

CASE REPORT

Transfer and implementation of knowledge and attitude – a particular challenge for caregivers in dementia care

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Abstract

In order to ensure quality of life for people suffering from dementia, caregivers need to have both a suitable attitude to their clients as well as the corresponding expertise in caring for them. It is important to note that knowledge should be communicated simply and practically, because caregivers often have little prior knowledge and bring with them past learning barriers.

What is the best method of educating and training caregivers in dementia care? The literature on approaches to adult education does not provide a clear picture which approach is most effective.

This article focuses on Bandura's Social Learning Theory, or learning by observation, as a fruitful approach to educate and train care professionals working in care homes – an important environment for clients with dementia because the number of those affected continues to rise in care homes. Based on the analysis of this particular group of caregivers, I argue that this model has considerable advantages in spite of its criticized behaviorist roots. The suitability of the model, which is comparable with that in the UK, is also discussed in the light of experiences gained in the Vitanas Company, a private institution of care homes in Germany. Two promising field methods are presented: "Humanitude" by Gineste and Marescotti and "Marte Meo" by Aarts; both are based on the approach of observational learning as well as relevant results from neurobiology.

Key words

Alzheimer disease, Geriatric nursing, Education, Geriatric psychiatry, Inservice training, Mentors

Introduction

Work situation in care homes

Workforce is a very broad term regarding conditions and locations. To reduce this complexity the following article focuses on the situation of caregivers in care homes. This takes into account that the number of people with dementia in care homes increases rapidly. Two thirds of care home residents in the UK suffer from dementia ^[1]; in Germany this number is assumed to be about 60% ^[2, 3]. Accordingly, the need for well-trained caregivers is rising in order to develop and secure good quality of life.

Determinants for a learning-theoretical approach

The question of what are effective approaches to caregiver learning needs to be addressed in light of the structure and situation of the workforce in care homes.

Figures of the Federal Statistical Office in cooperation with the European Data Service show that 80% of caregivers are women and a significant proportion of caregivers have a low level of education. According to the Eurostat Labor Force Survey ^[4] this relates to about 16% of the employees in the UK and approximately 24% in Germany. Even people with secondary school certificate but different professional backgrounds work as care assistants. Moreover, a significant proportion of employees have a migration background which is associated with language barriers in the communication with clients. In the UK this amounts to approximately 12% and in Germany to about 7% ^[4].

Furthermore, in both countries about 50% of caregivers have no specific training ^[5, 6]. The immediate life-quality-defining contact to persons with dementia makes the need for training urgent, especially given the close link between trained skills, job satisfaction and care quality ^[7].

Internal polls conducted within the company show that employees are generally interested in training of dementia care. These anonymous in-house polls were conducted by the management of the individual institutions over a period of several years and addressed the perceived need and desired time frame of training. Caregivers were also asked to provide feedback about past training sessions (i.e. in-house training, case studies to specific topics, etc.). Responses suggest that even though interest in training is generally present, willingness to participate drops if training sessions are held in the afternoon after work hours. Häggström and Bruhn ^[8] similarly found in their studies that the motivation to participate drops if the training takes place outside of working hours.

Specific challenges in the advanced training of caregivers

Despite their expressed interest in training, care home employees still have many resistances and barriers to learning, especially those caused by negative experiences in learning situations ^[9]. Our staff's experiences confirm this. Among the most common difficulties are fear of failure, limited understanding of theoretical requirements, feelings of being overwhelmed by work especially in women with significant family responsibilities, and the sense that we do already know all but the external circumstances (time, human resources) do not allow better work ^[10].

During many meetings that took place not only in our facilities but also externally, it turned out that the subject of "dementia" is often regarded as very "unreal". Employees and family members spoke openly about the fact that they often find it difficult to empathize with the unrealistic ideas of the client, which are opposite to reality. Additionally the theory of dementia is very complex and therefore not easy to fully comprehend. It is also important to remember that the issue of "dementia" and therefore the people concerned (client, family members, caregivers) are in a "social offside" and confronted with negative attitudes ^[7, 11]. This fact is recognized by social support groups which back up with campaigns such as the German movement of the dementia- friendly- commune.

Crucial in the discussion of the appropriate learning theory is also the economic factor. Training of any kind needs time, which is associated with financial resources. Economic bottlenecks in care often lead to training times being kept very short.

In brief, it is the goal to impart knowledge as soon as possible to caregivers, who usually have little prior knowledge about adequate behavior concerning clients with dementia and face barriers to learning due to various negative learning experiences. Based on these reasons, caregivers have low self-esteem so that many feel helpless against the challenges of care and, therefore are more likely to develop negative attitudes towards training ^[12, 13]. Through training, they get a chance to develop more certainty of action and a more positive attitude towards themselves and the client with dementia.

When reading the relevant literature, it quickly becomes clear that none of the existing learning theories includes an exhaustive treatment of the nature of adult learning^[14].

Bandura's social learning theory is a branch of the behaviorist approach and though his approach is closer to the cognitive approach^[40], it is not without controversy. The main criticism is that his social learning theory does not provide specific explanations of intra-psychic processes in behavior. However, this theory can be a way for better training the caregivers. According to the above it should be discussed to which extent it fits to the employee group described.

Bandura's social learning theory: Learning on models

According to Greener, "Bandura suggests that most human learning is done by observing and imitating other's behavior provided the potential learner attends, can retrain, reproduce and wants to do these things"^[15, 16]. In doing so, new behaviors can be learned and old practices can be successfully changed^[17].

In addition, learning on models has the advantage that complex behavior (language, driving, professional activities, etc.), which is composed of a variety of single behavior steps, can be more easily and quickly acquired as when individually reinforced^[17]. Thereby intensifiers (rewards) can be used as information source, but they are not necessary^[18].

However, Bänder^[19] declared that it is necessary that the learner can ..."pay attention to the essential features of the behavior to be modeled and observe it as accurately as possible..." Learning on models can be improved by an emotional relationship between learner and model person who should have a reasonably high status. In addition, the behavior to be learned needs to be accessible, accountable and feasible for the learner^[17, 19]. An important concept in Bandura's theory is "self-efficacy"^[15]. To build-up self-efficacy means becoming aware of one's own resources, perceiving one's own competences and, thus, coming to the opinion of having achieved something, which can positively affect the motivation to learn^[20, 21]. Self-efficacy has been found to have a positive effect on the resilience of caregivers even in very challenging situations^[22].

Advantages of the concept of learning on models for caregivers

Given the group of caregivers and their work conditions as described above, learning on models seems to have many advantages. It allows learning in the practice, which is important for adult learning as Knowles^[23] explained in his basic principles of adult learning. The learning matter should be applicable to real life situations and be applied as soon as possible. This is consistent with research on learning styles by Kolb^[24] and Vermunt^[25] and discussed by Coffield^[26], who found that a considerable group of people prefer learning by doing. This preference is often noticed in our own training events and described by the participants.

Beyond training courses learning on models is easier and can be immediately used in daily practice. This may be important in situations in which there are frequent and serious difficulties in interactions with clients with dementia. This assumes that the "model" should be a recognized, specially trained caregiver from the nursing field who works in the practice and is present for the nursing staff as often as possible to help consolidating the learning matter.

To ensure the necessary attention of the observer for the model, the model should chose situations that are particularly challenging for caregivers. After the model has completed the situation successfully, the observing assistant caregiver should be motivated to try out the behavior herself^[27].

Often very complex processes must be arranged that can be implemented well by observation (e.g. dressing of clients with differently graded verbal and/or practical needs, which have to be followed exactly to avoid challenging behavior of the client).

This approach is also helpful where language barriers exist between staff members or with clients and caregivers.

The approach is also supported by the finding of Skowronek ^[28] that people with low self-esteem, which in my own experience is not unusual for caregivers with little prior knowledge about caring for persons with dementia, learn much more quickly by means of models.

Bandura ^[29] detected in behavioral-therapeutic situations that talking alone does not effectively modify human behavior. People prefer practical guidance. Altalib and Tollett ^[30] similarly observed that "visuals trigger feelings the quickest, go the deepest and stay with us the longest. Words cannot do that".

Advantageous in learning on models is also the flexible adaptation of the performance steps to the currently shown capabilities of the observer and the option to immediately ask questions ^[31].

Learning on models allows changing working hours into learning times, which may increase the caregivers' motivation to learn. Knowledge is mediated practically rather than theoretically, which can reduce resistances. A lot of knowledge can be transferred in a short time, which is advantageous from the economic point of view and benefits the clients in daily care more quickly and effectively.

Known successful strategies are mentoring, learning on the job and apprenticeship.

Successful examples from the practice

Two practical approaches that are based on learning on models in the care of people with dementia are the methods "Humanitude" and "Marte Meo".

"Humanitude" or "Care in the Personhood" was developed by Gineste and Marescotti over 25 years specifically for difficult care situations ^[32]. They worked in 400 hospitals and care homes with 17,000 people who were described by caregivers as being particularly difficult because they were defensive, solitary and bedridden. Their relationship management rests on the four pillars: eye contact, stimulation with words, touch and alignment of the clients. This approach, which was implemented successfully in France, Switzerland and Canada, is similar to other person-centered approaches, but differs in the form of knowledge transfer. Gineste's teaching is done in large part directly "at the care bed" by step-by-step he shows rules of action. Learning takes place through his model-like work and by using videos. "Practical nursing care according to precise rules presented with communicative competence – this organic compound is something special in our scientifically overloaded care world," commended Hoefer ^[33].

Marte Meo means "on own force" and is an approach to support development. It aims to encourage and support people to further develop themselves ^[34, 35]. Originally developed by Maria Aarts ^[36] for supporting parents with autistic children in the Netherlands, this method is now successfully used for developing basic communication skills of caregivers in the care of people with dementia ^[37]. Besides, learning according to the Marte Meo method partly bases on Bandura's learning on models via videos, where caregivers see themselves at work ^[19].

Bünder ^[19] declared "Due to viewing selected video scenes, Marte Meo opens the possibility to parents (and caregivers - note by author) for supportive interactions and to perceive themselves as a model". These successful interactions, even the smallest ones, give a sense of competence and motivate to continue. Marte Meo seems to be particularly helpful in difficult care situations, which often make caregivers helpless and overwhelmed.

To implement this method, however, some important conditions must be met. First, working with video recording requires the consent of all parties. The client with dementia and his or her legal guardian must agree in advance. Second, even during video recording, the well-being of the client needs to be paid attention to. The client is the director. Third, this approach requires a very sophisticated training and frequent supervision of all employees. Such monitoring is ensured by

special Marte Meo coaches and supervisors. The staff receives training for 6 days, which is offered over a period of 6 months. During this time, situations are recorded, which are then discussed with the Marte Meo coach. The recordings are used only in the protected area of the team. Prerequisite for this is the support of all employees to this method. Only this very responsible approach can provide the framework for Marte Meo.

Recent findings in brain research

Interestingly the form of learning on models used in Marte Meo is supported by results of neurobiological brain research, even though the specific program of Marte Meo has not been evaluated. According to H  ther^[38] Marte Meo is consistent with newest findings about neurological processes in the brain during learning on models, and applies these in a practical context. Specifically, H  ther suggests that the brain is an organ that generates images of different modalities and therefore also "visual images". When pre-existing mental images differ from incoming information new "perceptual images" are created and thus learning occurs. This form of learning is particularly well developed in humans. When viewing videos the caregivers can see themselves in situations where their actions are successful, which is a good experience. Especially helpful is that they no longer need to be persuaded that these "new", through the video identified behavioral skills now should be used purposefully.

The scientific findings on mirror neurons are also discussed as neurobiological confirmation of the learning model according to Bandura^[39]. Mirror neurons are a neurological system that controls human actions and feelings, but which is also active when we only observe actions performed by other people. Here the mirror-cell response is also described as spontaneous and involuntary and as basis for the ability of empathy even in adults^[40]. This is an important note that learning on models can obviously change not only behavior but also attitudes^[39].

Limits of learning on models

Learning on models seems to be an essential learning method even in adulthood. However, it should be critically noted that with his approach Bandura goes beyond its original behaviorist roots, since he explicitly assumes internal processes as basis of learning^[18, 41]. He abandoned the orthodox position of the behaviorism regarding the exclusive determination of the behavior by the environment. Thus, his approach is closer to the cognitive approach^[42] but does not say anything about deeper explanations of intra-psychic processes in the behavior^[43]. Indeed it still requires extensive research to analyze the complex interactions of various factors, such as observer, model and their relationship to each other and to the situation. Particularly the original features that a model should have to work more effectively should be explored more precisely.

A critical issue is that in terms of education the learner is more a passive recipient. The social model, which should be well trained, is responsible for what is true and has to be continuously communicated.

Certainly, learning models can only be effective in a company where management creates appropriate conditions. Two important conditions are well-trained staff members that can serve as effective social models and a learning-conducive environment. In planned projects supported by the management, the Vitanas Company tries to develop these necessary conditions. Specially trained staff members, who have an extensive experience in person-centered work and expertise in the evaluation and development of quality of life for clients with dementia, will serve as social models in these planned projects.

Conclusions

In conclusion, learning on models, even when critically analyzed, has advantages for training of caregivers for clients with dementia residing in care homes – in the UK as well as in Germany because the situations are comparable. It was discussed

that several possible resistances, which may occur when caregivers learn (e.g. fear of failure, limited understanding of theoretical requirements, etc.), can be reduced by this approach. The approach is also advantageous from the economical point of view because learning on the model can be directly used in the daily working process. The responsible and successful implementation of two methods based on learning on models (Humanitude and Marte Meo) corroborates the practical relevance of this approach. Finally, the latest neurobiological research shows that learning on the model can develop an empathetic attitude.

Certainly, there is not the one theory of learning that is completely convincing in this context. Therefore, learning on models should be seen as mosaic in the learning process. Finding a combination of different learning methods well adapted to the relevant needs of the participants is probably the most effective way to develop good dementia caregivers. Projects like the one described above are needed to gain experience with caregiver training.

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