VIPS Communication Skills Training for Paraprofessional Dementia Caregivers: An Intervention to Increase Person-Centered Dementia Care

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A communication skills intervention was developed based on Dawn Brooker's four elements of person-centered dementia care: Valuing people, Individualized care, Personal perspectives, and Social environment (VIPS). The aim of this study was to test the feasibility of a series of workshops built around VIPS, intended to increase the person-centered communication, beliefs, and attitudes among paraprofessional dementia caregivers in a long-term care facility. The effect of the intervention on communication strategies, caregiver burnout, and other variables associated with the quality of caregiving was examined using a pre- and post-test design. Details of the intervention design and execution are discussed, as are findings regarding intervention outcomes. The intervention was determined to be highly feasible based on successful implementation, positive caregiver feedback, and promising exploratory analyses of outcome measures. Following the workshops there was a reduction in caregiver depersonalization of residents and an increase in both empathy and hope for those with dementia. In addition, caregivers reported using more concrete communication strategies known to be effective with those who suffer from dementia. Given this encouraging preliminary evidence, the VIPS communication skills intervention is suggested as

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a useful tool to improve the quality of dementia care provided by paraprofessional caregivers in long-term care facilities.

KEYWORDS   communication skills, dementia caregivers, person-centered care, training

In the 1980s and 1990s, growing attention to disability rights and the low quality of institutionalized care led to a movement of new and better approaches to caring for those with dementia. One of these approaches was "person-centered dementia care." Kitwood (1988, 1997) made the first reference to the person-centered approach in relation to dementia care. Drawing on Carl Rogers' model of person-centered psychotherapy, Kitwood used the term to represent a philosophy and mode of care in which communication and relationships played a central role. Although the term "person-centered" has since become frequently used in the field of dementia care and has come to denote quality care, there was a lack of consensus as to the exact meaning of the concept. Brooker (2004) reviewed the existing literature on person-centered dementia care and identified four essential elements of the approach: valuing those with dementia and their caregivers, recognizing the individuality of those with dementia, acknowledging the perspective of those with dementia, and promoting an environment that facilitates optimal well-being for those with dementia. Following Kitwood's tradition of presenting ideas as equations, Brooker summed up the elements as follows: PCC (Person-centered care) = V (Value) + I (Individualized) + P (Perspective) + S (Social Environment). The present study involves a communication skills intervention for paraprofessional caregivers that is organized around Brooker's VIPS model of person-centered dementia care.

PARAPROFESSIONAL CAREGIVERS

The majority of paid workers in long-term care facilities are paraprofessional care providers. These paraprofessional caregivers are hired to meet the physical and emotional needs (e.g., feeding, bathing, toileting, comforting) of older adults and those with impairments in care facilities and play a crucial role in ensuring function and quality of life for their charges. Unfortunately, despite the demanding nature of their job, these paraprofessionals are often underappreciated, receive low wages and benefits, receive little training, and shoulder heavy workloads (Stevens-Roseman & Leung, 2004; U.S. Department of Health and Human Services, 2001). These conditions and the resulting burnout that ensues have resulted in high turnover and vacancies, which is problematic in light of the growing number of older adults in need of long-term care (U.S. Department of Health and Human Services, 2001; Zimmerman et al., 2005).

Caregivers of those with Alzheimer's and other dementias are at a particularly high risk for burnout (Mackenzie & Peragine, 2003; Takai et al., 2009). Burnout is a state of exhaustion—emotional and physical—that erodes mental health and organizational commitment (Pines & Aaronson, 1988; Williams, Savage, & Linzer, 2006). Three hallmarks of burnout are patient/client depersonalization, emotional exhaustion, and reduced sense of personal accomplishment (Maslach & Jackson, 1981). A number of studies on dementia caregivers have established a strong association between burnout, depression, and reduced quality of life, especially psychological quality of life (Takai et al., 2009). In addition to adversely affecting the individuals experiencing it, the negative affective states characteristic of burnout reduce the quality of care provided to care-recipients (Miller, Birkholt, Scott, & Stage, 1995).

Importantly, staff turnover creates a disruption in continuity of care and the caregiver-resident relationship, impeding the delivery of quality care (Boyle & Miller, 2008; Seavey, 2004). Specifically, knowledge of individual residents is fundamental to the concept of person-centered care; without such knowledge, a decline in person-centered care is inevitable. In a 2010 report, the Center for Excellence in Assisted Living (CEAL) clearly states that, "Without staff stability, it is impossible to sustain PCC [person-centered care] or any other quality effort" (p. 17). According to the CEAL, existing staff often feel overwhelmed by the added responsibility of training new employees on top of their other numerous duties, a strain which can negatively impact resident care. Furthermore, new employees must become oriented with care protocol and form relationships with residents and fellow caregivers, both of which take time and pose interruptions to person-centered care provision in the care facility (CEAL, 2010). Lack of training is another notable challenge. It is widely recognized that paraprofessional skill training is an "under-met need" and it is suggested that providing training is one way to help ease the strain experienced by those in the occupation and improve quality of care (Stevens-Roseman & Leung, 2004). A 2005 "Better Jobs Better Care" report states that, "direct-care workers are put in situations that require unusually sophisticated interpersonal and communication skills" for which they do not receive sufficient training (as cited in CEAL, p. 18).

INTERVENTION EFFORTS

A number of interventions directed at dementia caregivers working in long-term care facilities have indicated that communication skills-training programs possess the capability to improve caregiver job satisfaction and quality of care for residents. The importance of communication skill training is not surprising, given the communication difficulties (e.g., trouble comprehending and producing messages) experienced by those suffering from

dementia, often leading to problematic interactions between caregivers and residents.

Williams, Kemper, and Hummert (2003) administered a communication-training intervention focused on reducing patronizing speech ("elderspeak") used by nursing home staff. The intervention resulted in significantly less elderspeak, replaced by speech rated as less controlling and more respectful by coders. An intervention by Stevens-Roseman and Leung (2004) for paraprofessional caregivers at a dementia center involved instruction on topics such as active listening, techniques for communicating with residents with memory loss and emotional and physical pain, and methods to assist residents in expressing themselves. The training was effective in creating more positive beliefs about aging and older adults, greater knowledge of communication techniques, and improved communication skills. In their FOCUSED program Ripich, Wykle, and Niles (1995) taught long-term care facility caregivers verbal and nonverbal techniques to improve communication with residents suffering from Alzheimer's disease. Among some of the FOCUSED techniques offered were facing the individual with Alzheimer's disease, using touch, eye contact, and the resident's name; repeating nouns rather than pronouns; and restating a conversational topic throughout the conversation. Following participation in the program, caregivers had increased knowledge of communication strategies, and reported feeling more satisfied and in control when in conversations that in the past would leave them feeling frustrated and ineffective. Bourgeois, Dijkstra, Burgio, and Allen (2004) implemented a communication skills program with dementia caregivers in a nursing home, via didactic in-service and one-on-one training. Numerous specific communication behaviors were reviewed, such as "address the resident by name," "give short and clear instructions," and "talk about resident's life or day." When compared with a control group, trained caregivers demonstrated significant improvement on all targeted communication skills and maintained improvement from baseline levels even at three months post-test. Finally, McCallion, Toseland, Lacye, and Banks (1999) assessed the impact of the Nursing Assistant Communication Skills Program on both dementia caregivers and residents. The program consisted of several sessions in which effective (e.g., yes/no questions, reducing background noise) and ineffective communication techniques (e.g., ignoring, correcting) were discussed and practiced. The caregiver training resulted in improved knowledge of communication techniques and reduced turnover among staff. Significant improvements in behavior among residents were also noted—behavioral disturbance, depression, and physically and verbally aggressive behavior all declined and remained low months after the conclusion of training.

Though there have been a range of efforts involving communication skills training for dementia caregivers, no existing program has been organized specifically around set principles of person-centered care. The aim of this study was to examine the feasibility of a communication intervention

for caregivers based explicitly on Brooker's (2004) four elements (VIPS) of person-centered dementia care and to see whether the intervention fostered more person-centered attitudes, beliefs, and communication behaviors.

METHOD

Setting

The study took place in a for-profit long-term care facility in the US Southwest that specializes in memory issues. The majority of the residents suffered from suspected Alzheimer's disease, although some residents also suffered from other dementias (e.g., Lewy Body Dementias, Parkinson's disease, etc.). The residents lived in "cottages" with about 15 residents per cottage (70 beds total); cottages were organized by stage of disease, with similarly functioning residents grouped together. Staff are consistently assigned to the same cottage (hence to the same group of residents) wherever possible within the constraints of organizational scheduling. The facility has approximately 30% annual turnover in caregiver staff. All new staff are required to have 16 hours of training specific to dementia, in a program nationally recognized as an excellent model for communities specializing in dementia. Training is based on a program that focuses on residents' abilities, not liabilities, in a failure-free environment. The areas covered in initial staff training are: normal aging versus Alzheimer's disease, communication, managing behaviors, personal care, quality of life system (activities), the caregiver and family, and ethics. In all of the modules communication is discussed, but the module specifically addressing communication is focused on learning how to communicate with people who have dementia, and is roughly two hours long.

Participants

Fifty caregivers at the facility were eligible to participate. A final sample of 26 caregivers attended at least two workshops and completed pre- and post-test measures; 18 of these 26 attended all four workshops. Attendance was not mandatory and was outside of regular work hours (although it was compensated); hence 100% participation was highly unlikely. Questionnaires were completed at monthly staff meetings, one of which occurred 4 weeks before the beginning of the intervention, and the second of which occurred about 6 weeks after the end of the intervention. Most caregivers in our sample were female (89%); 46% were 18 to 30 years old, 27% were 31 to 49 years old, and 27% were 50 years of age or older. Ethnicity data were not gathered on the sample, but of the caregivers at the facility, approximately 35% were South or East Asian, 35% were Hispanic, 15% were White, and 15% were Black.

Design

The intervention was offered in four 1-hour workshops over a period of 4 weeks, with each weekly workshop devoted to one of the four elements of Brooker's (2004) person-centered dementia care. Each session featured an explanation of the week's concept (V, I, P, or S) and communication skills training, focusing on communication skills that were shown to be effective in the dementia care literature and that corresponded with the particular element of person-centered care being taught. Workshops included videotaped vignettes, power point slides, discussion, group and dyadic activities, role-playing and guided visualization exercises. Though participation in the workshops was not required, caregivers were encouraged to attend, and attendance was counted as paid time. Every session was offered three times, organized around shift-changes to make attendance convenient. The intervention was facilitated by two university faculty members with research expertise in gerontology and provider-patient communication. Materials for the workshop are available from the authors and will be distributed via the web per request. Detailed description of the structure and content of each session is provided below.

SESSION 1

The first session began with an introduction and overview. The facilitators explained that the goal of the workshops was to improve the quality of care provided to residents and maximize caregivers' interactions with residents, making their jobs more rewarding and in some cases, easier. The caregivers were asked to share what they felt was especially challenging about caring for those with dementia. Responses were written on a large easel by one facilitator while the other led the discussion. Caregivers identified the following challenges: resistance when attempting to feed and bathe residents, meeting resident demands and emotional needs, communicating with residents, limited resident attention span, resident anger and aggression, resident range of function, homesickness, wandering, searching for spouse, and family coping. The facilitators explained that material covered in the workshops would assist the caregivers with many of these challenges. A record of the challenges was retained, and throughout the four sessions, when concepts or communication techniques were applicable to a caregiver-listed challenge, this relevance was clearly elucidated. In an overview of the workshops, facilitators explained the origin and concept of person-centered dementia care, and Brooker's (2004) four elements (VIPS) were reviewed briefly. It was specified that each of the four workshops would be devoted to a different element of VIPS.

"*Valuing people*" (V) was the focus of Week 1. According to Brooker (2007), those with dementia and their caregivers must be recognized as valuable human beings who possess rights and are worthy of respect. Attitudes

about aging were explored after first asking the caregivers, "What happens when you age?" After receiving a majority of negative responses (e.g., "You lose your memory," "You can't do things for yourself"), the group discussed the content and consequences of negative attitudes about aging. Additionally, negative attitudes about Alzheimer's disease were addressed. A positive gerontology perspective was then offered—that is, older adulthood does not diminish one's capacity to learn, grow, and enjoy life (Harwood, 2008). Furthermore, by making social and environmental adjustments, functioning and quality of life can be improved for those with Alzheimer's disease (Dawson, Wells, & Kline, 1993).

Respectful versus disrespectful communication was then discussed. Time was spent, in particular, on "elderspeak" or patronizing speech—speech characterized by "simplistic vocabulary and grammar, shortened sentences, slowed speech, elevated pitch and volume, and inappropriately intimate terms of endearment" (Herman & Williams, 2009, p. 417). Use of elderspeak by staff is widespread in long-term care settings, particularly when caring for residents with dementia. Use of elderspeak prompts resistance to care among older adults, primarily in the form of negative vocalizations which include such vocal behaviors as crying, yelling, and screaming (Herman & Williams, 2009). Participants watched three video vignettes from Williams and colleagues' (2003) intervention to reduce elderspeak. These clips depicted a caregiver and resident interacting in different scenarios and illustrated respectful versus disrespectful communication. Following the clips, participants were given examples of elderspeak and asked to provide an alternative, more respectful form of the message. Lastly, facilitators discussed the important role of the dementia caregiver; caregiving was acknowledged to be demanding, both emotionally and physically, and the great influence that caregivers have over resident quality of life was discussed. At the conclusion of the first session, caregivers were asked to practice one of the techniques from "Valuing people" with a resident prior to attending the next workshop, and to fill out and return a handout. Instructions on the distributed handouts prompted caregivers to write down which technique they had chosen and describe the situation in which they used it, how it felt to use the technique, and how the resident reacted.

SESSION 2

The second workshop began with a review of the main points of Session 1 followed by a discussion of the caregivers' use of Session 1's techniques. Volunteers were asked to share the experiences they wrote about on their handout, and the facilitators collected all of the completed handouts. Session 2 focused on the element "*Individualized care*" (I), which involves tailoring care in recognition of the fact that those with dementia are individuals who

each have their own unique personalities, life histories, and illness experiences (Brooker, 2007). The key concept of "personhood" was explored in this session. The dementia that accompanies Alzheimer's disease is often perceived as a "loss of self" in light of deteriorating cognitive function, memory, and communication ability. Kitwood (1997) challenged the concept of dementia as a loss of self, and asserted that personhood is constructed interpersonally, defining it as, "A standing or status that is bestowed upon one human being, by others, in the context of relationship and social being" (p. 8). Thus, the facilitators' role in the second session was to emphasize ways in which the caregivers could maintain and support residents' personhood.

In Session 2, a "quick poll" was taken in which caregivers were asked to raise their hands to indicate which option best described them. They were asked the following:

"Who takes a shower—in the morning? At night? Both?"
"Who is a—night owl? A morning person?"
"When you are sad—who likes to talk about it? Who gets quiet?"
"When it comes to meeting new people—who likes it? Who would rather not do it?"

All caregivers participated, and many were amused by each other's answers. The point was made that just as the caregivers have different personality traits and preferences, so do residents. Volunteers were asked to share differences they observed among the residents under their care—caregivers shared numerous differences in tastes, habits, and the like between the residents. Afterward, concrete techniques for individualized care were discussed. For example, the group discussed that some residents were more receptive to and capable of communication at specific times of day or during particular activities. Attending to those differences makes communication easier and more effective. Similarly, engaging residents in activities that they enjoy (art versus physical activity, group versus one-on-one interaction) influences the success of encounters. The session also included material on differences in resident abilities and limitations and discussion of how to respect and work with these differences.

Finally, the importance of recognizing and honoring residents' identities was covered. Caregivers were asked to take a few minutes to reflect and "Write down 7 to 10 things that make you *who you are*." Volunteers then shared what they wrote with the group; often, descriptions involved gender, family roles, occupation, ethnicity, hobbies, favorite things, and past experiences. A discussion followed, in which identity was emphasized as something that is created and maintained through interactions with others. Techniques for honoring resident identity were reviewed. For example,

caregivers were urged to learn about residents' work history and family, hobbies, sources of pride/joy, and significant life events like migration or war and use this knowledge to better understand, connect with, and manage residents. Two actual examples of caregiver-resident communication episodes ("The Supervisor" and "The General") were read from Dran's (2008) study on using residents' past to create satisfying and effective interactions in the present. During and after the reading, caregivers in attendance expressed a special liking for these real-life scenarios and commented that it reminded them of their own residents. A final activity for Session 2 was to provide caregivers with a list of residents possessing different characteristics or histories (e.g., a former teacher, a former nurse, a nature enthusiast, a resident who likes to laugh, and a proud mother of 9 and grandmother of 23). Volunteers shared specific things they could do or say to recognize these individual differences and the personhood of the resident. At the conclusion of the workshop, caregivers were asked to practice a Session 2 technique and complete a handout before the next session.

SESSION 3

The third workshop began with a review of the Session 2 key points, followed by a discussion of the caregivers' use of Session 2 techniques. Volunteers were asked to share the experiences they wrote about on their handout and afterward, all completed handouts were collected. Session 3 addressed the element of "*Personal perspectives*" (P). This element concerns the importance of seeing the world from the perspective of those with dementia in order to explain and understand their behavior and provide quality care (Brooker, 2004). Kitwood (1997) believed empathy to be a critical component of person-centered dementia care. As such, the mental and emotional experience of dementia was discussed in Session 3.

Effects of Alzheimer's disease on the brain were explained, and communication-related consequences of normal aging (e.g., high frequency hearing loss, short-term memory loss) and Alzheimer's disease (e.g., loss of word retrieval, difficulty understanding) were reviewed. In light of the communication challenges those with dementia face, the facilitators presented numerous nonverbal techniques (e.g., face residents at their level, utilize touch) and verbal techniques (e.g., use concrete language, repeat keywords) for better communication. These were drawn from the Alzheimer's Association (2010) and Ripich et al.'s (1995) FOCUSED program. Caregivers worked in pairs or groups of three to discuss techniques they already used and found helpful in their interactions with residents. These techniques were shared with the larger group.

Following the activity, further communication strategies were reviewed, including Sabat's (1991) notion of indirect repair (see also Gentry & Fisher,

2007). Indirect repair occurs when a listener repeats or rephrases an apparently "incorrect" statement by someone with dementia, with the primary goal of maintaining conversational flow rather than "correcting." For instance, an Alzheimer's patient saying "We're in Spain right now" might be responded to with "This is Spain?" The question seeks the patient's understanding of their current situation and encourages further talk. In contrast, a direct repair ("No, we're not in Spain") simply corrects the patient, shuts down further talk, and potentially disorients the patient. The concept of indirect repair was illustrated with transcripts from Sabat's work and the facilitators initiated discussion of ways in which indirect repair can facilitate smooth interaction with someone suffering from dementia. The final material covered in the session involved strategies (i.e., distracting and redirecting) for dealing with problematic behavior based on recommendations from the Alzheimer Association on avoiding arguments with Alzheimer's patients (Alzheimer's Association San Francisco Bay Chapter, 2012). Faced with an impossible request from an individual with Alzheimer's disease (e.g., "I want to go home" when they cannot), a caregiver might implement the strategy of distraction by telling the individual that their favorite ice cream is being served. The strategy of redirection might be utilized by telling the individual that they have to take a bath first before they go home. Because one feature of Alzheimer's disease is poor short-term memory, the original impossible request is forgotten when distracting and redirection are used. Before parting, caregivers were asked to practice a new technique they had learned from Session 3 in the following week and to complete their handout before meeting again for Session 4.

SESSION 4

The fourth workshop began with a review of Session 3 main ideas followed by a discussion of the caregivers' use of Session 3 techniques. Volunteers were asked to share the experiences they wrote about on their handout, and afterward all completed handouts were collected. The final session featured the element "*Social Environment*" (S), which concerns providing a positive social environment for interaction. This involves both compensating for impairments and maximizing well-being and potential for growth (Brooker, 2007). The facilitators presented techniques to encourage independence, which leads to improved resident health and happiness, more opportunities for quality time, and lower caregiver burden (Savundranayagam, Hummert, & Montgomery, 2005). After concrete techniques were provided, the group was given scenarios (e.g., a resident needs help putting on his shirt) and asked to share what they would say and do to facilitate greater independence. Their responses were discussed using the principles of engaging in communication with residents whenever possible and responding to any resident communication attempts. The use of memory aids (e.g., memory books) and alternatives and supplements to verbal communication

(e.g., nonverbal communication, writing, and illustration) were explored. The didactic portion of Session 4 ended with a poetic reading from Kitwood (1997) that described two contrasting environments from the perspective of a resident with dementia in a long-term care facility; one description was that of an environment that undermined personhood, the other was that of an environment where care was person-centered (pp. 84–85). The descriptions were intended by Kitwood to be emotionally moving, utilizing rich and vivid language; as such, caregivers were asked to close their eyes and visualize themselves in these environments during the reading.

To conclude Session 4 and tie together the VIPS concepts presented throughout the course of the intervention, the group was asked to role-play and practice what they had learned. Four different caregiver-resident scenarios were given and volunteers were selected to play the role of caregiver or resident. The acronym VIPS, along with a brief phrase to indicate the meaning of each letter, was displayed under each scenario description as the slide was left on the board during the enactment. The volunteer playing the caregiver was asked to communicate and behave in a way that utilized the VIPS principles of person-centered care. The caregivers watching were told that if the actor playing caregiver seemed to be at a loss for what to do or say next in response to the "resident," they could call out a person-centered suggestion to help. The scenarios were as follows: a resident becomes extremely upset in the midst of a routine activity; a resident wants to leave the facility to pick up her children from school (though they are middle-aged adults no longer in school); it's dinner time and a resident does not want to eat; and a resident is attempting to communicate a message but is very difficult to understand. At the end of each enactment, facilitators offered feedback on the use of techniques during the performance.

At the conclusion of the last workshop, an anonymous evaluation form was administered to participants to gather feedback and assess the overall perceived usefulness of the intervention.

Measures

All measures were administered 4 weeks prior to the intervention (T1: pre-intervention) and 6 weeks following the intervention (T2: post-intervention) for comparison. Several measures contained a large number of items at T1 assessment; however, it was quickly determined that the English literacy skills and reading abilities of some staff were being severely challenged by the materials. Of the 26 T2 respondents, 11 (42%) were not native English speakers. The T2 questionnaire was thus truncated to include a minimum of items, which inevitably resulted in using only subportions of previously validated but longer measures. Complete T1 and T2 instruments are available from the authors.

Empathy was assessed using five items from the empathetic concern and perspective taking subscales of Davis' (1983) Interpersonal Reactivity Index (empathetic concern, two items: T1 α = .64, T2 α = .64, sample item: "I am quite touched by things I see happen"; perspective taking, three items: T1 α = .69, T2 α = .60, sample: "I believe there are two sides to every question and try to look at them both"; 5-point scales, *"Does not describe me" – "Describes me very well"*).

Happiness was assessed with two items from the shortened depression-happiness scale (Joseph, Linley, Harwood, Lewis, & McCollam, 2004; T1 α = .75, T2 α = .77, sample item: "I felt happy"; items were rated for the frequency with which caregivers felt that way during the previous 7 days of work; 4-point scale, *Never – Often*).

Burnout was assessed using the emotional exhaustion and depersonalization subscales of the Maslach and Jackson (1981) Burnout Inventory; these subscales of the measure are the ones most consistently associated with compromised patient care. Emotional exhaustion was assessed with three items (T1 α = .72, T2 α = .66, sample item "I feel used up at the end of the workday"), as was depersonalization (T1 α = .72 [T2 α could not be calculated because of limited variability on two items], sample item: "I feel I treat some residents as if they were impersonal objects"; seven-point scale, *"Never" – "Every day"*).

Attitudes about aging were gauged with two items from Braithwaite, Lynd-Stevenson and Pigram's (1993) attitude to the aging process scale (T1 α = .85, T2 α = .88, e.g., "Old age for me will be the most enjoyable time of life"). Attitudes towards dementia were assessed using the hope and person-centeredness subscales from the approaches to dementia questionnaire (Lintern, Woods, & Phair, 2000). The hope dimension was measured with three items (T1 α = .55, T2 α = .45 [reliability for this scale was low], e.g., "There is no hope for people with dementia" [reverse coded item]). Person-centeredness was measured with three items (T1 α = .62, T2 α = .73, e.g., "People with dementia need to feel respected, just like anybody else").

Quality communication was measured with 14 items designed to assess use of communication strategies described in the workshops. Each was assessed on a five-point frequency scale (*Never – Very often:* for items and sources see Table 1). A number of the items came directly from Wanzer, Booth-Butterfield, and Gruber's (2004) 13-item scale of patient-centered communication. The Wanzer scale was originally designed as a tool for nurses and patients to evaluate physicians' patient-centered communication, but has been adapted and used as a measure for physicians to report on their own patient-centered communication with patients (Passalacqua & Segrin, 2012). The present study also adapts Wanzer and colleagues' scale for use as a self-report measure, with adapted scale items asking caregivers about their use of patient-centered communication with residents. The remaining items

TABLE 1 Items in Communication Measure and Their Sources

Item	Source(s)
1. I use gestures to engage residents when communicating with them.	Wanzer, Booth-Butterfield, & Gruber, 2004
2. I use "pet names" for residents (sweetie, honey). (R)	Williams, 2006
3. When appropriate, I use humor when communicating with residents.	Wanzer et al., 2004
4. I ask residents simple "yes/no" questions.	Bourgeois, Dijkstra, Burgio, & Allen, 2004; Ripich, Ziol, Fritsch, & Durand, 2000
5. I use pronouns (e.g., it, her, his, that) when talking to residents. (R)	Ripich, Wykle, & Niles, 1995
6. I have a tense body posture while talking to residents. (R)	Wanzer et al., 2004
7. I wait and observe before helping a resident to do something.	Bourgeois et al., 2004
8. I use nouns (table, banana) and names (Mrs. Jones, Susan) instead of pronouns (he, she, it) when talking to residents.	Bourgeois et al., 2004; Ripich et al., 1995
9. I communicate in a clear and direct manner when talking with residents.	Wanzer et al., 2004
10. When asking a question, I give residents the choice between two options.	Bourgeois et al., 2004; Ripich et al., 1995
11. I use residents' names when talking to them.	Bourgeois et al., 2004
12. I speak Spanish at work (including when talking to other caregivers). (R)	Written specifically for this project
13. I use *short* sentences when talking to residents.	Ripich et al., 1995
14. I respond and try to keep the conversation going when a resident tries to talk to me.	Sabat, 1991; Ripich et al., 1995

Note. (R) indicates reverse-scored item.

were written for this study, building on the sources listed in the table. In most of these cases (Bourgeois et al., 2004; Ripich, Ziol, Fritsch, and Durand, 2000; Williams, 2006), the items were modified from observational coding systems used by those authors. For instance, where Bourgeois and colleagues had independent coders check for whether or not a caregiver addressed a resident by name, we asked caregivers to self-report this behavior. Clearly, the distinction between coding and self-report is an important one; however, given that our intervention was at the early stages of development, self-report measures represented a substantially less resource-intensive method of evaluation. The Spanish-speaking item (question 12) was designed specifically for our investigation. Apart from English, Spanish was the most widely spoken language among the caregivers; the facility's administrators were concerned about use of Spanish between caregivers in the context of residents who were almost exclusively monolingual English speakers.

Finally, a seven-item measure (created for the present study) asked caregivers to report the amount of time at work that they had spent engaging in seven different types of activities; some of these activities included cottage

chores (e.g., cleaning, cooking); personal care of residents (e.g., bathing); and leisure time with residents (e.g., playing games). The goal of this measure was to understand whether the intervention facilitated provision of more socioemotional care (as evidenced by social and leisure activities) rather than care that was narrowly focused on routine maintenance (e.g., bathing, cooking). Each item in the measure concerned a particular activity, and caregivers were asked to indicate the percentage of time in the past week that they had spent on each activity. Responses were indicated on a 1–10 scale (1 = 0 to 10% of work time in the past week; 10 = 90 to 100% of work time in the past week).

The objective throughout data analysis was to compare pre-test and post-test scores; accordingly, paired *t*-tests were used for most comparisons. Assessing changes for time spent on activities necessitated inclusion of a control variable for reasons outlined in the results section; hence, repeated measures analysis of covariance (ANCOVA) was used for the analysis of the time measures.

In addition to (but distinct from) the T1 and T2 survey administration, a questionnaire was distributed to the intervention participants at the end of the last session. The questionnaire was anonymous and asked for feedback on the workshops. The questionnaire featured open-ended questions asking what the caregivers liked and disliked about the workshops and what they found useful and not useful. Quantitative assessments on this form were limited to two items. One item asked participants to circle a number in response to the question, "Overall, how useful were the workshops?" (1 = *Not at all useful*; 5 = *Very useful*). The second item asked caregivers to circle how many workshops they had attended (1, 2, 3, or 4).

RESULTS

Results are divided into two sections: exploratory analyses of intervention outcome measures and evaluations of the workshops by the participants.

Outcome Measures

Comparisons of pre- and post-intervention data indicated that there were significant changes in depersonalization and hope and a change in empathy that approached significance (Table 2). The direction of effects for all three outcomes is promising: following the workshops, caregivers reported less depersonalization of residents, more hope for Alzheimer's patients, and more empathy. Effects that were significant and those that approached significance also emerged for four of the communication variables studied. Caregivers reported using more gestures, more humor (approaching significance), asking more yes/no questions, and giving the choice between two

TABLE 2 Time 1 – Time 2 Comparisons of Means on Psychosocial and Communication Measures

	Time 1		Time 2			
	M	*SD*	*M*	*SD*	*t*	*d*
Psychosocial Measures						
Depersonalization	1.71	1.36	1.16	0.43	2.10*	0.86
Hope	2.76	1.13	4.48	1.16	4.63**	1.89
Empathy	4.18	0.78	4.50	0.56	1.78†	0.73
Communication Measures						
Use gestures	3.52	1.01	4.16	0.85	2.78*	1.13
Use humor	3.58	1.02	4.04	0.96	1.75†	0.73
Ask yes/no questions	3.92	0.95	4.36	0.81	2.11*	0.86
Give choice between two options	4.12	0.88	4.48	0.65	2.09*	0.85

Note: $N = 24–26$, $^*p < .05$, $^{**}p < .01$, $^†p < .10$

options more after the workshops as compared to before (Table 2). We do not report details of the remaining nonsignificant effects.

When reports of time spent on specific activities were compared, estimated time spent on the majority of activities was reported to have significantly increased over time. To control for this overall change and uncover the activities that changed the *most* in terms of time devoted to them, we elected to control for average change in time spent on all activities as we examined change in time spent on each specific activity. Average change in time spent on all activities (the covariate) was calculated by computing mean time spent on all activities at T1 and T2, and then calculating a difference score for this measure (T2–T1). Seven repeated measures ANCOVA tests were run, using the T1 and T2 scores of each activity measure as the key variables, and including the previously described covariate. Leisure activities emerged as the only significant change; reports of time spent in leisure activities increased after the workshop even controlling for the change in reported time spent on all activities, $F (1,24) = 5.75$, $p = .02$, partial $\eta^2 = .19$; T1 $M = 3.04$, $SD = 1.78$; T2 $M = 5.38$, $SD = 2.90$. That is, reported time spent on leisure activities increased even over and above the general increase reported in time spent on all activities.

Participant Evaluations

Caregiver evaluation of the workshops was largely positive—the single item measure of the "usefulness" of the workshops yielded a mean of 4.05 on a 5-point scale ($SD = .99$). In the written feedback provided regarding what the participants liked and disliked and found useful and not useful, responses qualitatively echoed the general sentiment expressed via their scale ratings. The most common remark made was that the communication tips and techniques were especially useful, with caregivers also naming a

variety of specific techniques they found valuable. The second most fre-
quently made observation was that the workshops were full of information.
Some additional comments noted that the training was useful to new staff, a
good refresher for more experienced staff, or provided new information for
staff (e.g., "I've learned so many things that I didn't know").

Miscellaneous feedback included remarks that the workshop was "fun,"
the workshop "was to-the-point," that caregivers appreciated the time spent
exploring the perspective of the dementia resident and caregiver and also
enjoyed "interaction with the instructors," "the role-playing," "feedback," the
opportunity to be "able to express our concerns," "hearing co-workers talk
about their jobs and experiences," and "that there are people who care
enough about our vulnerable population to actually take the time to do
this." When asked on the feedback form to share what they did not like
or find useful, most caregivers indicated that they enjoyed and found all of
the information useful. Out of the handful of caregivers who did provide
specifics, however, some individual comments included not liking filling out
the homework sheet, not liking role-playing, and feeling that the information
was "not necessarily *not* useful, but to me a lot of it was just common sense."

DISCUSSION

A focused person-centered communication skills intervention based on the
theoretical work of Kitwood and Brooker was successfully implemented
with paraprofessional dementia caregivers in a long-term care facility.
Smooth execution of the workshops, positive evaluations from participants,
and promising trends in outcome measures indicate the feasibility and use-
fulness of the program. Caregivers' increased hope concerning dementia is
important—the positive gerontology approach emphasizes maintaining the
idea that improvements and development are always possible. Furthermore,
hope concerning dementia reflects endorsement of "*Valuing people*" with
dementia. Enhancing empathy is vital, as empathy is considered a funda-
mental element of quality care, is associated with higher satisfaction among
both caregivers and their recipients, and reduces caregivers' susceptibility to
burnout (Hojat, 2007; Miller, Stiff, & Hartman-Ellis, 1988).

Decreased caregiver depersonalization of residents is a particularly
encouraging finding, in that one of the fundamental principles of person-
centered dementia care is honoring the personhood of those with dementia.
Kitwood's person-centered dementia care was, from its inception, advocated
as an alternative to dehumanizing modes of care. Depersonalization, or treat-
ing a resident as a "case" or set of symptoms rather than an individual,
is precisely the type of phenomenon that proponents of person-centered
dementia care strive to eliminate. Depersonalization among providers is
known to be associated with suboptimal patient care practices (Shanafelt

et al., 2002). Consequently, then, reductions in depersonalization would theoretically predict corresponding reductions in sub-optimal patient care and the improvement of care practices.

Furthermore, depersonalization is an element of burnout, and reductions in depersonalization are symptomatic of decreased burnout among the caregivers. Any reduction of the state of burnout is beneficial, as burnout is detrimental to both caregiver and care-recipient. Burned out caregivers experience feelings of reduced self-worth, increased irritability, unhappiness, dissatisfaction, and are more likely to leave their jobs (Maslach & Jackson, 1981; Zimmerman et al., 2005). High turnover, caused in large part by burnout, results in reduced likelihood of patient-centered care (Seavey, 2004). Conversely, reduction in burnout increases the well-being of caregiver and care-recipient, making the lowered post-test burnout scores in the present study a promising finding.

Post-intervention, caregivers were exploring new ways of communicating that reflected a person-centered approach to dementia care. Notably, yes/no questions and giving choices between two options increased substantially from pre- to post-test. Both strategies are designed to enhance resident choice and hence control (Rodin & Langer, 1977), while operating within their level of competence (closed ended questions are easier to process for those with moderate to severe dementia symptoms: Shulman & Mandel, 1993). The increased use of gestures and humor also suggests substantive attempts to explore varying routes to shared understanding.

Caregivers reported spending significantly more time on leisure activities following the intervention. One of the goals of the intervention was that caregivers would be more focused on addressing holistic aspects of the residents' personalities, and less focused on routine chores, reflecting more "*Individualized care*" and creating a positive "*Social Environment.*" The intervention appears to have been successful on this front.

The absence of certain effects merits comment. In particular, substantial time was spent discussing respectful versus patronizing communication or "elderspeak." As such, an attempt was made to persuade caregivers to reduce addressing residents by "pet names" (e.g., honey, sweetie; Hummert & Ryan, 2001). This issue raised notable resistance among the staff, a number of whom insisted that residents enjoy pet names. Unsurprisingly, the statistical test revealed little change in this variable. While disappointing from a skills training perspective, the finding does indicate that the caregivers were active, selective, and critical consumers of the workshop content, which signifies that they processed the material more carefully than a passive audience.

In terms of limitations, the sample size is small. Access to caregivers in these positions can be challenging, and there are also ethical issues with implementing an untested intervention on large populations. However, the statistically significant effects are fairly large, which is a promising sign;

a larger sample would have yielded more numerous significant results. Additional trials should be implemented to examine the intervention's effectiveness with larger samples and different populations of caregivers at different facilities. Furthermore, an experimental design with random assignment to a control and an intervention condition is needed to demonstrate that the observed changes in the dependent variables were directly attributable to the skills training workshops. Moreover, because literacy challenges necessitated shortening the questionnaires used to collect pre- and post-intervention data, future studies should utilize more complete measures that are either longer yet simpler, or shorter and previously validated. One last concern is the reliance on self-report data, which raises issues concerning demand characteristics. Additional research should aim for third-party observational data of caregiver-resident interactions to complement self-reports and might also make assessments using a tool such as Dementia Care Mapping (DCM). DCM involves making a series of detailed and systematic resident observations and was developed to facilitate person-centered practices and quality of life evaluations in formal dementia care facilities (Brooker, 2004). Using third-party observations and/or DCM, in addition to caregiver self-reports, would provide valuable means to establish whether or not the skills training workshops were positively impacting caregivers and residents. There was, however, considerable variability of caregiver responses in our results, suggesting that among the sample there was not a homogenous desire to please the researchers with "appropriate" answers. The internal consistency of the measures was acceptable, but not high in some cases. It should be noted that some of the caregivers had limited education and/or were not native English language speakers. The researchers were present at data collection and provided clarification on problematic questions; however, there are undeniably implications for statistical reliability of responses with this subject population. At least one variable (hope) had reliability substantially below standard levels. The responses may have included more noise as a result of potentially not clearly understanding the questions, and the low literacy levels also resulted in the use of minimal multi-item measures; small numbers of items are inevitably associated with lower alphas. Hence, consideration of all results, and particularly those including hope, should factor in the low levels of internal consistency.

The intervention reported here appears to provide a viable means for teaching person-centered communication skills to paraprofessional dementia caregivers. The training program was designed to implement the concept of person-centered dementia care in terms of concrete communication strategies—paraprofessional caregivers as a group are especially in need of such interpersonal and communication skill training given the challenging nature of their jobs (CEAL, 2010). The present intervention, the first to be based on Brooker's (2004) VIPS principles, appears to have been successful

in facilitating attitudes, behaviors, and modes of communication consistent with the person-centered dementia care approach. As the older population grows, demand for paraprofessional caregivers will further increase; it is important to continue developing caregiver training to assist in the provision of high-quality care and maintenance of optimal well-being for those with dementia and those who look after them.

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