

**Building Relationships to Enhance Resident-Centered Care:
A Trainer's Guide to an Emotion-Focused Intervention**

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Our goal in writing this manual is to provide ways for direct care staff to improve their own and residents' lives by 1%. Our target is deliberately modest; its magnitude acknowledges the tremendously complex and challenging nature of caring for persons with dementia and the absence of any "quick fixes." At the same time, there is room for improvement. Faced with an almost continuous downward spiral of cognitive and functional losses, even small, momentary experiences of positive feelings represent a step toward improved quality of life - for both staff and residents.

This Manual

You are about to embark on an exciting approach to enhancing resident care in your facility: "resident-centered care" (Rader, 1995). As a first step, we ask that you take the time to read the preliminary sections of this manual before diving in to the hands-on applications. Although the exercises are self-contained, we feel the background is important because it explains our way of thinking and sets the stage for the applications. As a trainer, you will be better equipped to respond to questions from the personnel you are teaching if you have a fuller understanding of the concepts behind this approach.

This manual will begin with a discussion of the rationale for resident-centered care, taking the notion of psychosocial models of care as a starting point. Our approach draws extensively upon the work of Joanne Rader (e.g., 1995) and Thomas Kitwood (e.g., 1997, 1993) in emphasizing the importance of caring for the whole person, not just his or her physical needs, and of considering the special challenges posed to professional caregivers charged with this task. Although the principles are not new, we believe that they have not yet been integrated adequately nor translated into a form that can guide care providers in their awesome job. The two-pronged

implications of resident-centered care - for the care provider and for the resident - will be elaborated throughout the manual.

The manual will establish a framework based on the centrality of emotion in all experience. Emotion will be a continuing and guiding theme, tying together the entire manual. The role of emotion in the lives of care providers introduces our version of “Physician, heal thyself:” the proviso that care providers must take care of their own feelings before they may begin to take care of the residents’. Turning to the residents, we discuss emotion as an indicator of quality of life, its role in dementia, and the clues it provides to understanding and addressing behavioral symptoms.

Next, the manual applies the first notion with a series of group exercises on “Taking Care of Your Feelings First” (Part I). Several important points receive additional attention in sidebars on emotional intelligence, body language, cognitive-behavioral feeling logs, positive coping strategies, and resources for material to further inspire and motivate your staff. The second set of exercises address “Taking Care of Residents’ Feelings” (Part II), applying the principles presented in Part I to resident care and adding an in-depth look at the skills of active listening. Parts I and II overlap to some degree, so that either may be presented independently. However, in keeping with our overall model, we strongly recommend that Part I be included and be delivered first.

Resident-Centered Care

In her excellent book, *Individualized Dementia Care: Creative, Compassionate Approaches* (1995), Joanne Rader defines a paradigm shift in how we approach care for persons with dementia. Moving away from a medical, paternalistic model (Evans & Strumpf, 1995), the new approach emphasizes holistic, individualized care based on the resident’s unique needs. In

describing resident-centered care, Rader (1995) convincingly argues for the value of establishing a relationship with each resident as a means for understanding often seemingly illogical behavior as a reflection of an unmet need and thereby improving the provision of care. It is only within the context of a trusting and mutually respectful relationship that high quality care can be delivered (Zgola, 1999). We would further contend that, more than facilitating care provision, the relationship itself *is* care provision, and is at the heart of resident-centered care.

Despite its intuitive appeal, the philosophy of resident-centered care has not yet been widely embraced. Resistance stems from both the institutional system and the direct care provider. System level obstacles include regulatory and sanction pressures and the fear of litigation if one deviates from tight conformation to uniform protocols, high staff turnover rates which make it difficult for staff to get to know and develop relationships with residents, and a lack of clear standards to guide the provision of more individualized, humanistic care (Rader, 1995, p. 6).

At the level of the direct care provider, the pervasive operation of a “hospital model” (Rader, 1995, p. 3) and deficits in both skills and motivation may drive the failure to fully adopt a philosophy of resident-centered care. For Certified Nursing Assistants (CNAs), for example, vocational training typically emphasizes physical care. The work environment is based on a medical model in which power is held by those at the top of a hierarchy of medical professionals and residents are described almost exclusively using medical language (e.g., “patients”), reduced to the sum of their physical complaints. In such an environment, CNAs are unlikely to feel that psychosocial care, let alone resident-centered care, is within the parameters of their job description. If they do attempt to adopt a model of resident-centered care, professional caregivers find themselves in the unenviable position of being asked to perform a wide range of

physical care tasks with great efficiency, while simultaneously being expected to offer warmth, nurturing, and meaningful companionship to the residents for whom they care. Although a strategy of emotional detachment may allow staff to meet the everyday demands of caring for an exceedingly needy population, high quality resident-centered care imposes the additional burden of offering residents an emotional connection.

Providing high quality care requires a combination of skill and motivation. A growing body of research demonstrates that we can teach CNAs specific skills such as behavior modification, empathy, and positive communication (Baltes, Neumann, & Zank, 1994; Brandriet, 1995; Burgio, 1993-97; Kihlgren et al., 1993; Stevens et al., 1998). An appreciation for the “emotion work” (Hochschild, 1983) required of direct care staff suggests that the skills of emotional intelligence are equally critical, though as yet untested. Extending the emotion focus to the resident reveals the value of teaching staff to attend to and assist in regulating the emotions of the resident, for example by applying skills in active listening.

A neglected area of study is the motivation that underlies the provision of quality care. Attempts to explain staff’s motivational deficits lead one to explore - and, ultimately, to intervene in - the emotional lives of the staff members themselves. Poor motivation may stem from feeling unappreciated by both the residents and one’s supervisors. Learning about the limitations imposed by dementia may help the care provider to adjust his or her expectations of being shown traditional signs of gratitude. The problem of feeling unappreciated by one’s supervisors brings us full circle back to the model; as long as the supervisor is tied to a medical model, he or she will be unable to define “good” psychosocial, relationship work and so to offer deserved praise.

Motivation also may be affected by the painful losses and deterioration that staff witness daily in the residents for whom they care. In addition, some residents, especially those with behavioral symptoms, simply may have personality traits that are difficult to like. Finally, like everyone else, direct care staff are likely to have occasional bad days during which they feel unsociable, with no interest in interacting with *anyone*. Despite these challenges, when one asks CNAs what they value in their job, they report “simply being with and relating to their residents... making these connections proved to be a very valuable source of job satisfaction” (Speaking from Experience, 199*, p. 45). Therein lies the paradox with which staff are confronted every day: how to provide high quality psychosocial care, the hallmark of which may be entering into genuine, meaningful, emotional relationships with residents, in the face of residents’ extreme neediness, challenging and at times oppositional behavior, and inevitable death.

Intervention Delivery Issues

The humanistic philosophy that underlies resident-centered care extends to the conduct of this training intervention, as well, and requires that special attention be given to the manner in which the intervention is delivered. In this section, we will recommend a structure and process for the intervention that aims to optimize its reception by participants. Elements of the intervention’s structure include its timing, format, audience size, seating arrangements, and incentives for participation. This workshop may be especially useful if delivered at the beginning of a CNA’s career, perhaps as part of a training program or initial orientation to a facility. Keeping the sessions to one hour or less makes them easier to incorporate into typical training schedules. Given that the goal of this approach is, essentially, the development of relationships, it makes sense that the means for achieving the goal is itself interpersonal in

nature. Therefore, intervention in a group format is essential, although it may be complemented by other formats such as paired learning or small groups of three (Speaking from Experience, 199*). The optimal group size is 7-9 persons, to provide opportunities for contact among all group members while injecting enough variety to nurture a dynamic group experience. We recommend that participants arrange chairs in a circle to facilitate group interaction. However, some participants have noted a preference for seating around a table, which appears to provide a degree of protection for those who are not immediately comfortable with the personal nature of this group encounter. In such cases, it may be possible to progress to a more open seating arrangement as the group becomes more cohesive. Cohesiveness and comfort may be fostered by providing refreshments, which lend a social, casual, and warm tone to the interaction. It may be useful to offer incentives for attendance, including a lottery for a free meal or movie tickets. Ideally, the motivating force of these incentives will be replaced by the intrinsic reward of a positive group experience.

In *Speaking from Experience* (*, 199*), a manual for CNAs caring for persons with dementia that was developed from the contributions and creative problem-solving of other CNAs, the authors present a set of “helpful hints about group discussions” (Trainer’s Guide, p. 6). These include recommendations to graciously accept everyone’s contributions, validate and connect similar ideas by writing them on a chalkboard, involve as many people as possible, be patient in allowing for responses, and encourage participants to be highly specific in their solutions (p. 6). We would add the importance of being sensitive to broader, institution-wide dynamics that may be operating in the group, such as tensions within or across disciplines that may impede the participants’ willingness to share openly with the group. Although this intervention ultimately may offer some relief of these tensions, usually they are beyond the scope

of the group experience and should be respected when attempting to solicit participation. In fact, participants may spend a good part of the initial session simply venting, expressing their general discontent with their employer and job situation. It is critical that the trainer not take these outbursts personally and respond defensively. The venting should not dominate the session, but neither should it be squelched. In fact, as way of showing your support and lack of defensiveness, you can note the value of venting (or, “catharsis”), explaining how it can promote sense of empathy and universality, all of which are seen as “healing” factors of group interactions. When participants express a sense of fatalism, believing that this workshop won’t make any difference, it is important to acknowledge the need for bigger solutions but remind them of the 1% idea – and note that the 1% applies not just to the residents, but also to them. When they express mistrust of you, as an extension of their general mistrust of their employer, make it clear that they need not share anything personal if they are uncomfortable.

The delivery of the intervention is multifaceted, incorporating techniques of brief didactic presentations, large and small group discussions, repeated reviews of the principles, and applications through personal anecdotes from the trainer and participants. To maintain the focus on an interactive, collaborative learning experience, didactic instruction is kept to a minimum. Whole group discussions are augmented by having pairs or triads discuss a topic and present their conclusions to the larger group. Periodic solicitation of “gems,” or participants’ comments regarding what they have learned or found most valuable thus far helps to reinforce the material and ensure its comprehension by participants. Comprehension also is enhanced by describing how the material may be applied to very specific work situations and by connecting it to events in the participants’ home lives, including exchanges with family and friends. Often, an example that highlights a participant’s interaction with his or her children drives home an otherwise

abstract, dry message. Although they certainly are no substitute for genuinely interactive learning experiences, posters or buttons may serve to remind staff of the information they've learned in the workshop.

Caring for the Caregiver

Amid the overwhelming level of need in the nursing home, it is easy to forget the enormous challenges inherent in the job of caring for persons with dementia. Caregivers continually are faced with conflicting demands to be simultaneously efficient and nurturing. CNA and nursing training tends to emphasize physical care and the work environment operates according to a medical model wherein power is held by the medical personnel, residents are referred to as "patients," and "care planning" often devolves into a discussion limited to bodily functions. This emphasis on medical and physical care pulls for efficiency, and does not convey to staff that resident-centered - or even psychosocial - care is part of one's job. In fact, staff may face explicit conflicts, such as complaints from supervisors and peers, if they try to focus on residents' emotions and psychosocial needs in the face of demands for efficiency.

Within this context, deficits in skill and motivation contribute further to the challenges facing caregivers. Psychosocial skills simply are not routinely taught to CNAs; performance in these areas cannot help but suffer. Without the skills necessary to deal with their own emotions, staff may adopt a strategy of "numbing" themselves, whereby they attempt to stifle all feelings in order to get through their shift without exploding at a resident in anger or despair. Lacking basic emotion-related skills such as listening actively or recognizing emotions in persons with dementia, the task of providing care may become overly daunting.

Motivational issues, including the dearth of extrinsic motivators and the emotional drain inherent in the caregiver's role, pose another set of challenges. Demented residents often are

unable to express feelings of gratitude in a traditional manner. If staff expect to see conventional expressions of recognition or acknowledgment, they may feel unappreciated and disheartened. Supervisors who don't value a psychosocial model of care will fail to reward staff for their efforts in this arena. Staff who feel unappreciated by residents and supervisors or who aren't rewarded for providing psychosocial care will feel little motivation to do so.

Although seldom acknowledged in the literature, direct care staff face tremendous losses daily, as they witness residents' cognitive deterioration, physical degeneration, or death. Given this inevitable decline, the best staff can do is attempt to maintain the residents' functional ability and well-being for as long as possible. Thus, the caregiver's job offers little opportunity to experience success, as conventionally defined. If one's barometer is set for improvement, one will be greatly disappointed. Fearing continuing losses, caregivers may be inclined to adopt a self-preserving strategy of emotional detachment that resembles the numbing described previously. At the extreme, detachment may lead caregiver to resign from the job - contributing to the startling turnover rates reported in the literature (recent estimates as high as 97% annually; AHCA, 1997). Only with extensive support to develop skills and meet the enormous challenges of maintaining relationships can caregivers be expected to carry out the "emotion work"(Hochschild, 1983) that is the hallmark of their job. That is, we first must care for the caregiver before we can expect the caregiver to be sensitive and to develop meaningful relationships with residents.

Importance of Emotion

Emotions may be seen as important for two primary reasons. First, they are central in all our experiences and represent indicators of quality of life (Lawton et al., 1999). Second, they serve important appraisal, motivational, and communicative functions (Bowlby, 1969). In Lawton et

al.'s (1999) model of quality of life, positive and negative emotions represent the primary subjective indicators of quality. Attention to emotion in dementia serves several purposes related to quality of life. Recognizing that a person continues to feel helps us to respond to his or her individuality and humanity, restoring personhood. By attending to emotions we gain important clinical information that guides care provision. Because this knowledge likely will help us to understand the person better, our relationship with him or her will be improved. By tuning in to someone's emotions we can tell whether they are satisfied or whether something should be changed in their environment or in the way care is being provided to help minimize negative feelings and maximize positive ones. Informal monitoring of emotions also helps us determine what might be provoking a positive or negative emotional reaction. For example, we may detect triggers for agitation or catastrophic reactions, or identify activities or care approaches that the person will respond to with pleasure or interest. More formally, we can use documented emotional experiences in planning care and tracking intervention outcome. Finally, attending to emotions fosters a sense of agency in caregivers. Staff morale depends on maintaining a sense of accomplishment or an ongoing demonstration that one's efforts have an impact on resident well-being. *When a caregiver is sensitive to someone's emotional signals, the caregiver receives feedback that may be highly reinforcing, as the feedback means that the caregiver can make a difference for the care recipient (Lawton, 199*).

Emotions also serve important functions. The experience of an emotion provides an appraisal of a situation, furnishing information that organizes and directs our behavior (Bowlby, 1969). For example, a woman's feeling of jealousy provides an appraisal of her husband's inattentiveness that may inspire her to hatch a plan to surreptitiously follow him all over town, in an effort to catch him in the act. In their motivational function, emotions provide the impulse to

take action. The jealous wife will be motivated to carry out her stalking plan. Finally, emotions serve a communicative function, signaling our needs to others and allowing others to take efforts to address them. The jealous wife's facial expression might show a combination of sadness, anger, and fear; if detected by her husband, this expression should communicate that she needs some reassurance about their relationship.

Emotion in Dementia

Despite initial impressions of residents' challenging behavior and confused cognition, the nursing home is a world of emotions. Although some research suggests that persons with dementia may show a reduction in their emotional responses, in fact, the bulk of the evidence indicates that these individuals remain emotionally reactive. Studies demonstrate that persons with dementia experience depression, and verbalizations that at first may appear unrelated to the environmental context often, with careful consideration, are revealed to be meaningfully related to what is going on and to represent a language of strong emotion. Overall, we can expect persons with dementia to continue to respond to emotional stimuli and to express emotions.

For persons who may no longer be able to report their thoughts and feelings verbally, emotional expression becomes a subtle but critical indicator of the impact of others' behaviors or the broader environment. Tuning in to these small signs may be the only means by which staff can detect their impact on the resident, whether positive or negative, and thereby adjust their care. Even small responses from residents provide CNAs with a sense that what they are doing matters, essential to maintaining morale and their commitment to providing quality care.

It is important to recognize the centrality of emotions not only because emotions help to explain behavior, but also because failing to do so may compromise care quality. That is, if caregivers adopt a theory of dementia that ascribes challenging behavior or cognitive impairment

to deliberate attempts at manipulation or to shortcomings of character, they are less likely to offer a compassionate response or one that is successful in ameliorating the identified problem (let alone alleviating the demented person's distress). In contrast, learning to interpret "problem behavior" in light of the emotion that stimulated it offers caregivers clues to successful intervention and can guide the provision of care.

The next sections of this manual detail the specific steps of the intervention, beginning with a focus on staff members' feelings and then shifting to an exploration of how to improve resident care by taking care of residents' feelings. The staff intervention ("Taking Care of Your Feelings First") is divided into two sessions. The first session introduces the centrality of emotions and the importance of being aware of what we are feeling and being able to exert some control over our impulses. The second session discusses how we can manage emotions to create a better life for ourselves at work and at home. Trainers should feel free to elaborate throughout the workshop; real-life examples usually are the most persuasive. Likewise, trainers must be prepared to respond flexibly to whatever examples or questions the participants throw out. It is preferable to maintain a comfortable dialogue with participants rather than rigidly conform to the prescribed workshop plan.

Conclusion

The power of our emotional lives, the overarching theme of this intervention, is nowhere more evident than in the experience of the intervention itself. With your skillful guidance, participants will tune in to and share their emotional experiences, an exploration which we hope will have lasting impact on the way they approach their work and home lives. To extend the impact of this intervention, it is important to follow up by assigning additional homework

exercises and by offering continuing incentives, acknowledgment, and praise for the practice of resident-centered care.

With this manual, we have attempted to present a philosophy and approach to care that, while certainly not new, has yet to come into its own in the practice of long term care. Resident-centered care emphasizes the primacy and healing value of relationships, which emerge from and are woven with emotional experience. Bringing care providers on board with this approach begins with highlighting the world of emotions that permeates their every interaction with residents, family, and friends and helping them to recognize and strengthen their ability to take control of their emotional lives and to manage the emotions of demented nursing home residents to optimize positive feelings for both. A four-session intervention can barely begin to accomplish this ambitious goal; the real work remains for institutional leaders to embody and model these principles and to reward staff members who aspire to develop meaningful connections with the residents for whom they care.

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