrichment (Rabins et al., 2007). Music therapy is based on the evidence that the use of sound brings multiple benefits, such as socialization, communication, coordination and expression (Cammissuli et al., 2016). It is a controlled way of using

music through both playing and listening, and it can be used both in group and as an individual approach (Testad et al., 2014). A number of reviews have found a moderate evidence base supporting the positive effects of music therapy on the reduction of a range of BPSD, including anxiety, depression, agitation, and apathy (Cammisuli et al., 2016; Chang et al., 2015; Livingston et al., 2014; Millán-Calenti et al., 2016; Strøm, Ytrehus, & Grov, 2016). However, Ledger & Baker (2007) study shows that a 42-week music therapy group intervention do not reduce range, frequency and severity of agitated behaviors over time.

Emotion-oriented approaches include reminiscence therapy (RT), multisensory stimulation/Snoezelen, emotion-oriented care (EOC), VT, supportive psychotherapy, simulated presence therapy; and are often used to address issues of loss, and to improve mood, behavior, cognition, and quality of life (Rabins et al., 2007; Verkaik et al., 2005). RT was developed from Erik Erikson's theory of psychosocial development, in which the eighth "wisdom" stage is characterized by reviewing and integrating (Kasl-Godley & Gatz, 2000), and was based on Ribot's law (1982, cit in Cammisuli et al., 2016), which shows that recent memory is more likely to be lost than the more remote one. It involves helping a person to relive past experiences, especially those that might be positive and personally significant (Douglas et al., 2004). It is often assisted by props such as videos, pictures and objects, and conducted with an individual or in a group (Testad et al., 2014; Woods, O'Philbin, Farrell, Spector, & Orrell, 2018). A Cochrane review (Woods, Spector, Jones, Orrell, & Davies, 2005) states that no firm conclusions could be reached regarding the effectiveness of RT for dementia. However, a considerable number of studies have been published since that period, considering RT as one of the most popular psychosocial interventions in dementia care, reducing depressive symptoms and improving psychological well-being (Gonzales, 2015; Haslam et al., 2010; Hsu and Wang, 2009; Cotelli, Manenti, & Zanetti, 2012). RT can also be integrated into VT (Feil & Klerk-Rubin, 2012). Multisensory stimulation combines relaxation and exploration of sensory stimuli (visual, auditory, tactile, olfactory and gustatory stimulation), and is based on the idea that BPSD may result from periods of sensory deprivation. Interventions occur in specially designed rooms and last 30 to 60 minutes or 24 hours (Livingston, Johnston, Katona, Paton, & Lyketsos, 2005). The aim is to maintain or improve contact with the person, and to improve her/his well-being by positive stimulation (Verkaik et al., 2005). Although, this therapy is useful during the sessions, according to some authors it has no longer-term effects (Livingston et al., 2005). EOC is a method that mainly consists of VT, combined with the other emotion-oriented treatments already mentioned above (Finnema et al., 1998; Finnema et al., 2000). Droes (1998) defined it as a care aimed at improving emotional and social functioning, and the quality of life of old adults suffering from dementia by assisting them in coping with the cognitive, emotional and social consequences of the disease. Spector, Orrell, and Goyder (2013) identified two EOC studies in their systematic review:

in the Finnema et al., (2001) study, EOC showed to be effective reducing BPSD; in the Schrijnemaekers et al. (2002) study no evidence of the benefits of EOC on BPSD was found.

At last, VT is a method rooted in Rogerian humanistic psychology of communicating verbally and nonverbally with very old adults or persons diagnosed with dementia (Feil & Klerk-Rubin, 2012; Livingston et al., 2005). The main VT principles are (Feil, 1992; Feil & Altman, 2004): all people are valuable and unique, and should be accepted as they are; there is a reason that underlies the behavior of people with dementia; when recent memory fails, people try to restore balance by recovering past memories; when the five senses fail, people stimulate and use their “inner senses” (people see with their “mind’s eye” and hear sounds from the past); when feelings are ignored or suppressed will gain strength; and, people can live on several levels of awareness, often at the same time. VT explains that many disoriented people, who are often diagnosed as having dementia, enter a final life struggle called “resolution” of unfinished issues to die in peace. This struggle has four phases: 1, malorientation, the person is mostly oriented to time and place, and starts expressing past conflicts in disguised forms; 2, time confusion (TC), the person is not oriented to time and place, and she/he is no longer holding onto reality; 3, repetitive motion (RM), the person uses movements instead of speech to express human needs and/or to work through unresolved conflicts; 4, vegetation, the person gives up trying to resolve living, has minimal movement, blank expression, and no speech (Feil, 1992; Validation Training Institute, 2012). Although, people tend to oscillate between phases (e.g. a woman may be oriented at 7 a.m., at 8:30 p.m. be convinced that a man is under his bed and at 8 p.m. want to go to her mother's house), there is one phase that prevails over the others. VT includes specific techniques based on the needs of the individual and her/his phase of resolution, such as: i) the use of nonthreatening, simple, concrete words; ii) speaking in a clear, low, empathic tone of voice; iii) rephrasing verbal communications; iv) responding to the meanings explicit and implicit in verbal and nonverbal communications; and v) mirroring verbal and nonverbal communications. Using validation techniques (delivered one-on-one or in a group setting) is an opportunity to disoriented people express what they wish to express verbal or non-verbally; and when people express the things that have often been suppressed for many years, the intensity of the feelings diminish, people communicate more and are less likely to withdraw into further stages of disorientation (Validation Training Institute, 2012; Feil & Klerk-Rubin, 2012). The evidence base for VT is small and shows mixed findings. A case-control study (Tondi, Ribani, Bottazzi, Viscomi, & Vulcano, 2007) suggests that VT is able to reduce the frequency and severity of BPSD, such as agitation, apathy, irritability, and nighttime disturbance. However, several reviews found insufficient evidence for the efficacy of VT in reducing BPSD (Livingston et al., 2005; O’Connor et al., 2009; Olazaran et al., 2010; O’Neil et al., 2011). It should be noted that VT is probably as effective as other NPIs, not because of the specific techniques, but for what it implies. More than the

techniques, what is effective is the affirmation of the value of the person, the attention given to the individual and to her/his needs, the more intimate relationship between the person and the caregiver, the emotional support, the recognition of the dignity independently from her/his psychophysical condition (Deponte & Missan, 2007). Probably, the reason why VT was never investigated thoroughly has to do with the specific ethical, practical and complex methodological problems one runs up against in experimental research in this field (Finnema et al., 1998).

These interventions were mostly designed to support people with dementia. However, these persons need a formal or informal caregiver; therefore, most of them have been developed in order to support the in/formal caregivers.

BPSD interventions for in/formal caregivers

In addition to interventions targeting on people with dementia, there are also family and staff caregivers interventions. Family interventions provide education and support to informal caregivers of old adults with dementia and assistance in managing BPSD by using unmet needs and behavioral interventions (Ayalon et al., 2006). They include psycho-education, integrated family support, such as counselling and advocacy, training in awareness and problem solving, and support groups. Although the findings are not consistent, some improvements can be found in behavioral outcomes for people with dementia after caregivers had received psychoeducation and/or training in managing difficult behaviors (Dickson et al., 2012).

Staff (formal caregivers) interventions comprise five categories (Spector et al., 2013): i) behavioral-oriented, which help staff understand and modify the sequence of events which lead to behavioral problems, by identifying activators, behaviors and consequences; ii) communication, which teach staff practical communication strategies, enabling them to understand how their communication can trigger behavior and encourage conversations; iii) person-centered, which help staff understand each person as an individual and focusing on their own needs and abilities; iv) emotion-oriented, which train staff to validate and respect the feelings of people with dementia. These trainings may also incorporate other techniques, such as reminiscence therapy, using multi-sensory tools and developing care plans; v) other approaches, which did not fit into any of the previous categories. There is some evidence that staff interventions can reduce BPSD in residents with dementia living in care homes. Also, there is no consistent link between the theoretical approach and the effectiveness of the intervention. In this paper, we use the terms “formal caregiver” and “staff” interchangeably to describe those who work in the RCF delivering direct care, and bringing them together in the term DCWs (direct care workers).

VT training interventions for staff in RCFs: a worldwide perspective

To our best knowledge, seven intervention programmes using VT have been published, six targeting formal caregivers (Table 1). Three studies (Finnema et al., 2005; Schrijnemaekers et al., 2002; van der Kooij et al., 2013) investigate the effect of EOC (which includes VT), and the remaining three use VT as the main intervention. Only Canon's (1995) study holds together both staff and family caregivers in the intervention and control groups. Some programmes evaluate caregivers' benefits, such as satisfaction with quality of relationship with the resident (Canon, 1995; Soderlund, Norberg & Hansebo, 2011; Soderlund, Norberg & Hansebo, 2014), while others focus on behavioral and/or mood variables of residents (Finnema et al., 2005; Schrijnemaekers et al., 2002; Toseland et al., 1997). All studies involve supervision (except for Canon's (1995) study) and control group (except for Soderlund's (2014) study).

Table 1
Training programmes using VT

Authors & Location	Aim	Training Programme	Participants	Programme's evaluation	Main findings
Canon (1995) Texas/USA	To measure the effect of VT training on the quality of the relationship and the satisfaction with communication with patients with dementia	VT by Naomi Feil Two-day workshop (14 hours) or one-day workshop (8 hours)	Family and formal caregivers (n=36)	Control group (caregivers who would like to attend the programme but could not); experimental group (participants) Pre and post training assessment: Hecht's Interpersonal Communication Satisfaction Inventory Dementia Caregiver Quality of Relationship Inventory (developed for this study)	Participants show increased satisfaction with communication
Toseland et al. (1997) USA	To examine the effectiveness of VT in comparison to SC and UC for reducing problem behaviors, use of physical restraints or psychotropic medications, and for increasing positive social interactions and well-being in residents	VT by Naomi Feil Supervision 52 weeks	Residents (n = 31) 4 VT therapists providing VT	2 control groups (residents receiving SC and UC); experimental group (participants) Assessment at baseline, 3 months, and 1 year: Multidimensional Observation Scale for Elderly Subjects Minimum Data Set-Resident Assessment Protocol Cohen-Mansfield Agitation Inventory Geriatric Indices of Positive Behavior	Reduced physically and verbally aggressive behavior on VT group reported by staff (non-participant observers do not confirm these reductions) No significant effects on the psychological functioning, positive behavior, use of drugs and physical restraints

Schrijnemaekers et al. (2002) Netherlands	To investigate the effects of EOC on the behavior of residents with cognitive impairment and behavioral problems	EOC by a qualified teacher Supervision 3 months	Formal caregivers (n=128) Residents (n = 77)	Control group (residents provided with UC); experimental group (residents provided with EOC) Assessment at baseline and after 3, 6, and 12 months: Dutch Behavior Observation Scale for Psycho-geriatric Inpatients Geriatric Residents Goal Scale Cohen Mansfield Agitation Inventory Activities of Daily Living	Results do not confirm the presumed beneficial effects of the EOC
Finnema et al. (2005) Netherlands	To investigate the effects of EOC on formal caregivers and residents with dementia	EOC by a nursing advisor Supervision 9 months	Formal caregivers (n = 46) Residents (n = 67)	Control group (caregivers attending UC training and residents receiving UC); experimental group (participants) Assessment at baseline and 7 months: Residents: Cornell Scale for Depression in Dementia Cohen-Mansfield Agitation Inventory Geriatric Resident Goal Scale Philadelphia Geriatric Center Morale Scale Caregivers: Organization and Stress Scale General Health Questionnaire Dutch Work Satisfaction Scale	Residents: EOC improves emotional adaption and maintenance of a positive self-image for residents with mild to moderate dementia Caregivers: reduced stress symptoms for sub-group of staff who applied more emotion focused strategies

				The number of days of absenteeism	
Soderlund et al. (2011) Sweden	To describe formal caregivers' experiences of relationships with residents before and after a VT training programme	VT by a certified supervisor Supervision 12 months	Formal caregivers (n=12) Residents (n = 29)	Control group (staff with VT experience); experimental group (staff attending VT training) Qualitative interviews about the influence of the programme on daily care	Positive changes in qualitative nature of relationships (improved communication skills and closer relationships) and in residents' mood (quieter, happier, more open-minded, and physically and socially active)
Soderlund et al. (2014) Sweden (The programme in this study is the same as the one described above)	To explore formal caregivers' experiences of a VT training programme and to describe ratings of work climate	VT by a certified supervisor Supervision 12 months	Formal caregivers (n=12)	Experimental group (participants) Creative Climate Questionnaire administered before and after the programme to the entire nursing staff Qualitative interviews	Clear changes in communication strategies Improved work climate
van der Kooij et al. (2013) Netherlands	To investigate whether receiving EOC changes formal caregivers' way of working and whether offering EOC is more time consuming than UC	EOC by a trainer Supervision 9 months	Formal caregivers (n = 61)	Control group (formal caregivers attending the UC training); experimental group (participants) Observation Survey	Increased emotion-oriented skills and knowledge of the residents among participants No significant differences found in how staff spend their time, suggesting that providing EOC is not more time consuming than giving UC

Notes. VT, Validation Therapy; SC, Social Contact; UC, Usual Care.

Current situation in Portugal

In Portugal, the family members play a significant role in the care of old and dependent people. However, in high challenging situations (as dementia) families need formal care services, namely Residential Care Facility (RCF), to provide care (Ministry of Labour, Solidarity and Social Security [MLSS], 2015). RCF consists of an establishment for collective housing with temporary or permanent use, in which social support, meals and health care are provided (MLSS, 2018). According to Decree-Law no. 67/2012 of 1 March, the maximum capacity of the RCFs is of 120 residents; it also establishes the minimum of staff, considering DCWs and qualified professionals (care-home manager, animator, nurses, and sometimes a psychologist). The care-home manager should be a qualified professional with higher education in social and behavioral sciences, social or health services, who coordinates and supervises staff, oversees residents' care and schedules activities.

In 2016, mainland Portugal had 2 445 RCFs (with a total capacity of 94 976 residents) with an occupancy rate above 90% (MLSS, 2018). Given the limited (nonexistent) facilities specifically developed to care for people with dementia, these old adults tend to be institutionalized in conventional RCFs (Barbosa, Cruz, Figueiredo, Marques, & Sousa, 2011). The DCWs are the core of the residential care system, since residents spend most of their time with them. Yet, the overwhelming majority are middle-aged women and the educational level is typically lower than that of health care workers, not being required some kind of training in gerontology or in dementia (Fujisawa & Colombo, 2009; Stone, 2012). Therefore, training staff to understand and manage BPSD seems essential for the safety and quality of life of old adults with dementia (Ballard et al., 2001; Spector et al., 2013; Stone, 2012). During the past few years, institutions have acknowledged the need for education and training of staff members and have reacted with a multitude of initiatives and programmes, offering further education and training for formal caregivers (Kuske et al., 2007). To the best of our knowledge, VT training programmes have never been implemented in Portugal before. However, considering the effectiveness of this humanistic approach (Finnema et al., 2005; Feil, 1992; Feil & Klerk-Rubin, 2012; Soderlund et al., 2011), it seems important to train staff in communication and interactional skills. VT training is provided to help caregivers develop communication skills in their interactions with residents with dementia, by accepting residents' reality and by validating their feelings with the use of multiple verbal and non-verbal communication techniques (Feil, 1992).

The aim of this study is to design, implement and evaluate a VT training programme (V^{AL}IDA) for staff members of a RCF in Aveiro, Portugal.

The RCF where this study was performed has a capacity of 30 residents (plus 10 users for day care), located at Aveiro. The old adults have different degrees of in/dependence, and variable mental perturbations, such as dementia and Parkinson. Residents usually have their own bedrooms and share common areas; have access to services, such as meals, assistance with

personal care, help with medications, housekeeping, and laundry; 24-hour supervision; and social and recreational activities. The day care provides supervision, care during daytime hours (usually only on weekdays), a variety of activities, meals and some therapies.

Planning

V^{AL}IDA was developed based on research and literature from the VT, primarily developed by Naomi Feil (Feil, 1985; Feil & Klerk-Rubin, 2012; Sunrise Senior Living [SSL], 2011). V^{AL}IDA was meant to improve skills of the staff about dementia, in order to understand and manage BPSD, and consequently improve well-being for both residents and staff (Kuske et al., 2007). The programme was named V^{AL}IDA, which is an acronym that brings together two Portuguese words, meaningful within the VT: “validar” that means to validate; and “vida, which means life.

The training programme was developed in a RCF in Aveiro with around 36 residents/users (nine diagnosed with dementia). It was approved by the direction of the institution and announced according the institution common procedure (includes: a poster in the staff room with key information, such: topics, and schedule; and a notification in the book of incidents).

Then, the programme design was embedded by the needs reported by the staff. The facilitator was in the RCF for one month (around 15h per week) to collect the needs, observe and become familiar with the context, and to establish a link with the staff. The needs and difficulties were gathered during dialogues through daily work routine, and comprise two main components. First, general information on understanding dementia as a chronic disease (sometimes it is assumed that people with dementia pretend some behaviors, such as swearing), and dealing with the challenging behaviors (such as: how to deal with a person who is recurrently returning to the past). Second, dealing with specific behaviors of residents with dementia. It was observed that the stages two (TC) and three (RM) (according to Feil, 1985) are the most common in the RCF among residents with dementia. The staff reported struggling with people in TC, since they “ask questions and demand answers”, and staff often have “to lie” since they do not know another way (lying is a big burden). Regarding RM, the staff struggled with the bizarre and intrusive behaviors (such as clapping hands and/or graving others), since this promotes conflicts between residents.

Planning a training programme in an institution that operates 24/7, every day of the year, with some members of the staff working in shifts, demands some adjusted arrangements. It was decided that the participation was voluntary (although highly encouraged), there was no previous registration, and participants could attend the session/s they wish (i.e., a participant could come just to the session 3, or could be in all).

In addition, it was decided to carry out each session twice, so the participants could choose the one that better adjusted to their schedule. Moreover, the RCF has 28 staff members, what would be too big for just one training group (mostly it would hinder discussion/debate). All the

sessions were scheduled for Tuesday (previously defined by the care-home manager as the day for training; from 10:30 to 11:30 am, or 15 to 16 pm (periods between residents meals).

Participants

Globally, 22 (out of 28) staff members participated in at least one session. However, due to working circumstances, only 15 were present in at least three sessions (the *completers*) (Table 2).

Table 2
V^{AL}IDA: Participants and completers

Characteristics	Participants (n=22)	Completers (n=15)
Age (years) <i>M</i> ± <i>SD</i>	46.19 ± 11.91	48.27 ± 12.64
Gender n (%)		
Female	21 (95.5)	15 (100)
Male	1 (4.5)	0 (-)
Academic qualifications (%)		
Up to 4 years of schooling	4 (18.2)	6 (40.0)
5 to 9 years of schooling	7 (31.8)	3 (20.0)
Secondary education	5 (22.7)	2 (13.3)
Higher Education	6 (27.3)	4 (26.7)
Education on geriatrics and/or gerontology n (%)		
Yes	4 (18.2)	2 (13.3)
No	18 (81.8)	13 (86.7)
Professional category n (%)		
DCWs (direct care workers)	18 (82.0)	13 (86.7)
Care-home manager	1 (4.5)	0 (-)
Administrative assistant	1 (4.5)	0 (-)
Psychologist	1 (4.5)	1 (6.7)
Animator	1 (4.5)	1 (6.7)
Total years of care experience n (%)		
Up to 1 year	2 (9.1)	0 (-)
1 to 4 years	8 (36.3)	5 (33.3)
5 to 9 years	10 (45.5)	8 (53.3)
≥ 10 years	2 (9.1)	2 (13.3)

Notes. M, mean; SD, standard deviation.

Participants average age is around 46 years old; mostly females, frequently without education on gerontology and/or geriatrics; predominantly DCWs, with 5 to 9 years of experience, and low education. *Completers* average age is slightly higher than the participants' (around 48 years old); all female, with almost half of them having up to 4 years of schooling; with the exception of two *completers*, all are DCWs, have no education on gerontology and/or geriatrics and predominantly 5 to 9 years of experience.

Procedure

V^{AL}IDA comprised two components: training sessions in group (Table 3); and individual monitoring between sessions. The group training included four sessions held during a period of 6 months. Between the sessions, the facilitator (1st author) accompanied each participant (in particular the DCWs, who are the direct caregivers) weekly for individual monitoring in the application of the contents; the monitoring aimed to supervise the practice of VT techniques, and support the staff to develop their skills in their interactions with the residents.

Each session was planned for 1h of duration. The four sessions were structured as follow (Table 3): beginning with the center exercise (excluding the first), doubts and revisions, new topic and debate, and finalization (with more doubts and fulfilling the post-session questionnaire). In each session, participants received a handout summarizing the most important information. It was planned to have a query box available during all the programme duration for participants to expose their issues; however, participants preferred to expose the doubts personally to the facilitator during the monitoring (and, therefore the box was removed after the 2nd session).

The first author, who is a psychologist with vast knowledge in VT, facilitated all the sessions. As stand by Feil (Feil, 1992; Feil & Klerk-Rubin, 2012), VT is an approach that requires personal qualifications (be able to listen attentively and be truly present in relationships), that the facilitator should have embedded in her/his posture. The methods/activities involved theoretical exposition of contents, debate, sharing of experiences, clarifying doubts and playing games (Table 3).

Table 3
V^{AL}IDA: Sessions structure

Sessions	Content
1	Presentations (facilitator; participants; program) Main topics: VT, dementia, and ageing Centering exercise
2	Centering exercise Revisions Query Box: doubts Further validation techniques
3	Centering exercise Second stage of resolution (TC)
4	Centering exercise Third stage of resolution (RM) with the game <i>Repetopoly</i>

First component: Group-training sessions

Session one

The first session aimed at familiarizing participants with the VT and V^{AL}IDA. It began with the presentation of the facilitator, the participants, the programme objectives and format, and the query box.

The facilitator was in the RCF for one month to prepare the training, so was already known by the staff; and the staff worked together for a long time. So the presentations were made in the following way: each participant presented the colleague sitting next to it (the facilitator was included in this dynamic), indicating the name, main hobbies and favorite artist. This was after framed as a way to underline the importance of knowing the preferences of the residents with dementia (it is important to look at the whole person, not just her/his disease process, losses or weaknesses). The aim of the programme was to provide the staff with VT techniques that allow them to interact with residents with dementia in an empathic way. In fact, according to Feil (2012) by using VT techniques, the staff can improve the lives not only of the people for whom they care, but for themselves as well. Therefore, this training will improve the staff and the residents' well-being. The query box was present as a way for the participants to expose their doubts anonymously. Participants were encouraged to write down their queries and put them in the box; and, in the following session, the facilitator would respond to them.

The main topics involved bringing together VT, dementia and ageing; i.e. gathering what they already knew with the new topic on VT. This was addressed through nine interlinked cards. Each card had a word/expression and a related picture. Mainly the cards aimed at: raise awareness for the identity of the person to the detriment of the disease, and the importance of (verbal and non-verbal) communication; identify barriers when communicating with residents; provide communication strategies; briefly clarify the VT, its principles (e.g. do not lie nor discuss), and the resolution phase; and introduce the centering exercise.

The cards words/expressions were (presented in the following order) (Feil & Klerk-Rubin, 2012, SSL, 2011): 1) Person with dementia vs person with Dementia; 2) Communicate; 3) Barriers; 4) Bridges: empathy, validation, reminiscence; 5) Past (returning to); 6) Express (to dump the heavy backpack of emotions); 7) Do not argue; 8) Do not lie; 9) Levels of awareness. Randomly, each participant received one of the cards; when participants were less than the cards, casually some of the participants received two cards. The participant with the card showed, the facilitator explained, and then the participants might present their experiences and doubts.

Regarding card 1, Person with dementia vs person with Dementia, the facilitator emphasized the importance of viewing people with dementia as very old people in a final life struggle (rather than as “a disease”). Participants stated that when a resident is upset “*it becomes more difficult to put the person first*”, since “*we absorb the energies of the resident*” [Constança¹]. Participants asked for a technique that could help them “*to have a kind of shield to deal with*

¹ All names are entirely fictitious

residents” to avoid the “*negative transference of emotions*” [Carmo]. The facilitator introduced the centering exercise (which was planned to be performed at the end of the session), as a resource to better cope with those emotions.

The card 2, communicate, was presented as a challenge: the participant who got it had to transmit its content without using words (emphasize the power of non-verbal communication). Participants acknowledged that people with dementia often express their emotions and feelings through the body. They were particularly concerned about negative emotions and behaviors (e.g. crying, beating, and pounding). Hence, the facilitator introduced the underlying unmet needs: to restore a sense of equilibrium, when eyesight, hearing, mobility and memory fail; to make sense of a painful reality (to find a place that feels comfortable and where relationships are familiar); to feel recognition, identity and self-worth; to be loved and secure; to be useful and productive; to be listened and respected; to have sensory stimulation; and to reduce pain and discomfort.

The card 3, barriers, was immediately associated by the participants to their lack of time: “*we would like to spend more time with them, to talk, give love and affection, but we cannot*” [Constança]. They also mentioned that “*residents often speak of past situations and we don’t know what to answer, (...) always repeat the same things and pronounce unclear words with no apparent meaning*” [Constança]. The facilitator explained that people with dementia have their own reality, often “located at the past”; this is coupled with diminished ability to communicate verbally; i.e. they use more body than words. Other barriers were related to sensorial deterioration (as, hearing, sight) and impaired memory or ability to recognize friends and loved ones.

The card 4, bridges: empathy, validation, reminiscence, was focused on how caregivers can access to residents’ reality (bridges enable to cross the barriers). Participants related the term empathy to “put ourselves in the residents’ shoes”. The facilitator emphasized the centering exercise, as a way for the caregivers to be free of their own emotions and to accept/feel the emotions of the person. The terms validation and reminiscences were new for the participants. The first was explained as an empathic way for the staff to enter into the world of disoriented people and feel what they feel. The second was a way to explore the past of any person, so to help the person to remember ways she/he coped with difficulties, which can enable coping in the present; and/or remind the person of pleasant experiences that can bring joy and comfort in the present.

The card 5, past (returning to), emphasized that it is age appropriate for the very old people to return to the past to solve unfinished business, in order to die with peace. Participants shared that “*this is the most common in the RCF, they talk about the past, the father, the mother, their professional life*” [Constança].

The card 6, express (to dump the heavy backpack of emotions), means that in old age, people with dementia struggle to dump a backpack of emotions they have lugged. They will feel relieved when her/his emotions are validated with empathy. Participants gave some examples of

residents who need to express emotions from their past, and that “*clearly express the need to be loved and safe*” [Constança].

The card 7, do not argue, underlined the importance of respecting the reality of the person, and avoid orientation to “our” reality. Participants wanted to know how to answer in regular situations; for instance, they talked about Mrs. Paula who “*wanted to go to work, because it was time*” [Carmo]. The facilitator suggested the focus in the emotion and not in the content, for example asking “you don’t like to be delayed for work, don’t you?” (Touzinsky, 1998).

The card 8, do not lie, closely related to the previous one, since the caregiver should not discuss, neither lie to the person. Participants underlined that lying is a burden they carry since they find difficult not to lie. “*I think since I came here I’ve learned to lie... I often don’t know what to answer, ‘your mother is coming soon, don’t worry!’*” [Carmo]. The facilitator suggested the use of two techniques: rephrasing (the caregiver repeats the essence of what the person has said, using the same key words, pacing the tone and cadence of speech); using factual words, like ‘what’, ‘who’, ‘when’, ‘where’, ‘how’ (instead of “why”, that confronts the person with their feelings, leading to retreat).

The card 9, levels of awareness, depicted that people live at different levels of awareness, often at the same time. That means that we should not lie to those with dementia because on some level they know the truth. Participants were surprised but recognized that, both in themselves and in the others; and wondered about the situation of some residents, such as: “*Mrs. Pilar seems not to be aware of things most of the time, but maybe deep down she is...*” [Cátia].

Then, the centering was fully introduced, and practiced as an additional resource. Participants acknowledged the benefits, “*centering myself and getting into the right mindset will help me a lot to deal with residents*” [Cátia]. By the end of this session, participants stated that they are always tired, since they have an exhausting job, and asked to receive handouts with the summary of each session topics (this was provided). The session lasted approximately 1 hour 10 minutes.

Session two

This was mainly a support session which aimed to respond to participants’ doubts and introduce further validation techniques. It started with the centering exercise, followed by a brief revision of the previous session. Then the session focused the questions left in the query box, which were also used to present other validation techniques (Feil & Klerk-Rubin, 2012). The three questions were printed font size 120 in a paperboard, and in the session showed and discussed.

The first question was “*what should the caregiver do when interacting with a resident with dementia?*” The facilitator suggested three essential techniques (centering, empathy, and linking the behavior with the unmet human need), that were already introduced in the first session with some further explanations and examples. Participants also shared some of their experiences:

“Before going to bed, many of them [disoriented ones] tell us to kiss them; it’s definitely the need to be loved” [Constança]

“Sometimes they tell us to lie down on the bed next to them, to sleep too!” [Clara]

“We need to see how they have been in the past, and respect them where they are now [...] and support the needs that are being expressed!” [Clara]

“Entering their world doesn’t mean lying, as we said in the last session!” [Camila]

The second question was *“should we enter their world? Does it mean lying to them?”*. For the participants the topic of lying is quite relevant, since they prefer not to lie, but they lack alternatives. So, the facilitator explained that entering the person’s world is not lying, but accessing their world, helping her/him to relive pleasurable moments of the past. Some examples involving residents were provided. Mrs. Palmira is always asking for her deceased mother and the staff usually say *“she is coming soon”*. It was suggested that they use rephrasing (*“do you want to see your mother?”*) and factual words (*“what did she look like?”*).

The third question was *“which techniques should be applied when communicating with Mrs. Petra?”*. Mrs. Petra is confused, sometimes knows where she is, while other times she thinks she is still at her home. Then, the facilitator described the four phases of resolution, and explained that Mrs. Petra is mostly in TC. Some validation techniques were recommend and exemplified. For instance, when she says *“I don’t want to be here”*, it is possible to use polarity, and to ask *“this is really the worst place for you to be”* (in the facilitator experience, Mrs. Petra becomes calm and explains that that place is not the worst to be). Participants understood and stated that: *“I’d never thought that way, but it makes sense”* [Carmen].

Such as the first session, the second lasted approximately 1 hour 10 minutes. It was decided to stop the query box, since participants were sharing their doubts during the in-between sessions monitoring and they preferred to talk instead of writing.

Session Three

The aim of this session was to characterize the TC phase (most common in the RCF) and deliver validation techniques for this stage. The session began with the centering exercise, and participants shared their experience with this technique that they were using:

“It’s a way of helping us get rid of our own problems!” [Claúdia]

“This is quite relieving. I have taken some deep breaths at home, because sometimes I feel something bad is going to happen, and deep breathing relieves!” [Carla]

Regarding TC phase, the facilitator started by describing the main physical and psychological characteristics. Then, participants described features of the residents that matched; for example:

“They are constantly grabbing our hands!” [Cidália]

“Their gaze is unclear, I couldn’t agree more!” [Carla]

“Mrs. Pamela had a doll. It was her son, she saw him as a real baby. First we had to dress the ‘baby’ and only then we could dress her!” [Celia]

“I had no idea they could still read, I thought they had already lost that ability!” [Clara]

Then, the facilitator presented the 12 validation techniques recommended for this stage (each printed in A5 cards): centering; factual words; rephrasing; polarity; genuine, close eye contact; ambiguity; clear, low, and loving tone of voice; mirroring; linking the behavior with the unmet human needs; preferred sense; touching; music. Some were already approached in the previous sessions, and therefore just briefly explained; while the ones’ that were new were more deeply explained. For the participants, some of these techniques were felt as more useful and easier. About the use of a loving tone of voice, participants shared *“no one likes to be spoken loudly”* [Célia]; *“neither they nor we like being spoken loudly. It scares!”* [Cecília]; and *“we don’t have to speak loudly, we just need to speak closer to the person’s ear”* [Cíntia]. Mirroring was found as more difficult, since it *“mess with my own emotions”* [Cidália]; the facilitator suggested that participants may use the centering exercise, and should choose the technique that is more congruent with their own feelings. Identifying and using the preferred sense allows the caregiver to step into the person's world. Participants were surprised, but acknowledged that this technique is of great relevance to their work. Again, during this session, participants (mostly DCWs) were very tired, and some linked the lack of time with not doing the best they should with the residents, and some dissatisfaction with their own job performance:

“The important thing to work with old people is to give love and more love, but often we do not have time!” [Catarina]

“There’s always a need behind the behavior, but sometimes we have so much to do that we don’t even think about it. We do so many things wrong in our work!” [Cecília]

The session lasted between 50 minutes to 1 hour.

Session four

The last session aimed to characterize the person in RM and provide techniques that caregivers could use to prevent the withdrawal to vegetation. It was structured differently from the previous ones, as it closed the cycle of VT training: started with the centering exercise and then a board game inspired by Monopoly® was played. The game was named *Repetopoly* since it refers to phase three of resolution (repetition of movements). Participants randomly formed teams of two; each team was represented by a small plastic token (maximum six teams). The teams took turns in order, with the initial team determined by chance before the game. The turns began with the rolling of the dice and advancing the token clockwise around the board to the corresponding number of squares. A game controller (the equivalent to the shift manager) was required, and the participants chose it.

The *Repetopoly* game-board consists of thirty-six (the number of residents/users at the RCF) spaces, comprising: spaces with indication to move on, to move back, or to play again; eight question spaces; and eleven information spaces. When a team lands on a question or info space, the game controller draws the top card from the respective “question” or “information” deck and read the question/information aloud. The team members can talk to each other, but only one, the spokesperson of the team, should give the final answer. If the answer is correct, the team rolls again; if it is wrong, the team turn ends. The facilitator, whenever necessary, complemented the cards’ information. A team wins by being the first team to land directly on the space labelled “Go”. The staff participated with great enthusiasm and attention, and team cooperation was strong (particularly around the debate about answers). Some answers were easily responded; while others were more challenging. Some of the standing moments of the game are depicted next.

Regarding the information card: “Memories of early and consolidated movements are revived in order to people in RM survive the painful present”. The facilitator highlighted that repetitive movements at RM stage, are a way for people to restore their dignity, and satisfy basic human needs. Participants noted “*probably when the Mrs. Palmira is clapping, this may symbolize a consolidated movement from the past, because she’d clap to attract the attention of her pupils. When she claps her hands, it’s also to draw our attention*” [Cecília].

In the question card: “True or false? People in RM use body parts, other people, or objects to symbolize significant people or events from the past” [Answer: true]. Participants answered correctly and linked to their experience: “*Mrs. Pamela always carried the doll with her; perhaps it was the desire to have a child. She was married but had no kids*” [Cidália]; “*she confused the care-home manager with her niece, I believe it was because of her voice and physical appearance. She took care of her niece when she was little*” [Clorinda].

In the question card: “True or false? It is common at this stage people repeat sounds they have learned in childhood, including cackling, groaning and chanting” [Answer: true]. Participants showed that they now understood better some of the residents; for instance: “*sometimes they make children’s noises, but I never thought it was normal!*” [Cidália].

About the information card “Use the ambiguity to respond to the person. If she/he speaks unknown words, use a vague pronoun to answer her/him (“he”, “she”, “it”, “someone” and “something”).” The facilitator explained that people in RM tend to move their tongue, teeth, lips and jaw, creating new words (non-dictionary words); also combining several words into one (for instance, Mr. Paulo, as the adult speech goes, often says “cêcemplo”, “contenter”, “tátatatátãm”). Participants described ambiguity as “*a way of not breaking their reasoning when they are trying to communicate with us*” [Cátia].

In the information card “True or false? Unlike maloriented, people in RM need touch as a way of relating to the present reality” [Answer: true]. The facilitator enhanced that people in RM are no longer aware of where they are. To communicate with them, the caregiver must enter

their world and touch them in the same way a loved one would touch them (sometimes they start speaking after that). The participants compared behaviors between residents in RM and the maloriented ones; for instance: Mrs. Pierrina, at the maloriented stage, still independent and does not show need for touch; while Mr. Paulo, at the RM stage, is always grabbing people to touch and kiss.

In the information card “Mirroring the person’s motions is a recommended technique for RM phase. The caregiver should mirror the movements of the person's feet and hands, and facial expressions.” The facilitator highlighted that the purpose of this technique is not to imitate the person, but to reflect empathically and genuinely their movements. The caregiver should observe her/his eyes, and pacing. Participants did some sharing; for instance, Cidália said: *“I usually mirror when resident C. is clapping, but I didn’t know I was doing well!”*.

For the information card, “Disoriented people have to go back to the past, in order to dump the heavy backpack of emotions they have lugged for years, and feel that life was worth it.” The facilitator stated that disoriented people need to release all the painful feelings they have carried throughout their life, to die with dignity and self-respect. Also, it is emphasized the key role of caregivers in accepting and validating the person’s feelings. Participants mentioned *“validation is indeed a therapy to relieve the burden, to die in peace; it works with our emotions”* [Camila].

At the end of the session, the participants shared their perspectives about the benefits of V^{AL}IDA, thanked the institution for providing quality education, and congratulated the facilitator for her performance:

“Thank you very much for all of this. Thanks to the institution for providing us with these trainings. These trainings help us deal with difficult behaviors. What we had here was a moment of sharing, and clarifying our doubts. I’d definitely attend this kind of trainings whenever the institution offers it!” [Cíntia]

“Sometimes we do things in practice, but we don’t know if we’re doing well. For instance, using mirroring that we talked here. I used to mirror with the resident C., but I didn’t know it was a technique, or even if it was correct to do. With this training we have the confirmation if we’re doing well or not! Thank you!” [Cidália].

This session lasted between 1 hour to 1 hour 20 minutes.

Second component: Individual monitoring in-between sessions

The aim of this component was to give individual and private attention to each member of the staff doubts, and to support them adopting the VT techniques in daily practice. The facilitator embodied the empathic principle of VT, and in these periods the staff gained support for professional and personal issues. Individual monitoring occurred between sessions with both DCWs and other qualified staff. With DCWs it was performed by accompanying them during

daily routines; while with others was through conversation and exchange of ideas and information.

Regarding DCWs, the monitoring occurred mostly at the night shift (6pm to 11pm), because it is a quieter moment, when the RCF has only residents and DCWs. In addition, night and in particular before bed time is a moment where “all comes about”. This monitoring was planned to be individual, but in some occasions, it involved two staff members, because they were together delivering care. Often this monitoring occurred in the bedrooms, while residents were helped to go to bed. It was mainly a moment to talk about their own life, both personally and professionally; doubts about use of the techniques were clarified. Usually each member of the staff got monitoring once a week. This bounded the facilitator and the staff, creating a close and affectionate relationship (involving hugs and kisses, and small gifts).

Programme evaluation

Objectives and methodology

The programme was evaluated in order to: collect suggestions from the participants to better adjust the programme to their needs; and to identify the personal and professional benefits. The methodology of data collection comprised two modalities: post-session questionnaire to evaluate the session functioning and the facilitator performance, given to participants at the end of each session; focus group interviews with the participants, six months after the end of the programme (to understand what has been maintained).

Post-session Questionnaire

Post-session questionnaire was designed by the facilitator to evaluate the functioning of each session. It is an individual questionnaire based on a 4-point Likert scale (1 – insufficient, 2 – sufficient, 3 – good, and 4 - very good), comprising 9 items; 6 evaluating session functioning, and 3 assessing facilitator performance (Table 3). There were also two open questions: would you recommend this kind of sessions to other professionals/ caregivers? what improvement suggestions would you like to make?

Focus group: instrument and sample

The focus group (Greenbaum, 2000) was aimed to get feedback about the programme from the participants and to get a deep knowledge of its impact in a medium-term. The focus group was performed through a semi-structured interview, consisting of three questions: 1) What is your opinion concerning the functional aspects of the V^{AL}IDA?; 2) What is your opinion concerning the contents and activities used in the sessions?; 3) What are the personal and professional benefits of participation in the V^{AL}IDA? As the interviews were in group (5-8 elements), the participants heard other participants’ responses and made additional comments as they went along, knowing that they did not have to reach any kind of consensus or to disagree.

This made participants more comfortable, as they were not being evaluated. The interviews were led by the facilitator at the participants' workplace with an average duration of 60 minutes; were transcribed and submitted to content analysis. The sample corresponds to the *completers* (e.g. Table 2).

Results

Post-session Questionnaire

Main findings indicate that classifications are all around the value 4 (very good); excepting the item relating to the duration of the first session that was scored at a lower value, as the participants thought the sessions would be longer. Concerning the open questions, all participants responded that they would recommend V^{AL}IDA to other professionals or caregivers, and asked for more sessions (once a month is not enough) with longer duration (Table 4).

Table 4
Post-session questionnaire means

Domain	Session			
	1 (n=14)	2 (n=16)	3 (n=16)	4 (n=13)
	M/SD	M/SD	M/SD	M/SD
Session functioning				
Were the objectives of the session clear?	3.4 ± 0.5	3.4 ± 0.6	3.8 ± 0.4	4 ± 0
Was the session well structured?	3.6 ± 0.5	3.4 ± 0.6	3.6 ± 0.5	3.9 ± 0.3
Were the topics convenient?	3.7 ± 0.4	3.7 ± 0.6	3.8 ± 0.4	3.7 ± 0.4
Were the materials appropriate?	3.5 ± 0.5	3.3 ± 0.7	3.4 ± 0.6	3.8 ± 0.4
Were the activities interesting?	3.8 ± 0.3	3.7 ± 0.5	3.8 ± 0.5	3.8 ± 0.4
Was the duration of the session adequate?	2.8 ± 0.7	3.1 ± 0.7	3.3 ± 0.7	3.1 ± 0.7
Facilitator performance				
Was the facilitator clear in the exposition?	3.7 ± 0.4	3.9 ± 0.7	3.8 ± 0.5	3.8 ± 0.5
Did the facilitator master the subjects?	3.7 ± 0.4	3.7 ± 0.5	3.8 ± 0.4	3.8 ± 0.4
Is the facilitator available for your questions?	3.8 ± 0.3	3.8 ± 0.5	3.9 ± 0.5	3.8 ± 0.3
	n	n	n	n
Would you recommend this kind of sessions to other professionals or caregivers? Yes	14	16	16	13

Focus group

With regard to the spacing between training sessions, participants were unanimous to consider that *“once a month is not enough”* (Clara), *“the sessions should be closer to each other to avoid forgetting, I mean at least twice a month”* (Clarinda). However, they recognized that *“logistically speaking it’s difficult”* (Candida). The spacing between sessions was also associated by participants with the duration of each session, considering *“if it were two monthly sessions, 1 hour would be perfect, and it was no longer needed to extend the sessions’ time”* (Cândida). However, they recognized that *“as you did, between 45 minutes to 1 hour, is enough. If it were more than that, we’d fall asleep. (...) the brain turns off”* (Cláudia).

With respect to the composition of the training groups, all participants agreed that it was good to *“mix everything”* (Clara), that is, bringing all the staff members together, *“regardless of their level of education”* (Celeste) and role (psychologist, care-home manager, sociocultural animator), because *“we are a team. We participate in everything together all year long. (...) It doesn’t make sense to be selective here”* (Carmen), and *“it is the importance of multidisciplinary”* (Candida). They pointed out that *“we are also getting to know each other better”* (Clara), because in the work routine this is not always possible. For the number of participants in each session, participants considered that *“it has never affected us, as long as we respect each other. It is important to listen to our colleagues, not interrupting the other person”* (Clara).

Regarding the adequacy of the themes, participants considered that *“it was good, because [themes] were about our day-to-day work and clarified our doubts”* (Clarinda), and *“sometimes it was about our life, which is also important”* (Clara). They emphasized that the themes were appropriate since *“all the things we talked about here, we actually do it in practice”* (Cármen). However, they pointed out that *“sometimes it is difficult not to lie”* (Cármen); this was a difficult subject to understand and would require more discussion. They stated that *“sometimes lying is the way”* (Carolina), otherwise *“we lose control of the situation and consequently they [residents] become more disoriented”* (Cecília). At this moment, some examples were given by staff members, and the facilitator clarified the difference between lying and entering the reality of the person with dementia. In the examples (*“if we wanted Mr. Pedro to collaborate with us we started talking about the papers, because he wanted to sign, he spent his whole life signing papers because of his job”*, Carolina), it is clear that participants were not lying as they supposed, but entering the reality of the person to relive pleasant moments, and satisfying basic human needs (the need for productivity/utility).

Concerning the methodologies, which combined both expositive and active methods, they considered that *“both are essential, the most theoretical part first, and then the practical part to apply the new concepts”* (Cristina). The group context was also valued, since it allowed normalization (*“I did like sharing experiences with the group, and knowing that my colleagues*

also have similar situations in their interactions with residents”, Carolina) and cooperation (“to help each other how to deal with residents’ behavior. If it worked well in this way, and the resident was quieter, I can share my technique with the group”, Cláudia). Participants emphasized the fun and learning playing *Repetopoly*, remembering who was first and second, and some questions from the cards (“I still remember, we came in second place. There was a question and suddenly I remembered the example you [facilitator] had given us about Mr. Paulo”, Carolina).

Participants did not report negative impacts. The positive impacts were felt both on personal and professional level. On a personal level, participants said that it was useful for their lives (“we learned not only to apply the techniques to our residents, but also to ourselves. We learned to release what is going on inside us, to dump the heavy backpack of emotions”, Celeste), and also to deal with their relatives (“it helped me to better understand my mother, who was diagnosed with Alzheimer disease... It also helped me to accept her the way she is right now”, Clara). Participants stated that V^{AL}IDA has helped them to separate the professional life from the personal life (“we separate work from home affairs, we can now separate things. Sometimes we took work issues home with us, and vice versa. Now I can separate things a lot better because it was not being good for me”, Celeste). On a professional level, they felt that V^{AL}IDA has helped them: i) feeling more empowered and skillful, and less stressed (“I’m more satisfied with what I am doing. I feel more secure in performing everyday care and satisfied to be able to do a little more for the residents”, Clara; “it helped me to better understand the other person, and not be affected by the situations as much as I were before”, Cármen); ii) to better understand dementia, and accept the person with dementia (“gave me another sensitivity with residents with dementia and dementia itself”, Carla); iii) understanding and supporting colleagues, releasing emotions and improving communication skills (“it helped me to better understand my colleagues, and to be more with them, since sometimes (...) we forget they are people like us and have their own problems too”, Clarinda; “we learned to (...) dump the heavy backpack of emotions, and to express more what we think and feel”, Celeste); iv) dealing with conflict situations with residents (“it helped me to better solve problematic situations with residents”, Cristina).

Discussion

This study focused the design, implementation and evaluation of V^{AL}IDA for staff members of a RCF in Aveiro, Portugal. Globally, it showed to be well accepted by all the participants, with personal and professional impacts on the well-being. This programme was designed based on VT (Feil, 1985; Feil & Klerk-Rubin, 2012), and implemented according to VT principles. It is our perspective that a VT programme should be congruent by using validation in all its aspects.

Therefore, the design was developed respecting (validating) the setting, the staff, and the residents. Some features of the design underlined its validating approach. The setting, a RCF, is a facility where a number of old persons inhabit (with different ages, degrees of in/dependence, and variable mental perturbations), cared by a limited number of staff 24/7. Therefore, the training sessions needed to be limited to a small number during a medium period (four sessions, in six months), and be supported by monitoring during daily routines. The staff were involved in a voluntary basis, without previous registration, and could attend the session/s they wish/can. This was a way to validate the emotional and physical demands of the job, where staff have to deal in a daily basis with suffering, mental perturbation, and working mostly in shifts. The residents were not directly involved, but sessions were designed considering the main stages of dementia in the RCF, and monitoring was held also in direct care.

In terms of implementation, participants stated that V^{AL}IDA was well structured regarding the spacing, duration, contents, methodologies, composition of the groups, and number of participants. In terms of spacing between sessions, participants first pointed out that it would be better twice a month, however they recognized that it would be logistically difficult. In addition, the duration (approximately 1 hour) seemed to be preferable, considering the fatigue and attention levels of the participants. The themes addressed the daily care and life issues, which were both considered important and appropriate. So, a VT training needs to recognize and validate the participants, what was recognized since participants reported professional and personal gains/impacts. Concerning the methodologies, it was emphasized its order (the lecture part before the more practical/active one), and the *Repetopoly* was appointed for its educational and fun purposes. Therefore, for a staff with a high demanding job, it is relevant to adopt a mix of methods; bringing together passive and active approaches (it should be noted that sometimes the staff was so tired that they could fell asleep during the sessions). The groups in the training sessions involved members of the staff, despite their education and function; the participants considered this as a good option, because they are a team that works together all year long. The participants stated that a group context is important, since it allowed for the normalization of experiences and cooperation between members. In addition, they also think the individual monitoring was of value, because it allowed for clarifying doubts and building a close relationship with the facilitator. The role of the facilitator in a VT training needs to be emphasized. The

communication incongruence, i.e. when verbal and non-verbal information are inconsistent, diminish trustworthiness (Morioka et al., 2016). Therefore, the facilitator needs to embody the validation techniques (being able to listen to and empower, motivate, and be respectful and empathic). It is also relevant that the facilitator spends time in the RCF (beyond training) to know the RCF dynamics, the staff, and the residents' characteristics (and have examples from the residents in the training).

Two main situations were underlined by the participants: lying and conflicts. Lying was the way staff were dealing with the residents in the TC stage, reported as a burden that the staff was carrying and needed to release. During the sessions, the principle of not lying was pointed out as difficult, and the main uncertainty was whether entering the person's world and lying were the same. This topic requires more attention in future trainings, probably integrated into practical exercises, such as role-playing. Conflicts among residents with and without dementia are common (Ferreira, Tavares, & Sousa, 2018), mainly when residents with dementia are in RM stage; the staff struggled with their own inability to break conflicts. Beyond the techniques shared within the programme, future training could involve a component for the oriented residents.

The evaluation indicated that participants reported well-being on both personal and professional levels, and the improved capacity to separate personal life and work. On a personal level, the participants stated that they were provided with techniques, which allowed them to deal with their elderly parents, and to work internally on themselves. Professionally, participants stated empowerment, self-efficacy, and less stress. Mostly DCWs underlined that this was the first time they had a psychologist in the institution to also care for them, which made them feel more valued and supported, and consequently more confident about their skills. In-between sessions monitoring established a close relationship between the staff and the facilitator, maintaining the adherence to the training. Additionally, the participants reported a changed approach, focusing more on residents and on their communications; and that the training helped them to support each other.

RCFs in Portugal struggle with balancing the budget, since it is a high cost service that serves the older population that in Portugal have in general low pensions. Therefore, costs are an important issue. V^{AL}IDA demands a professional with high training in VT, working during about six months, in half time. However, it may have high benefits (at least in a medium term) such as: diminishing stress levels of residents and staff; lessening doubts related to dementia and consequently improving care quality and reducing pharmacological interventions; and promoting a good work climate where staff members support each other more.

Limitations and research perspectives

The main limitation of this study is the small sample size. Further studies should involve the replication of this programme in other RCFs, in order to increase the sample. This would

also be a way to use quantitative measures and carry out randomized control trials. It would be relevant to assess staff well-being, job satisfaction, work climate (Soderlund et al., 2014), and perceived stress levels. The individual monitoring component could be enhanced by using supervision (as Soderlund et al., 2011) including a video recording of one conversation with the same resident once a month, plus feedback from the supervisor on the conversation. In terms of further improvements, it would be relevant to add two other components to the program: VT training with the oriented residents to increase understanding, and diminish conflicts; and VT training with family members, for a better understanding and reinforce the work/approach by the staff.

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