

Dementia and interaction

**A qualitative exploratory study of Marte Meo
counselling for staff in dementia-specific care units**

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Abstract

Approximately 70–80% of all persons who live in nursing homes have dementia. Enhancing communication and interactions that promote mutuality, dignity, and respect can be challenging because of the residents' decreased abilities to understand and interact and the staff's difficulties in understanding and interpreting vague communication from the residents. Positive interactions between persons with dementia and nurses are essential to promote dignity and avoid undesirable and conflicting situations. The manner in which nurses act in encounters with residents appears to greatly impact the well-being and behaviour of the residents.

The main aims of this dissertation were to explore whether Marte Meo counselling (MMC) may contribute to positive changes in the daily interactions between persons with dementia and staff in dementia-specific care units (DSCUs) and to explore the nurses' experiences of MMC.

MMC is a video-supported counselling method that has been adopted in recent years to enable staff to recognise and improve communication and interactions when working with persons with dementia. It is based on the assumption that a heightened awareness of what comprises effective communication can facilitate greater contact and mutuality in interpersonal interactions between persons with dementia and their caregivers.

This dissertation was based on three studies:

Study I aimed to investigate whether changes could be identified in the interactions between persons with dementia and their nurses during morning care following MMC. An intervention study based on video recordings before and after MMC intervention was used. Thirteen nurses and 10 residents from six DSCUs at six different institutions in Norway participated. Data were collected through the video recording of six pairs (nurse and resident) during interactions before and after the staff received MMC. Four pairs were included in the comparison group. The findings suggest that nurses who received MMC succeeded, to a greater degree compared with the comparison nurses, in providing care consistent with promoting positive interactions. We identified clearer indications of increased positive interactions and a reduction in inappropriate interactions in the intervention group. In the comparison group, the variation was greater, with both good and poor interactions present in a given case. This study indicated that MMC can facilitate positive interactions and reduce inappropriate interactions.

Study II sought to explore the staff members' experiences of participating in MMC with a particular focus on their learning experiences in four DSCUs. This was a qualitative descriptive study. Data were collected through 12 individual and four focus group interviews (N=24). Findings emerged through manifest and latent content analyses. The nurses acquired new knowledge regarding the residents

through MMC, which resulted in an improved capability to interpret the residents' expressions and an increased awareness of the residents' competence. New knowledge concerning themselves as nurses also emerged; they recognised how their actions affected the interactions, which consequently made them aware of the usefulness of taking time, pacing their interactions, maintaining eye contact, and describing the situation in words during interactions. This increased knowledge appeared to increase the resident's perception of being able to cope. This study indicated that MMC helped nurses to learn how to improve interactions with residents with moderate and severe dementia.

Study III sought to identify factors that affected the learning outcomes from MMC. Twelve individual interviews and four focus group interviews (N=24) with staff who had participated in MMC were analysed through a qualitative content analysis. The study found that the learning climate had significantly influenced the experienced advantages of MMC and indicated that the learning climate depended on three conditions: establishing a common understanding of the content and form of MMC, ensuring the staff's willingness and opportunity to participate, and securing an arena in the unit for discussion and interactions. Clear leadership was essential to ensure a good learning climate.

This dissertation suggests that MMC may contribute to positive changes in the daily interactions between persons with dementia and the staff of DSCUs. Further research is necessary to evaluate the effects of MMC.

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Abbreviations

DSCU	- Dementia-specific care unit
FSE	- Function supporting element
HOD	- Helse og omsorgsdepartementet (Ministry of Health and Social Affairs)
II	- Inappropriate interaction
MM	- Marte Meo
MMC	- Marte Meo counselling
MMT	- Marte Meo therapist

List of original papers

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1. Introduction

In Norway, approximately 70,000 persons have been diagnosed with dementia, which is a cluster of progressive cognitive degenerative diseases. A close connection exists between longevity and dementia because the primary risk factor for dementia is age. The rapid growth in the number of individuals over the age of 65 means that the number of persons with dementia will rise to approximately 160,000 cases by 2050 (Hjort & Waaler 2010). A similar increase can be expected globally. In Europe and other western societies, approximately 1% of persons 60-64 years old have dementia, whereas 45% of persons 95 years and above have this disease (Swedish Council on Technology Assessment in Health Care (SBU) 2008).

In Norway, persons with dementia receive more municipal services at the end of life compared with any other group (HOD 2005-2006), and approximately 80% (35,000) of the residents in nursing homes have dementia. Dementia-specific care units (DSCUs) care for 32% of the persons with dementia in nursing homes. DSCUs have fewer residents and increased staff compared with ordinary nursing home units and provide residential care to patients in the middle to late stages of dementia. DSCUs are present in 88% of the municipalities in Norway (Eek & Kirkevold 2011).

While there are no cures for dementia disorders or the cognitive symptoms that result from these diseases, opportunities remain to optimise the function and quality of life. In light of the modest effectiveness of medical treatment, the use of non-pharmacological interventions has gained prominence (SBU 2008, Hoover & Sano 2013). The diversity of these interventions is impressive, but the methodologies for testing them have been described as generally poor (SBU 2008, Hoover & Sano 2013).

The Norwegian Ministry of Health and Care Services (HOD) (St.meld.nr.25, 2005-2006) has emphasised that staff members are the basic resources in care services. Good care occurs as a result of positive interactions between the staff and residents. The caregivers' knowledge, attitudes, skills, and personal characteristics are crucial for the quality of care. The HOD (2005-2006) recognised that quality of care is vulnerable to fluctuations in staffing, the qualifications of the staff, and the level and quality of collaboration. It has claimed that without adequate and competent personnel, elderly persons with reduced functional abilities, and other users of care services will not receive adequate help. Through interactions with residents and their relatives, nurses should determine the individual needs of the residents and create the conditions that facilitate a dignified, safe, and meaningful life for each resident.

The care approach of nurses is crucial and must be based on the best available knowledge on how to support and provide care for individuals with dementia. Failure to understand the wishes and needs of

persons with dementia may increase suffering from dementia (SBU 2008), and nurses have an obligation to interpret and understand the residents' needs and desires.

The municipalities are responsible for providing staff with the necessary training and support to meet the challenges of interacting with persons with dementia and to meet their needs. Counselling for nurses who work with persons with dementia has shown promising results, but a comprehensive documentation of the proper approaches and benefits derived from counselling are not available (SBU 2008, Levy-Storms 2008, Vasse et al. 2010).

The Marte Meo counselling (MMC) method focuses on how to support persons in building a relationship by focusing on their dialogue with each other. The method is consistent with Stern's developmental psychology (Rough 2002) in emphasising how interactions with others can affect the experience of coping (Stern 2003). How we are influenced by others can affect how our identity and integrity develops and are maintained (Stern 2003, Bråten 2007). This is also evident in research related to dementia, which has shown that the significance of relationships is crucial for persons with dementia to preserve their identity and integrity and to perceive themselves as dignified (SBU 2008, Kihlgren 2011, Wogn-Henriksen 2012). A trusting relationship between a nurse and an person with dementia is a very important factor in creating good quality care according to the SBU (2008).

MMC was introduced and has been in extensive use in dementia care in Scandinavia since the beginning of 2000 (Munch 2008). This approach has shown promising results, i.e., increased job satisfaction and increased understanding of resident needs by nurses (Munch 2006, Hatløy & Alnes 2007, Hansen & Ytrehus 2011, Lunde et.al 2012, Becher 2012). This dissertation is based on the need for a thorough evaluation of MMC to determine if and eventually how this method can influence interactions in dementia care.

2. Background

2.1 Dementia and its implications

2.1.1 Characteristics of dementia

The term dementia is an umbrella term for a group of diseases that result in a multitude of complex symptoms and disabilities. Dementia affects mental function, which includes changes in cognition, emotions, and behaviour that result from neurodegenerative changes in the brain. The primary degenerative disease is Alzheimer's disease, which is present in 60% of dementia cases. Secondary dementia includes several vascular forms of dementia caused by cerebrovascular diseases and is present in approximately 20% of patients. Other forms of dementia, such as dementia with Lewy bodies, frontal lobe dementia, and alcohol-related dementia, are found in the remaining 20% of dementia cases (SBU 2008, Engedal et al. 2009).

The progress of dementia disease is often classified into three stages (SBU, World Health Organisation (WHO) 2012). The early or first stage is accompanied by symptoms that include forgetfulness, losing track of time, getting lost in familiar places, language impairment, and psychiatric symptoms, such as withdrawal, suspiciousness, general anxiety, irritability, and aggressiveness. The middle or second stage is referred to as the manifest stage and is associated with symptoms that include forgetting recent events and names, getting lost at home, experiencing increased difficulty in communication, requiring help with personal care, and experiencing behavioural changes, such as wandering, spatial disorientation, and repeated questioning. The third stage involves severe or terminal dementia, with symptoms that include having no sense of time and place, difficulty recognising relatives and friends, a growing need for assisted self-care, difficulty walking, and escalated behavioural changes, such as aggression. In this last stage, it can be difficult to determine if the person has maintained intelligible ideation (ICD 10).

The disease progresses over a period of approximately 10 years, with considerable variation between individuals (Engedal et al. 2009), and the three stages are very approximate measures. A thorough understanding of the symptoms and complications of the disease and knowledge of each person with dementia are necessary to determine the specific issues that need to be addressed and the resources necessary to facilitate the care for each individual. As the disease progresses to moderate and severe dementia, individuals require extensive help; approximately half of persons with dementia in Norway live in residential homes or in nursing homes (Eek & Kirkevold 2011).

As the disease progresses and more areas of the brain are affected, it becomes difficult to distinguish the symptoms of the various diseases. This dissertation focuses on persons with moderate to severe dementia. Consequently, differential diagnosis is less important. Therefore, the term dementia is used,

rather than the specific diagnoses. However, specific symptoms related to a specific diagnosis will also be mentioned when appropriate. In the next section, I will highlight some of the common symptoms in dementia in the moderate and late stages, which can be organised into cognitive, neuropsychological, and motoric deficits.

As the disease progresses, cognitive problems become apparent and both short-time and long-term memory become affected. For some, memories are barely present. Memory loss, decreased attention span, impaired judgment, abstractions, and reduced visuospatial abilities result in complications in communication (Frazier-rios & Zembrzuski 2005). The ability to decode and understand information (receptive language) and to encode and express information (expressive language) is reduced. In persons with moderate to severe dementia, aphasia in many forms is frequently present (Gjerstad et al. 2013). One study has demonstrated that the verbal reaction time is longer for persons with Alzheimer's disease compared with normal aging subjects with mild cognitive impairment (Midi et al. 2011). Because attention is affected, the completion of two tasks at the same time, such as walking and talking, can be difficult. Apraxia involves a problem with planning and acting in a given manner, which makes all daily living (ADL) complicated. Limitations in visuospatial skills, such as room directions, can make it difficult for persons with dementia to orient themselves even in familiar places (Gjerstad et al. 2013).

Persons with dementia often have one or more clinically significant neuropsychological symptoms (NPSs), which include psychiatric symptoms (such as delusions, hallucinations, depressive symptoms, anxiety, or euphoria) and behaviour symptoms (such as agitation, aggression, apathy, and disinhibition). Reviews have shown that symptoms such as depression, anxiety, aggression/agitation, and apathy are common in nursing home patients with dementia. The highest prevalence was for agitation and apathy (Selbæk et al. 2013). Depressive symptoms include changes in mood, decreased positive affect, and fatigue, changes in sleep and appetite, and worthlessness. Depressive symptoms have been associated with increased aggregation and agitation (Hoover & Sano 2013). Anxiety in dementia has been associated with increased irritability, aggression, and pathological crying, as well as repetitive behaviours, such as pacing, chanting, and focused motor movements. Anxiety may also manifest as repetitive questions to caregivers (Hoover & Sano 2013). Verbal agitation can include screaming, repetitive verbalisations, demands for constant attention, repeated complaints, moaning, muttering, and threats (Bédarda et al. 2011). Apathy can be defined as a loss of motivation, diminished initiation, a lack of interest, low social engagement, and a blunted emotional response (Bieliauskas & Drag 2013). Apathetic symptoms appear to be specifically associated with facial expressions in Alzheimer's Disease and thus could contribute to a disregard for the patient's needs in everyday life because of the limited response (Seidl et al. 2012).

In the late stages of dementia, the ability to coordinate motoric behaviour fails. This failure can cause a parkinsonian gait and/or difficulty getting up or sitting down. A lack of muscle coordination may also cause problems with using a knife and fork and chewing food. Motoric problems also involve urinary and faecal incontinence (Engedal et al. 2009).

Dementia results in changes to important aspects of an individual's personality, and as long as the dementia progresses, changes in the personality can be observed. In addition, it is important to be aware that dementia, particularly in Alzheimer's disease, has a slow disease progression, and the development of the disease varies greatly, even within the same dementia disease (Gjerstad et al. 2013). For persons with Alzheimer's disease, insight and understanding of one's own situation can remain even after substantial disease progression (Burgener & Berger 2008), but there can be fluctuations in insight in the earlier stages of the disease. For other categories of dementia, such as frontal lobe dementia, a lack of insight regarding one's own situation and the disease are common (Gjerstad et al. 2013).

2.1.2 Living with dementia

In the last decade, several studies have focused on the experience of living with dementia (Steeman et al. 2006, Clare et al. 2008, Svanström 2009, Wogn-Henriksen 2012). A common finding in these studies was that living with dementia involves a feeling of uncertainty and a struggle to maintain dignity and self-respect. Many persons with dementia consider their own life to be good but are worried about other individuals' opinions of them (Steeman et al. 2007). In a survey of 27 respondents with dementia, Beard et al. (2009) showed that the respondents felt they could cope with the condition but struggled to maintain an identity without the associated stigma and major social consequences. Thus, not only the symptoms of the disease but the stigma that arises from the social context must be managed. In an observational study of an adult day centre, Sabat & Lee (2012) concluded that losses in social functioning "appear to be caused more by social dynamics involving healthy others than by brain injury alone" p.315. This finding emphasises the great demands placed on healthy individuals, such as nurses, who may act to prevent this stigma.

In a qualitative study, Wogn-Henriksen (2012) interviewed seven persons with dementia four times for a period of three and a half years to describe the challenges of persons with dementia. She found that individuals with dementia are not passive victims of their disease, but they adapt and develop new approaches and thus create a life based on the new premises that the disease sets. She also found that close relations with a wife or husband developed new meaning but could also be challenging because of the progression of the disease. She concluded that the increased need for help challenges the autonomy of human beings and their capacity for trust.

Living with dementia in nursing homes

Living in a nursing home can contribute to a more secure life for ill and vulnerable individuals (Sørbye et al. 2011). However, it can also lead to limited privacy (Hauge & Heggen 2008), which can challenge the individual's identity. Because of communication deficits, it can be challenging to gain access to the experiences of persons with moderate to severe dementia and their experiences (Raymond et al. 2009). However, there have been several studies on this topic (Zimmermann et al. 2005a, Crespo et al. 2012, Moyle & O'Dwyer 2012).

In a quantitative study of 39 nursing home residents with severe dementia that used a quality of life proxy instrument to measure the observations of morning care situations, researchers found that the residents' quality of life could be described as moderate (Raymond et al. 2009). In a review, Moyle & O'Dwyer (2012) found that self-ratings of quality of life were significantly higher compared with the staff and family ratings, but living with dementia in nursing homes was associated with a reduced quality of life because of an impersonal environment, a lack of privacy, staff attitudes, and limited relationships. The review showed that the key factors associated with quality of life included meaningful time spent on activities focused on the resident's interests, social engagement, positive staff attitudes, and an environment that facilitated a connection with others. Another recent systematic review suggested that a lower quality of life for persons with dementia living in institutions was related to depressive symptoms and agitation (Beerens et al. 2013).

In an exploratory qualitative study of 304 transcripts of conversations between researchers and 80 persons with moderate to severe dementia who lived in residential care homes, Clare et al. (2008) found that the residents were able to describe their situation and present conditions in an understandable manner. They described experiences of loss, isolation, uncertainty, fear, and a sense of worthlessness, which they tried to cope with by accepting and making the best of the situation. A positive relationship with others was crucial to maintaining a sense of well-being. A study based on interviews with six residents in a psycho-geriatric unit found that the residents appeared lost because they could not describe their location but became confident when describing their previous lives (Edvardsson & Nordvall 2008). An examination of three persons over ten interviews conducted by Graneheim & Jansson (2006) found that living with dementia in a nursing home involved a collapse of the relations with the self and others and involved feeling left alone without invitations to meaningful dialogues and activities. Feeling excluded in this context could be interpreted as losing meaning and feeling empty. The residents reported that they felt included when they felt needed and appreciated. Kelly (2010) conducted field work and obtained video recordings of 14 residents with dementia who lived in locked chronic care wards over a period of six months. Kelly concluded that while selfhood endures in persons with dementia, it is often unregistered and unsupported by the staff. Misperception

by the staff could result in limiting, damaging, or abusive behaviour and may diminish the well-being of the residents.

As the above review indicates, persons with dementia in nursing homes are highly dependent on the ability of caregivers to understand their needs. Even in residents with no cognitive deficits, the nurse's ability to facilitate conversations in everyday situations greatly affected the resident's experience of thriving (Bergland & Kirkevold 2008). Persons with dementia are even more dependent on this type of facilitation in order to participate in dialogues. How the nurses act and interact influences residents' everyday living and, in this way, affects their quality of life. The nurse's role is, therefore, very significant (Brooker 2008).

2.1.3 Challenges in interactions

In a quantitative study of 315 persons with dementia, Potkins et al. (2003) found that language disorders were associated with the behavioural and psychological symptoms of dementia and that impairment of the receptive and expressive aspects of language skills were associated with aberrant motor behaviour and delusions. Potkins et al. also found that there was a significant correlation between language impairment, reduced participation in social activities, and increased social withdrawal. Difficulties in recognition and word identification most likely fragments individuals' experiences and behaviours (Eggers et al. 2005). Living in a fragmented world that includes problems understanding what is said or happening and problems joining a conversation can have major consequences on understanding themselves and their ability to perceive themselves as equal citizens.

However, it is important to be aware that despite experiencing issues expressing themselves, research has shown that persons with late-stage dementia maintain some ability to communicate and express themselves. An ethnographic study (Kontos 2004), which applied the perspectives of embodiment inspired by Merleau-Ponty (1962) and Bourdieu (1990), demonstrated through observation and narratives that persons with Alzheimer's disease interact through an embodied way of being-in-the-world, even with severe dementia. Other studies have shown that individuals with dementia have the ability to convey expressions, communicate, and create meaning, which may be present even with severe dementia, but expressing experiences and meaning implies facilitation from nurses or others involved in the interaction (Normann et al. 2002, 2005, Sabat, 2005, SBU 2008).

Behavioural symptoms, such as irritability, wandering, and aggression, are often related to showering and dressing (Enmarker et al. 2011, Isaksson et al. 2011). Cohen-Mansfield et al. (2006) analysed the video recordings of 20 dressing situations in a special care unit. The interactions between the nurses and the residents were considered inadequate in most sessions. Communication was minimal and insufficient, and dressing situations were hurried. Skovdahl et al. (2003a, 2003b, 2004) studied "demanding" behaviour in persons with dementia during the morning care routine and found that

caregivers who focused on reaching their goals based on the residents' needs and wishes were more successful compared with caregivers who focused on accomplishing the task (e.g., bathing the resident) as the goal. One study indicated that persons with dementia must feel mutuality and equal power in the relationship with their caregiver to initiate positive interactions (Skovdahl et al. 2003b).

Sloane et al. (2007) studied the morning care routines of 17 persons with dementia who suffered from chronic pain. The study showed that the morning care routine, which involved washing, dressing, grooming, continence care, and transfer assistance, lasted from nine to 15 minutes. This indicates that care providers rushed through the tasks. These findings imply the need for greater efforts to make morning care an enjoyable activity in addition to merely a task to be completed. Residents should be helped to rest, relax, or enjoy the personal attention of one-on-one care during the morning care routine.

It can be challenging for nurses to interpret and understand the communications of residents with dementia, and the patient may find it difficult to communicate with and understand what others are saying. Wångblad et al. (2009) provided an example that showed that the physical strain that nurses may experience when moving individuals is not necessarily related to the weight of the resident but to misunderstandings caused by communication problems (Wångblad et al. 2009).

Some studies have shown that when communication is natural, relaxed, and facilitated, persons with dementia are able to communicate in a more understandable way than expected (Normann et al. 2002, Perry 2005, Normann et al. 2006). In a repeated-measures design that used direct observation and self-rating scales, the researchers found a correlation between the relational behaviour of the nurses and the moods of the residents (McGilton et al. 2012). When the residents were deemed to be resistant to care, the relational behaviour scores of the nurses decreased. Effective relational behaviour from the nurses was associated with positive moods and behaviours of the residents.

Providing care to persons with dementia in the late-middle or late stages of dementia requires substantial knowledge and adaptation from the nurses (Chang et al. 2009, Torvik et al. 2009). The studies reviewed in this section support the importance of increasing the relational competence of nurses who care for persons with moderate and severe dementia in long-term care.

2.2 Caring for persons with dementia

2.2.1 Person-centred care

Heavy demands are placed on nursing home staff to provide good quality, dignified care that empowers persons with dementia. One approach that attempts to facilitate such care is the approach referred to as person-centred care.

The roots of person-centred dementia care are found in the work that Kitwood (1993) did together with the Bradford Dementia research group in the United Kingdom (Kitwood & Bredin 1992). Kitwood's work defines dementia care as a process of "true meeting between persons" (Kitwood, 1993) p.51. According to Kitwood's theory (1997), interactions with persons with dementia are more dependent on inference than interactions between individuals without dementia. He maintained that the behaviour of nurses, relatives, or other individuals in the environment can make persons with dementia feel like an object, not a person. This does not imply malicious intent but represents a type of cultural inheritance when living in a "hyper-cognitive" society (Kitwood 1997). If society has a substantial focus on understanding and acting quickly, the tendency to depersonalise individuals with limited cognitive resources will be present. When this tendency is combined with little knowledge of the disease and consequences, interactions in ways Kitwood (1997) referred to as "malignant social psychology" result. This includes behaviour that causes other individuals to be invisible and reduces their worth. The behaviours include infantilisation, disempowerment (not allowing a person to use his or her abilities), stigmatisation (treating a person as if he or she were the disease and not a person with a disease), objectification, and ignoring persons. Based on this understanding, Kitwood & Bredin (1992) made a considerable contribution to the person-centred care theory by focusing on the importance of going beyond the diagnosis and revealing the person and his/her personhood.

As pointed out in 2.1.2 having dementia can be threatening in terms of maintaining self-respect, dignity, and identity. This understanding provides an important background for person-centred care, which has become the primary "philosophy" for caring for individuals with dementia (Sloane et al. 2004, Brooker 2007, Dewing 2008). The person-centred care approach is an "answer" to the biomedical conceptualisation of dementia. It emphasises the persons with a diagnosis rather than focusing primarily on the diagnosis (Kitwood 1997, Wogn-Henriksen 2012). Kitwood (1997) relied on Buber's (1958/2004) understanding of the relational aspect of interactions between individuals. Buber was concerned with how persons were involved with each other, and in his view, the basis for human existence was not individual or collective, but it was based on the encounter, i.e., a meeting between equals (Buber, 1958/2004). Based on this understanding, Kitwood suggested that meetings with persons with dementia should be equal and characterised by respect; in addition, they should consider the other's personhood. He described personhood as "a standing or status that is bestowed upon one

human being by others in the context of relationship and social being. It implies recognition, respect and trust” (Kitwood 1997) p.8.

Brooker (2004, 2007) pursued Kitwood's theory and argued that “person-centred” is the politically correct term for dementia care and can be understood in some situations to be synonymous with qualitative good care. Person-centred care is difficult to define and can initiate different associations in different contexts. Person-centred care may refer to individualised care, or it may imply a value-based phenomenological perspective and a means of communication (Brooker 2007). To provide a clearer direction in dementia care, Brooker (2007) argued that person-centred care encompasses four major elements, which are summarised by the acronym VIPS: i) valuing people, which is described as a value base “that asserts the absolute value of all human lives regardless of age or cognitive ability” p. 13, ii) individualised care, which recognises the uniqueness of an individual and appreciates that all persons have a unique history and personality, iii) personal perspective, which refers to the challenge of understanding the world from the perspective of the residents, and iv) social environment and care in the context of “providing a social environment that supports psychological needs” p. 13 (Brooker 2007). To be person-centred, the elements should occur simultaneously in daily care and focus on maintaining personhood.

In a systematic review regarding person-centred care for persons with dementia, Edvardsson et al. (2008) claimed that there is no consensus on the definition of person-centred care, and it is not sufficiently specific for guiding the practice of care. The concept of person-centred care primarily has value as a humanistic philosophy but requires the development of more specific strategies for delivering care.

The philosophy regarding person-centred care is embedded in the plans from the Norwegian Government regarding the care of persons with dementia. The Demensplan 2015 (“Den gode dagen”, HOD 2007) describes the following goal for care: “Proper dementia care means meeting the individual on his or her own terms and initiating individually adapted services based on insight into the individual’s life story and medical history” p.9 (translation).

2.2.1 Staff strain in care situations in nursing homes

As already pointed out, communication barriers may impact negatively on staff-resident interactions and make care challenging and stressful (Hansebo & Kihlgren 2002, Bertrand 2006). In a cross-sectional study, disruptive behaviours, such as aggression and screaming, and low ADL levels in residents with dementia were significantly correlated with a higher formal caregiver burden (Myiamoto 2010).

In a qualitative content analysis that examined focus groups with 35 nurses from different countries, Edberg et al. (2008) showed that strain was often related to “moral stress”. They defined moral stress as the discrepancy between the actions the nurses wanted to take and the actions that they were able to perform due to institutional constraints. The difference between what they thought and wanted to do and the constraints that prevented them from achieving it was the primary source of job strain (Edberg et al. 2008). This finding is consistent with study that examined perceptions of conscience, the stress of conscience, and burnout among nurses and nursing assistants (Juthberg et al. 2010). This study showed that registered nurses and nursing assistants in residential elder care facilities considered conscience to be an asset and not a burden. The stress of conscience was related to the lack of time necessary to accomplish their goals regarding the patients and to the workload interfering in their personal lives.

Quantitative research (Edvardsson et al. 2009) has shown that four predictors had a significant association with job strain in nursing homes: the caring climate on the unit, staff education level (lower education was a predictor of job strain), possibilities to discuss difficulties and ethical issues at work, and staff age (younger staff was more prone to job strain). The nurses stated that their jobs required skills and creativity and that providing nursing care for persons with dementia was mostly a positive experience from which they received many positive responses from the residents (Edberg et al. 2008, Edvardsson et al. 2009).

Caring for persons with dementia reveals the importance of person-centred care, but there is a gap between this overarching “philosophy” and practical implementation. This gap between philosophy and practice can be challenging for nurses who want to provide quality care but are limited by a lack of access to the specific knowledge that will enable person-centred care. It is therefore important to identify mechanisms to improve nurses’ knowledge and skills in person-centred care.

2.2.2 Staff training in dementia care

Research has shown that training and education of the caregivers of persons with dementia improves the quality of life of the residents and the staff (Passalacqua & Harwood 2012, Stein-Parbury et al. 2012, Söderlund 2012, Clare et al. 2013), by promoting a greater understanding of the person with dementia (Brown Wilson et al. 2013). Educational programs also appear to reduce the use of restraints in nursing homes (Testad et al. 2005).

Reviews have highlighted the importance of counselling, education, and training for staff in dementia and long-term care in nursing homes (Kuske et al. 2007, Levy-Storms 2008, McGilton et al. 2009, Egan et al. 2010, Vasse et al. 2010, Eggenberger et al. 2013), but there is no clear evidence that

indicates which interventions are the most effective, as the reviewers found that methodological weaknesses in these studies are common (Levy-Storms 2008, Kuske et al. 2007, SBU 2008). Vasse (2010) and Levy-Storms (2008) concluded that available evidence suggests that the best outcome occurs from training that is embedded in the daily activities in the unit, but there is still a need for further research. A cluster-randomised controlled trial of nursing home staff-training programs (Kuske et al. 2009) indicated that the complexity of the nursing home setting requires interventions that are more complex and that caregiver education is only the first step. The interventions require activities that facilitate a sustained transference of newly learned skills from theory to practice over time, and the authors maintain that the training programs must be associated with organisational and environmental changes in the units (Kuske et al. 2009).

The Demensplan 2015 (HOD 2007) indicates the need to enhance the competence of personnel working in the field through guidance, reflection, and the exchange of experiences. In a review based on her own research, Kihlgren (2011) suggested that the awareness of ethics is vital to protect the integrity and dignity of persons with dementia and that caregivers depend on reflection to understand the complexity of interactions with persons with dementia. Skovdahl et al. (2004) demonstrated that a nurturing and supportive climate and the nurses' competence appeared to facilitate reflection and promote creativity, and helped to develop positive ways to handle difficult situations.

Recently, three approaches have been used and, to some extent, been tested in Norway. Røsvik et al. (2011) explored whether a model based on the VIPS framework (Brooker 2007), the so-called the VIPS practice model, could facilitate person-centred care in in nursing homes units. The use of the indicators in the VIPS to analyse the care situation helped nurses apply person-centred care in a practical manner. However, the implementation varied and depended on the organisational structures in the units. In a qualitative study, nurses used the VIPS framework as a basis for discussions in reflection groups in the units. The nurses perceived the VIPS framework as helpful for reflection and discussion, but the study also showed that the VIPS approach was not sufficiently concrete to achieve practical outcomes in care for specific residents (Mjørud 2012).

A randomised controlled trial compared VIPS with DCM to determine if these interventions were improved compared to the education of the nursing home staff regarding dementia (control group) with respect to reducing agitation and other neuropsychiatric symptoms, as well as enhancing the quality of life of nursing home patients with dementia. Positive effects related to the outcome on agitation and psychosis were identified, but the authors failed to identify a significant effect of both interventions on the residents' quality of life (Rokstad et al. 2013a).

The third intervention is Marte Meo Counselling, which was mentioned in the report from the The Norwegian Directorate of Health (Helsedirektoratet 2007), together with DCM, as a tool for creating environmental conditions that facilitate individual treatment and care, based on knowledge of the individual person.

2.3 Marte Meo counselling

2.3.1 Background and general characteristics

The MMC method was developed using Maria Aarts' practical experiences working with autistic children (Aarts 2008). She developed the Marte Meo (MM) program in the 1980s. The term "Marte Meo" originated from Latin mythology (*mars martis*) and means that advancement can only take place "On One's Own Strength" (Aarts 2008). She found that the information provided to families by caregivers and teachers was often overly abstract and that parents needed more concrete guidance to connect with their children and for the interactions with the children to improve. By observing good interactions, she identified the basic elements in development-supported communication, which she referred to as the "developing elements" (Aarts 2008). She emphasised the importance of focusing on small elements that facilitate positive interactions to establish contact and mutuality. She called this the "natural recipe", which indicates that our ability to be in interactions is something inherent but can be disturbed during upbringing or by communication disorders. These small elements, such as helping persons to be in contact during interactions, are apparent in micro-situations (e.g., certain moments in a situation). She suggested that when an individual becomes aware of and a caregiver confirms the situations in which the "developing elements" are present, this awareness can develop the interaction and improve relationships between individuals. Thus, it also provides concrete "step by step" information regarding what happens in an interaction. To illustrate the "developing elements", video recordings of real interactions were used in the counselling. A parallel to these elements in dementia care is called Function supporting elements (FSE), see point 3.2.

A fundamental idea of Marte Meo is the basic assumption that all behaviour should be perceived as meaningful, including apparently inappropriate or meaningless behaviour (Sørensen 2002). The assumption is founded on the understanding that interactions and interplay are crucial for development, learning, well-being, and quality of life (Stern 2003) and that each individual is the subject of his/her own developmental process and the expert on his/her own life. Similarly, Aarts' idea was that changes must be understood and developed by the individuals who will implement them and that professionals should integrate new knowledge into their own mode of working (Vik 2010). The method intends to strengthen dialogue skills, stimulate positive change processes, and improve the perceived quality of the relationship (Sørensen 2002). The methods' main goal is to encourage individuals, under their own power, to promote and stimulate development processes so that children,

parents, professional caregivers, and supervisors can learn how to initiate contact and engage in a dialogue with each other (martemeo.no).

Since 1987, Maria Aarts has developed her own organisation called “Marte Meo International, On One’s Own Strength”. Furthermore, she developed a comprehensive training program for educating MM therapists (MMT). There are five levels of MM certificates: 1. MM practitioner, 2. MM colleague trainer, 3. MM therapist, 4. MM supervisor, and 5. MM licensed supervisor. These training programs are found in many countries in Europe and worldwide (Aarts 2008).

As a method of counselling, MM has established 29 different programmes with the same core elements, including the MM program for Autism and the MM Program for Crying Babies. Although the method is closely related to the development of children (Larsson 1998, Narvestad 2000, Wirtberg 2004), it has been used with adults and older individuals in the Scandinavian countries, especially in dementia care (Hyldmo et al. 2004, Munch 2008).

2.3.2 Research on Marte Meo Counselling

There are few studies concerning MMC. Searches in Cinahl, PubMed, the ISI Web of Science, and Ovid Nursing that used the term “Marte Meo” in January 2006 yielded one study (Axberg et al. 2006). In the same databases in March 2014, 12 scientific articles were retrieved, including the three articles on which this dissertation is based. In addition to two studies published in German (excluded here), a preliminary pilot study identified variables for the future evaluation of the efficacy and effectiveness of the MM method (Bunder 2011); another study presented a short summary of the development and description of the MMC method used in youth care (Bunder & Sirringhaus-Bunder 2008). Three articles in English were related to the doctoral thesis “From the outside looking in” (Vik 2010), which included a phenomenological study of postnatal depression, mother-infant interactions, and video guidance based on the Marte Meo principles. The studies revealed that for depressed mothers, seeing themselves in sensitive interactions with the new-born baby could mitigate depression. The mothers in the study reported that seeing themselves from the outside caused them to be more attentive to the child. They discovered that they had mastered the maternal role better and were more meaningful for the children than they had originally thought. The realisation provided them with the strength to mobilise renewed resources and contributed to better mental health. The mothers were able to “see themselves from the outside and the baby from the inside” (Vik & Braten 2009, Vik & Hafting 2009). In a study by Vik & Rohde (2014), MM was conceptualised in relation to Sterns’ theory (1998) of the “Schemas of being with”. They stated that MM methodology can contribute to the reinforcement of existing and creation of new patterns of mother and baby being together. This concept has been linked to an understanding that the infant’s interpersonal world and relational experience are related to self-experience and self-development (Stern 2003). Vik & Rohde (2014) argued that MM methodology can

guide new mothers with depressive symptoms and contribute to the creation of new schemes of being together.

In a quasi-experimental study, Axberg et al. (2006) applied MMC to show teachers how children with externalised behaviour problems at school require support and compared this group with a nonrandomised comparison group in the same surroundings. The symptoms of externalising behavioural problems were reduced in the intervention group and increased in the comparison group.

In a multiple case study by Lee et al. (2010), the authors used MMC to facilitate empowerment and the exploration of the strengths and resources of three mothers to improve mother-child interactions and relationships. All three mothers provided positive feedback on the program, which increased their awareness, sensitivity, and the responsiveness of their interactions with their children. In a qualitative study that aimed to determine if adoptive parents felt that this method helped them to interact with their child, Osterman et al. (2010) found that MM encouraged and motivated the parents to adjust their interplay to the child's actual behaviour, which led to a better adjustment to the child's tempo and rhythm. Further details concerning the studies published in English are provided in Table 1.

Table 1 Studies related to MMC in schools and families

Reference	Aim	Method	Results
Axberg et al. (2006)	To develop and evaluate the effectiveness of the collaboration model (i.e., coordination meetings plus MM interventions) as a tool for early detection and intervention in 4- to 12-year-old children with externalising behaviour problems at school.	A quasi-experimental design was used with a nonrandomised comparison. Collection of data was performed at two-year intervals. Baseline data from the parents were collected. The parents and teachers were invited to a coordination meeting, and the MM interventions began thereafter. Intervention: The child and teacher were video recorded in different classroom situations. Based on the video analysis, the MM-trained teacher discussed and, with the help of video clips, showed in concrete details the child's need for support. Thirty-four children were included. To measure changes in the children's symptoms, four different instruments were used.	As a whole, the comparison group changed for the worse, whereas the intervention group showed a significant reduction in symptom scores. In addition, 50% of the subjects in the intervention group had a clinically significant symptom reduction. The results were promising, and they indicated that it was possible to promote significant changes in a substantial subgroup of children who had been described as hard to teach and hard to reach.
Lee et al. (2010)	To describe the development and evaluation of 'The Boomerangs Aboriginal Circle of Security Parenting Camp Program', which is a clinical intervention based on an attachment framework using the Circle of Security and MM, in addition to drawing on traditional aboriginal culture.	Multiple case study. Three mothers with an aboriginal Australian background with preschool age children attended the 20-session Boomerangs Program, which included an initial camp and a second camp after six weeks. The camp provided the opportunity for parent empowerment and exploration of the strengths and resources of the mother to facilitate better mother-child interactions and relationships in a naturalistic setting. Data collection included questionnaires and observation of the mother-child interactions during play.	All three mothers provided positive feedback on the program in terms of increasing the awareness, sensitivity, and responsiveness of their interactions with their children. This program offers the first evaluation of an intense parenting program that used camps and MMC for aboriginal Australians.
Osterman et. al (2010)	To determine if observable themes or patterns recurred when the MM method was used with adoptive parents, and if the parents felt that working with this method helped them to interact with their child.	The study used qualitative methods and comprised two parts: the use of the MM method with couples who had adopted their first child within the past two months, and semi-structured interviews with the parents. The study group consisted of seven parent couples who had adopted children aged 5-15 months from overseas.	The method encouraged and motivated the parents to adjust their interplay to the child's actual behaviour, which led to better adjustment to the child's tempo and rhythm. This is important because the initial video recording revealed that most parents adopted a tempo that was too fast for their child. During this initial period, the MM method may be one way of working to meet adoptive parents' needs for advice and support in their efforts to be sensitive to the developmental needs of their child.
Vik & Hafting (2009)	To examine the experiences of video interaction guidance (MM intervention method). Offered to mothers who exhibited symptoms of postnatal depression.	Qualitative approach. 15 mothers. 45 in-depth interviews. Analysed through a phenomenological approach.	The findings were promising and indicated that mothers viewing their own interactions with their babies was critical to facilitating self-reflection, a renewed sense of vitality, and an increased capacity for mentalisation. This view had an overall positive influence on increasing sensitivity in the mother-child interactions and decreasing maternal depressive symptoms. A conceptual model is outlined.
Vik & Rohde (2014)	To describe an overview of basic MM interaction guidance concepts and describe the therapeutic performance in the method applied in the early-mother interaction and postnatal depression.	Utilised Daniel Stern's theory of 'schemas of being with' to understand the empirical findings and develop a stringent MM methodology.	They argued that MM methodology can guide new mothers with depression symptoms and contribute to new schemas of being with their new-born children.

2.3.3 Research on MMC in dementia care

MMC has increasingly been used in dementia care in Scandinavia, and both educated MMTs and practitioners use this method. Conducting MMC and training MMTs and licensed supervisors have been priorities of the The Norwegian Directorate of Health since 2008 to improve dementia care. The recommendations were disseminated through Ageing and Health, the Norwegian Centre for Research, Education, and Service Development, in collaboration with the Innlandet Hospital Trust and the Norwegian Women's Public Health Association's Olaviken psychiatric hospital for the elderly (Lunde et al. 2012). There are approximately 50 MMTs who work in dementia care in Norway (Lunde et.al 2012). Individuals with responsibility in this area maintain that seven of the 25 psychogeriatric units in Norwegian hospitals use MMC (Personal communication with Marianne Munch, August 2012). Data are not available regarding the use of MMC by educated MMTs in nursing homes in Norway.

Studies of the experiences with and possible benefits from MMC regarding dementia care are limited. The studies shown in Table 2 were identified by searching professional journals until March 2014. In a study based on interviews with eight MMTs, Andersen (2009) examined the therapists' perspective. The therapists found the method to be useful because it allowed the MM therapist to support the nurses in naming tacit knowledge. This is knowledge that is unwritten, unspoken, and integrated in all individuals. The knowledge can be shown in practical skills without the individual engaging in the skill being aware that they possess this knowledge (Polyani 1966/2009). After being able to state this tacit knowledge, their confidence increased. Based on focus group interviews with staff who participated in MMC (two groups with a total of nine participants), Hansen & Ytrehus (2011) concluded that MMC was generally accepted as positive by the caregivers and as a powerful method for increasing consciousness and reflection. Gudex et al. (2008) and Hatløy & Alnes (2007) conducted evaluation studies with promising findings. The staff regarded MMC to be helpful in understanding the residents' needs. A study from 2012 by Lunde et al. described and evaluated a practitioner education program for MMC in nursing homes. This study demonstrated that education could strengthen the ability of a staff member to work in a person-centred manner. Further details regarding the studies are shown in Table 2.

Table 2: Studies related to MMC in dementia care

Reference	Aim	Design	Results and discussion
Andersen (2009)	To obtain deeper knowledge of what it meant to MMTs in dementia care to have learned the method.	Open qualitative interview with eight MMTs. Analysed in line with grounded theory.	The core category: To be given knowledge that can be put into practice. A help to discover tacit knowledge, supporting the knowledge nurses already have and strengthen confidence.
Gudex et al. (2008)	Retrospective evaluation of the implementation of MM.	Qualitative interview study of management. MM tutors and staff, a questionnaire and the examination of the journals of 24 residents.	The staff's conclusion: MM was a useful tool that helped the care staffs' understanding of residents' needs and enabled them to communicate better. They believe the method has contributed to a reduction in problematic behaviour in residents and led to greater use of function-supportive actions, which were discussed by the staff. The evaluation concluded that MM helped improve the staff's communication skills and made them more professional. Individual ways of coping with difficult situations can be changed to a more concerted approach, with function-supportive actions discussed by the staff.
Hansen & Ytrehus (2011)	To study how the MM method affects the personnel's perception of coping in dementia care.	A qualitative design was used with focus group interviews. Two groups with a total of nine participants.	The results indicated that MM had a positive influence on the caregivers' perceived coping methods. All informants experienced reduced stress in difficult situations. A positive retrospective video-based assessment from the actual situations enhanced the collegiate collaboration and the feeling of security. MM was generally accepted as positive by the caregivers and as a powerful method for increased consciousness and reflection.
Hatloy & Aines (2007)	To explore if the MM guidance of staff caring for persons with dementia could influence challenging behaviour.	Observations and registrations of the behaviours of four patients were performed before and after the intervention. The staff answered a survey and participated in two focus group interviews before and after the intervention. Individual interview with the leader.	The results indicate that positive interactions increased, and 78% of the staff agreed that the intervention had been helpful. In the interviews, the staff said that they were more aware of the signs from the resident, they became more aware of being more predictable regarding the residents, and they experienced a strengthened fellowship in the unit.
Lunde et al. (2012)	1. Does the MM education make any changes in staffs' experience in giving person-centred care? 2. Does this education change staffs' degree of job satisfaction and their experience of psychosocial working conditions?	30 nurses from 5 units in 4 different nursing homes participated in this MM practitioner education. Statistical analysis N=30, three focus group interviews N=12 and qualitative interviews with leaders, N=3	Staff experienced an increased degree of providing person-centred care and increased job satisfaction. Staff described that the residents changed from resistance and helplessness to cooperation and initiative and from negative nonverbal signs to more positive signs with smile and touch.

The reviewed studies suggest a promising picture for MMC, but it is difficult to draw a conclusion on the benefits or effects of MMC based on this research. More research is necessary to evaluate the impact and effectiveness of MMC.

2.4 Rationale for the study

As the introduction and background demonstrate, creating quality interactions that maintain and enhance residents' personhood can be challenging. Persons with moderate and severe dementia in nursing homes provide weak communication signals that may be difficult to sense and interpret. A fundamental goal of nursing is to create good care situations for the residents, but nurses often lack the time, competence, or support to accomplish this goal.

Extensive knowledge exists concerning the basic values for good dementia care, including the guidelines and recommendations for person-centred care and the importance of promoting dignity for the residents (Kitwood 1997, Brooker 2004, 2007, Dewing 2008, SBU 2008). This knowledge must be more accessible and transferable to practice (Edvardsson et al. 2008), but scientific studies that have focused on training to promote the relationships and interactions between persons with dementia and nurses are limited (SBU 2008). MMC has been used extensively, even though it has a limited scientific foundation, and is recommended by The Norwegian Directorate of Health (2007) as a method to facilitate supportive environments for persons with dementia.

Given this state of affairs, we considered it appropriate to initiate a study in order to evaluate the usefulness of MMC in dementia care.

2.5 Aims

The main aims of this study were to explore whether MMC may contribute to positive changes in the daily interactions between persons with dementia and the staff in the DSCUs and to explore the nurses' experiences of MMC. Three specific aims were defined:

- To investigate whether changes could be identified in the interactions between persons with dementia and their nurses during morning care activities following MMC (Study I).
- To explore staff members' experiences when participating in MMC, with a particular focus on their learning experiences (Study II).
- To identify the factors that affect learning outcomes from MMC in a nursing home context (Study III).

3. Design and methodology

3.1 Design

In nursing research, it is important to evaluate whether interventions can create positive changes (Hallberg 2009, Thorne 2009, Wallin 2009) and to thus generate theoretical and practical knowledge to inform the delivery of care (Sidani & Braden 2011).

This dissertation was initially planned as a quasi-experimental, mixed-method study with six intervention groups and three comparison groups. The plan was to combine standardised pre- and post-measures of resident functioning and quality of life with qualitative, video-observations of interactions between nurses and residents and qualitative interviews with nurses experiencing MMC. The reason for this design was that we aimed to uncover whether changes occurred in the interactions between residents and staff as a consequence of MMC and to identify experiences of MMC and the interaction processes with residents. For several reasons, the initial plan could not be completed.

One important reason for not being able to complete the study as initially planned was that the Norwegian Social Science Data Services (NSD) would not allow us to register data on each individual person or each participating unit. They justified the decision on the basis of the obligation to maintain privacy and client confidentiality. Video recordings of persons with dementia for research purposes raises ethical challenges. Knowing the identity through video sequences of residents together with the measurements of aggression and quality of life on the same individuals would, according to the NSD, violate the privacy of the residents. Consequently, we were not allowed to collect identifiable data on the individual and unit levels. Rather, we could only collect data at the overall group level, including one intervention group and one comparison group. This approach prohibited us from comparing the changes in functioning and quality of life at the individual and unit levels.

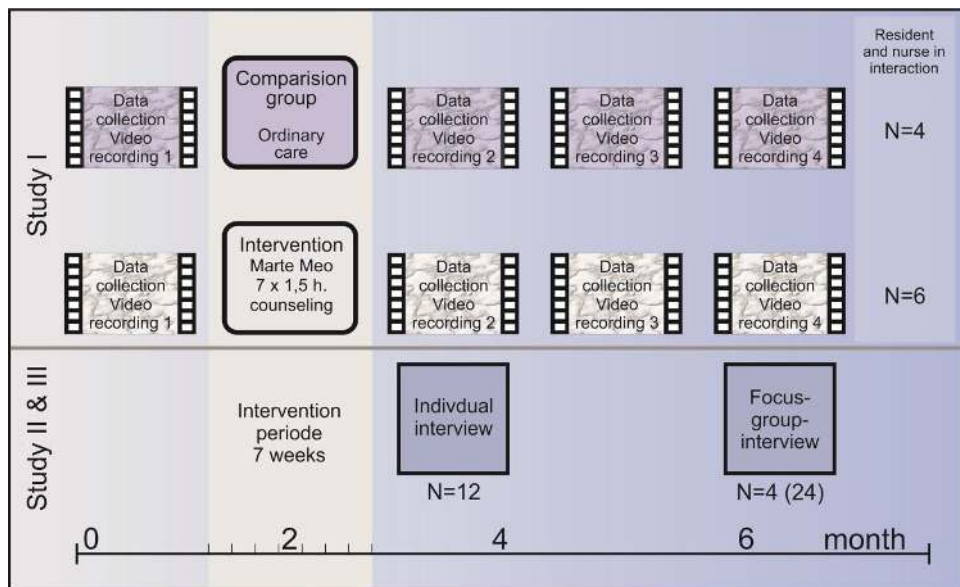
Another important reason for not being able to complete the study according to the initial plan was that we were unable to secure an adequate sample size to compare quantitative, standardised data at the group level. Originally, we planned to do the MMC interventions in six units. However, during the course of the study, one of the MM therapists became seriously ill. We did not succeed in replacing the MMT, which forced us to end the study after we had implemented MMC interventions in four units and obtained data in three comparison units.

Adding to the problems, we were not able to recruit a sufficient number of dyads (nurse and resident interacting pairs) in the participating units to gain sufficient statistical power in the study. We recruited fewer dyads for the comparison group dyads (for more details, see 5.1.2 Limitations).

Based on these unforeseen challenges, we had to reconceptualise the study. We converted the study into a qualitative and exploratory intervention study, which compared the intervention and comparison

groups based on an interpretive analysis of the video observations. We did retain the original idea of studying the experiences of the MMC and the interactions with residents in the participating nursing staff in the intervention units. Consequently, the study was conducted as a qualitative study with several qualitative data sources (video recordings, individual interviews, and focus group interviews). The research design is illustrated in Figure 1.

Figure 1 Illustration of the research design



3.2 The MMC intervention

The MMC intervention in this study consisted of 7 weekly, 90 minute, unit-based group counselling sessions between a trained MMT and all nurses who were available and willing to participate at the time of each MMC session. The counselling sessions were based on video recordings of the actual resident-nurse interactions filmed on the same day as the counselling session. The staff itself decided collectively who would be filmed in specific interactions each time. Following the filming of one resident-nurse dyad, the MMT analysed the recordings to identify the function supporting elements (FSE) (for a detailed description, see Textbox 2) that facilitated the interactions between the resident and nurse. During the counselling sessions, the MMT and the nurses reflected on the interactions and the elements that supported positive interactions and discussed how to promote more positive interactions with that specific resident. Each of the 7 counselling sessions followed the same basic structure described. The participants present varied because of the different working shifts, vacations,

and sick leaves. However, a majority of the nurses participated in most of the sessions on their shifts in their unit (for more details on the sample, see Table 3, p.40).

Function supporting elements

As already highlighted, Marte Meo (MM) was originally developed to support children and developmental processes, and Aarts (2008) underlined the need for adapting MM to each field. Adapting MM to dementia care focused less on development and more on support (Munch 2006). The modification to dementia care was first performed by Hafstad (2002), who wrote a booklet titled “Function supporting elements” (FSEs). This work provided a detailed explanation of each element, but a summary was required to make the elements more comprehensible.

Hatløy & Alnes (2007) made a comparison with Munch, who previously used these elements (Munch 2006), and compressed the text to produce the list shown in Textbox 1. This list of FSEs was available for the Marte Meo therapist (MMT) in the MMC interventions and was used to help the staff understand and name their actions in the video recorded interactions.

Textbox 1: FSEs adapted for the care of persons with dementia.

- FSE 1 Prepare for a good beginning and a positive atmosphere through tone and eye contact.
- FSE 2 Locate, confirm and follow the person's focus.
- FSE 3 State what is happening, what is going to happen, and what is being experienced.
- FSE 4 Reinforce coping ability by providing help to start and end an activity.
- FSE 5 Help the resident to be in rhythm in the dialogue by waiting for an answer or supporting the resident's initiatives.
- FSE 6 Help or support the resident to respond to new people or situations in the setting.
- FSE 7 Pay attention to physical contact.
- FSE 8 Lead in a positive way to bring the resident to the next step in the activity (e.g., ADL).

Textbox 2: The specific steps in the MMC intervention

1. The MMT met the staff in a morning meeting
2. The staff selected the resident-nurse dyad to be recorded based on informed consents obtained from the nurses, relatives and residents and on situations that the staff considered to be problematic or challenging.
3. The MMT entered the resident's room, and if the resident agreed to be recorded, a video sequence of 5 to 10 minutes of the resident-nurse interaction in morning care was conducted.
4. The MMTs analysed the video-sequence (sitting in a separate room in the unit) to identify the FSE, see text box 1, and prepared the counselling.
5. At approximately 11:00 or 14:00 O'Clock the same day, the MMC session occurred and lasted approximately 1.5 hours. The MMT used selected scenes from the video to illustrate the FSE in real-life situations, and the nurses could see, discuss, and reflect on the characteristics of the interactions and the elements that influenced the interactions, e.g., an effective beginning to the morning care session (FSE1) or the results of nursing following the resident's focus (FSE2).
6. Finally, there was a summation and discussion regarding what to focus on during the interactions in morning care with this specific resident.

3.3 Scientific perspective

After we reconceptualised the study, we decided to capitalise on the strengths of our qualitative data and chose to apply a hermeneutic interpretive approach. The term “hermeneutics” originates from the Greek word *hermeneuo*, which is translated as “interpret”, and the noun *hermeneia*, which means “interpretation” (Palmer, 1969). In the following section, I review the central concepts from the hermeneutic tradition that are relevant to this dissertation.

Understanding human experience

The hermeneutic approach seeks to understand the meaning of human experience (Gadamer 2006). A fundamental assumption of hermeneutics is that human beings create meaning in relation to their experiences of the world. Meaning is the result of the interpretation of experiences. According to Gadamer (1975/2004), human experience is not identical to merely being part of specific situations. In order to count as an experience, the person’s earlier understandings or preconceptions (his/her pre-understanding) must be challenged in some way. In this sense, an experience amounts to a situation in which some new insight is gained, i.e., where learning takes place. Gadamer referred to experience as a process that is essentially negative, in that it refutes previous experience. When human beings encounter situations that appear counter to previous experiences, they gain a new experience. The new experience requires the interpretation and the creation of a new understanding. This process is a fundamental human process. It is also the foundation for the hermeneutic interpretive approach (Gadamer 1974/2004).

In this study, the aims were to change the participating nurses’ understanding of interactions with residents, thereby changing their interactions as well, and to understand the experiences of the nurses who participated in MMC. For the first aim, the MMC intervention introduced new interpretations and understandings of the signals and interactions with the residents. For the second aim, the focus was on the nurses’ experiences related to participating in the MMC sessions and on their experiences related to their interactions with the residents.

Language as the tool for understanding

According to Gadamer (1975/2004), all understanding includes interpretation, and all interpretation is essentially verbal. Language is the medium for reaching understanding (Gadamer 2006). Human beings use language both to interpret and to convey their experiences (Gadamer 2006, Ricoeur 1977). Language is always embedded in a cultural and social context, as well as in the history of each person. Consequently, verbal narrations of experiences will always be partially subjectively constructed and partially formed by the interpersonal understandings that are embedded in the language available to the person. In Studies II and III, we invited the nurses to narrate their experiences through individual interviews and conversations with colleagues in focus group interviews.

Ricoeur (1977) expanded the perspective of hermeneutics by arguing that human actions could be considered analogous to verbal expressions. According to Ricoeur (1977), actions are meaningful in the same way as verbal expressions in that they “carry” or “express” the meanings, intentions, and understandings of the actor(s). Consequently, an action may also become the object of hermeneutic interpretation. According to Ricoeur (1977), actions must be approached as text to be interpreted. This typically means being “converted” to text by being written down and described in detail. Ricoeur argued that “action text” should be treated in the same way as text generated through the transcription of verbal expressions. Ricoeur emphasised that the process of transcription, regardless of whether it addresses transcription from the spoken language or actions, “fixes” the text and separates it from the specific “author” or “actor”. This process of separation is necessary, argued Ricoeur (1977), because it makes hermeneutic interpretation of the text possible. The goal of hermeneutic interpretation is not to uncover the intended meaning of the “author” (i.e., speaker or actor) but to uncover the meaning of ‘the issue at hand’ as expressed in the text in dialogue with the “reader” or interpreter (in this case, the researcher) (Gadamer, 2006, Ricoeur 1977).

In study I, the aim was to investigate whether changes could be identified in the interactions between persons with dementia and their nurses during morning care following MMC. Video observation was used to capture the complexity of the interactions. It is impossible to gain accurate knowledge of the changes in the interactions only by talking to the individuals who have participated in an intervention. Memory is selective, and there may be differences between what individuals tells that they have learned or accomplished and how this translates into action (Schön 1987). Video recordings have previously proven useful in research on interactions between residents and caregivers in morning care situations (Kihlgren et al. 1994, Skovdahl et al. 2003a, 2004). To assess whether any changes could be attributed to the MMC intervention, we conducted parallel video observations of a matched comparison group.

In line with the hermeneutic assumptions previously described, we “fixed” the interactions as video recordings and analysed and interpreted the video recordings as “text analogues”. We also “converted” the actions into text through detailed descriptions of the video recordings for analysis and interpretation and compared this with the “interaction patterns” identified from video analyses using Nvivo (see point 3.7.1)

Pre-understanding and dialogue – prerequisites for understanding

Understanding is achieved through conversations that occur between individuals or between an individual and a text (Gadamer 2006). New insights occur when our personal interpretations are challenged and refined when encountering the understandings and viewpoints of others. From a hermeneutic perspective, dialogue is essential. Dialogue refers to being open to the understanding and perspectives of others and trying to reach a common understanding of the issue at hand. This

description implies that the dialogue partners put forth their pre-understandings for questioning and are willing to change their pre-understanding by the new insights generated when being confronted with different perspectives (Gadamer 2006). Gadamer stated: “The true reality of human communication is such that a conversation does not simply carry one person’s opinion through against another’s, or even simply add one opinion to another. Conversation transforms the viewpoint of both” (Gadamer 2006, p.17).

Gadamer connected a person’s pre-understanding to the concept of a “horizon”. An person’s horizon is the sum of his or her pre-understandings, which are generated through previous experiences, understandings, and encounters with the world. It is not possible to be fully aware of one’s pre-understanding or “prejudices” (another term that Gadamer uses for pre-understanding). Gadamer argued that our behaviour in the world is “ a living in conversations” (Gadamer 2006, p. 26). Our pre-understanding (or prejudice) is a pre-requisite for understanding: “Our prejudices or preunderstanding are necessary conditions for our understanding of the present” (Debesay et al. 2008, p. 58). We never meet the world without prejudice; we always have preconceived expectations based on prior experience.

As a researcher, it is important to be conscious of the fact that an individual’s pre-understanding impacts one’s interpretations. Although it is not possible to be fully aware of one’s pre-understanding (Gadamer 2006), reflection might highlight how it influences our interpretations of the meanings conveyed by others.

My pre-understanding was informed, in part, by the fact that before this dissertation was initiated, I had conducted one study on this topic in a dementia care context. The experiences from that study provided me with important experience and knowledge regarding the issues to consider in planning and performing the current project because I have no course or education in Marte Meo. As a nurse and a nurse teacher, I am familiar with the nursing home context. This knowledge provided me with a foundation to build my conversations with the staff, as well as a starting point for my interpretations. Simultaneously, I realised that this might have limited my ability to be open to new perspectives (Nåden 2010). However, because this study was conducted in new contexts, with new individuals presenting their experiences and understandings, and because the design and methods were different, my previous experiences and pre-understanding were challenged.

The research group consisted of two professors in nursing science and me (the principal researcher). The two professors on the research team have contributed with their pre-understanding of, among other topics, dementia care and long-term care. Different backgrounds and perspectives have led to nuanced reflections on the basis of data from video material and text.

The hermeneutic circle

In principle, a hermeneutic interpretation is necessary only when confronted with situations, experiences, or texts in which meaning is not apparent or clear (Gadamer 2006, Ricoeur 1977). Confronted with a new situation, experience, or text, the researcher enters into the hermeneutic circle, a term that has been used to describe the process of human interpretation (Gadamer 2006). The hermeneutic circle refers to the process of understanding a “text” by seeking to interpret the meaning of the whole through the meaning of its parts, and conversely, by understanding the parts in light of the whole (Gadamer 2006). Lindseth & Nordberg (2004), who were inspired by Ricoeur (1977), described the hermeneutic interpretive process in a more methodological way. They described how naïve reading, structural analysis, and comprehensive understanding constitute the hermeneutic circle. Naïve reading constitutes a holistic interpretation or understanding of the text. The structural analysis constitutes an interpretive process in which the different parts are interpreted and understood within the context of the whole. The comprehensive understanding represents yet another holistic interpretive step, where the “reader” (researcher) once again seeks to understand the whole in light of the parts and to also interpret the text within a larger cultural and social context.

In this dissertation, the hermeneutic interpretation was guided by the approach described by Ricoeur (1977) and Lindseth & Nordberg (2004). We approached the interview texts, video recordings, and video transcripts by applying the three steps of naïve reading, structural analysis, and comprehensive understanding. Through these analytic and interpretive steps, we moved from the interviews and video recordings as a whole, through detailed structural analyses that focused on sentences and micro-situations in the video recordings, and back into a holistic, comprehensive understanding, interpreting our findings in light of the relevant theories and research.

In the following section, I detail the methods used.

3.4 Preparing for the interventions and recruitment

The intervention was aimed at nurses who worked in dementia care. Nurses were broadly defined in this study to include registered nurses (RNs) with a three year bachelor degree at the university college level, enrolled nurses (ENs) with two years of formal education at the high school level, and nurse’s aides (NAs) with no formal health care education. Leaders in the units also participated in the MMC sessions. The leaders for the unit and the leaders for the institution were also labelled as registered nurses in this sample to ensure anonymity. By “participating in MMC” means being involved in one of the video-sequences shown in the counselling or just participating in the MMC sessions.

3.4.1 Settings

This dissertation was conducted in dementia-specific care units (DSCUs) in nursing homes and municipal residences. Written information was sent to the nursing homes and municipal residences

with DSCUs in the central and Eastern parts of Norway. The major criteria for the selected institutions were as follows: (1) interest in participating in the MMC intervention, (2) a location that possessed a diversity of urban and rural areas, and (3) straightforward access to the institutions for the MMTs. Specialised skilled units for diagnosing dementia or units established for handling particularly problematic patient situations were not eligible for participation. Written invitations were sent to eighteen different nursing homes/municipal residences. Four different nursing home units and two municipal residences in three rural and three urban districts accepted the invitation to join the study. Of the first four units, two units were selected to be the comparison group, and the other two units were selected to be the intervention group. In the first unit, the intervention groups and comparison groups were assigned by lot. The next unit that agreed to join this project was selected as an intervention group, and the final unit to join the study was designated a comparison group. The comparison units were all offered MMC after data collection was completed. One unit was included in the intervention group in the study, and the other two units were not included because of time constraints and the severe illness of an MMT. The characteristics of the participating units are listed in Textbox 3.

Textbox 3: Characteristics of the six units that participated in MMC

Unit 1 was divided into three separate units. ENs were the administrative managers of each unit. A number of projects had been conducted in the unit, and some staff had previously taken part in counselling. MMC for the staff was conducted across the three units where they had their primary responsibility and where they were most familiar with the residents. An RN was the administrative leader of all three units. The unit was part of a nursing home.

Unit 2 had an RN as the administrative manager of the unit. The staff had no previous experience with research in the unit or with other types of counselling. The staff was permanently attached to the unit in which the counselling was implemented and knew the residents well. The unit was part of a nursing home.

Unit 3 had a head nurse as the administrative manager of several units. A part-time RN functioned as the leader of the DSCUs. The staff had no previous experience with research in the unit or with counselling. The staff in the unit varied somewhat with some of the staff working shifts in other units in the nursing home.

Unit 4 was a communal residence and had an RN as the administrative manager of the unit. The staff had no previous experience with research in the unit or previous counselling experience. The unit was a separate building with permanent staff, who knew the residents well. The staff was attached to the unit in which the counselling was implemented.

Unit 5 had a head nurse as the administrative manager of the units. The staff was permanently attached to the unit and knew the residents well. The staff had no previous experience with research in the unit. The unit was part of a nursing home.

Unit 6 was a communal residence and had an RN as the administrative manager of the unit. The staff was permanently attached to the unit and knew the residents well. The staff had no previous experience with research in the unit.

After the leaders for the unit agreed to participate in the MMC, the first step was to initiate a dialogue with the resident's next of kin and with the staff in each unit. The meetings took place in the units; this was an important step for understanding how this specific intervention could be tailored to the unit and included the contextual factors, which were important for the quality of the intervention (Wallin 2009, Blackwood et al. 2010, Sidani & Braden 2011). The Marte Meo therapists and I met together in these meetings, and information concerning the project was provided.

After this informal meeting, the leader of each unit asked the ENs and RNs with more than one year of experience to participate in a project group in the unit. Two to four nurses from each unit joined the project group, which was assigned the responsibility of organising and facilitating the MMC in their units.

Two trained Marte Meo therapists (MMT) were hired to conduct the MMC. One therapist was a psychologist with extensive experience as a MMT (MMT1) and did the MMC in units 2 and 3. The

other MMT (MMT2) was a geriatric nurse with vast experience in training staff in dementia care; MMT2 was recently trained as a MMT and performed the MMC in units 1 and 4.

The number of nurses who participated in each MMC session in the units varied from three to eleven due to shifts and because the nurses found it difficult to give priority to MMC because of the residents' needs in the unit and because of the time at which the counselling occurred, see Table 3. Table 4 shows the approximate staffing during daytime hours and the total number of residents in the different units. The exact number of the staff in the units could not be determined because some units worked with other units, and they had extra personnel on call and in minor positions. Based on the available data, the patient-to-nurse ratio on the weekdays in the units varied between 3.1 patients per nurse to 4.2 patients per nurse. The average number in the DSCUs in Norway is 3.1 patients per nurse during day time (Eek & Kirkevold 2011). The staff included approximately 25% RNs, 50% ENs, and 25% NAs in the nursing homes, and there were no evident differences between the groups regarding the competence of the staff. For further information, see Table 4.

Table 3: The number of nurses who participated in each MMC session in the different units.

Nr. of MMC	Unit 1	Unit 2	Unit 3	Unit 4
1.	-?	7	5	5
2.	5	8	6	4
3.	3	9	7	5
4.	6	8	9	5
5.	6	7	4	4
6.	6	8	4	4
7.	6 (?)	11	7	5

Table 4: Residents per nurse during daytime hours and total number of residents in the units.

	Unit	Resident per nurse	Residents
Intervention units	1	3.1	25
	2	4.7	10
	3	4	8
Comparison units	4 *	4.2	15
	5	4.05	20
	6	4	8

*unit 4 was in first place a comparing unit afterwards an intervention unit

3.4.2 Sample, Study I

The sample in Study I (video-sequences for comparison) included ten pairs (each pair was a resident and a nurse, one resident had two nurses) in a morning care interactions. The inclusion criteria for the residents included being a resident in long-term care, written approval from the next of kin, and consent from the resident for each specific video recording. The individual who recorded the videos constantly determined whether the resident consented using verbal or non-verbal signals (Dewing 2002). The staff determined which residents and morning care situations were important to focus on because of the challenges involved in the care situations. We excluded the residents who indicated, using words or nonverbal signs, that they did not want to be recorded. We also excluded residents if we judged that the resident expressed reluctance or refused to be recorded when we reviewed the recordings (see point 5.1.3.).

The residents in the sample were all females aged from their early seventies to their late eighties who had lived in DSCU's for more than six months and had moderate to severe dementia. All subjects required assistance to complete their morning care activities. For more characteristics concerning the residents, see Table 5.

In terms of the nurses, the inclusion criteria included being an EN or RN who knew the resident they interacted with during video recordings. This typically meant being the primary nurse for the resident and having worked in the unit for more than one year. Thirteen nurses participated; two residents received care from more than one nurse. Seven nurses were ENs, six nurses were RNs, and all nurses were female. The nurses had worked in dementia-related care for between 3 and 30 years (mean 9.3 years). The ages of the nurses ranged from 36 to 61 years (mean 51 years). For additional information concerning the characteristics of the nurses, see Table 5.

Table 5: Characteristics of the residents and nurses (Study I)

	Case	Resident	Nurse	Years worked in DC
Intervention units	1	Age: late 70s. Moderate dementia, poor vision. Walked with a walker, required help with orientation of direction, maintaining personal hygiene, dressing, and undressing. Had good language skills.	RN1	5
	2**	Age: early 80s. Moderate to severe dementia. Problems getting up from bed. Spoke in monosyllables (yes and no). Expresses pain. Has trouble while walking, requires assistance from two nurses.	RN 1 RN 2 EN 1 EN 2	5 9 6 3
	3	Age: early 70s. Moderate dementia. Mild, gentle, spoke a lot, repetition. Managed substantial ADL when she was assisted.	EN	13
	4	Age: early 70s. Severe dementia. Walked well. Limited speech. Problem related to personal hygiene and dressing.	RN	6
	5	Age: late 80s. Severe dementia, became frailer in the final videos, in first place walked with help, later needed a wheelchair. Had limited speech that degenerated.	EN	4
	6	Age: late 80s. Moderate dementia. Walked well with some support, spoke a lot, did some ADL when facilitated.	EN	30
Comparing units	7	Age: mid 80s. Moderate to severe dementia, was active, walked a lot, spoke a lot, but difficult to understand (aphasia, apraxia). Could maintain ADL with extensive assistance.	RN	3,5
	8	Age: early 70s. Moderate dementia, spoke a lot, could maintain her ADL with some assistance, walked well.	EN	16
	9***	Age: 80s. Severe dementia, walked with support, very limited speech. Required help and extensive adjustment and support for performing some ADL. Expressed pain sometimes when she was walking.	RN EN	12 11
	10	Age: early 70s. Mild to moderate dementia. Spoke well, could do all ADL if assisted. Walked well.	RN	3

RN = registered nurse, EN = enrolled nurse, ADL = activities of daily living, DC = Dementia Care. * Age is not specified because of the limitations of the Norwegian Social Science Data Services (NSD). ** Different RNs and ENs alternate in Case 2. *** In the first video recording, the nurse is an EN; in the other video recordings, the nurse is a RN. The table describes the residents' ADL functions in comparison units and how long each nurse has been working in dementia care.

To compare the groups, we intended to record three pairs of nurses and residents in morning care interactions in each unit for a total of 18 pairs (see Table 6). Some pairs dropped out because the residents showed signs of discomfort when being recorded (non-verbal communication that they did not want to be recorded), other ethical judgments (such as being very focused on the recording and displaying abnormal behaviour), or for logistical reasons (nurses or residents were ill or had difficulties because of shifts). Consequently, we ended up with ten pairs (See Table 6).

Table 6: Number of residents who were asked and agreed to participate in video recordings for data collection before and after MMC

	Unit	Asked	Accepted
		Residents	Residents
Intervention units	1	3	1
	2	3	2
	3	3	3
Comparing units	4	3	1
	5	3	1
	6	3	2
In total		18	10

3.4.3 Sample, Studies II and III

All nurses, including RNs, ENs, and NAs, in the four units were invited to participate in the MMC. The total number of individuals invited to participate reached approximately 60 individuals, including part-time staff, night-shift staff, and unit leaders.

After the intervention was complete, the head of the unit asked the nurses in the three units that first completed MMC to participate in individual interviews. In total, twelve nurses were asked, and all nurses consented to participate. The nurses had an average of 9.7 years working in dementia care, with a median of 6 years, and they were an average of 47 years old, with a median of 48 years.

Information concerning the focus group interviews was distributed to the staff during staff meetings and using posters. All nurses that participated in MMC (i.e., were involved in one of the video sequences shown in the counselling or participated in one of the MMC sessions) were invited to participate in the interview. Twenty-four nurses (including leaders) participated, which included two men and 22 women. The mean number of years the group had worked in health-related care was 19.8 years. The nurses had worked in dementia care for a mean of 10 years, with a median of 6 years, and they were 50.5 years old on average, with a median of 50 years. Fourteen participants were involved in video recordings that showed interactions with the residents in the units. Nine participants confirmed that they had experienced MMC only through the MMC sessions in the units. Three of the informants did not answer this question. For further information concerning the sample, see Table 7; for the number of informants interviewed in each unit, see Table 8.

Table 7: Characteristics of the staff who participated in the interviews (Studies II and III)

	Profession	Years working in health-related care	Years working in dementia care	Age	Individual interview	Focus group interview	Participant in video recording MMC	Sex
1	EN	25	13	56	X	X	Yes	F
2	EN	20	20	47	X	X	Yes	F
3	EN	18	15	61		X	Yes	F
4	EN	32	27	56		X	Yes	F
5	EN	24	12	55		X	Yes	F
6	EN	12	7	50		X	No	M
7	EN	20	3	43	X	X	Yes	F
8	EN	20	15	49	X	X	Yes	F
9	EN	30	30	48	X	X	No	F
10	EN	-	6	-	X	X	Yes	F
11	EN	25	5	49		X	-	F
12	EN	18	18	54		X	Yes	F
13	EN	16	4	64		X	-	F
14	EN	26	4	50	X		-	F
15	EN	8	4	32		X	No	F
16	EN	25	3	48		X	No	F
17	NA	22	22	54		X	No	F
18	NA	-	0.5	50		X	Yes	F
19	NA	6	3	46		X	No	F
20	RN	5	2	26	X		Yes	F
21	RN	30	6	56	X	X	No	M
22	RN	12	6	36	X	X	Yes	F
23	RN	21	3	47	X	X	Yes	F
24	RN	33	9	55		X	No	F
25	RN	12	5	49	X	X	Yes	F
26	RN	34	5	57		X	No	F

EN = Enrolled Nurse, NA = Nurse's Aide, RN = Registered Nurse.

Table 8: Number of nurses who participated in interviews in the different units

	Unit	Informants in individual interviews	Informants in focus group interviews
Intervention units	1	5	4
	2	4	11
	3	3	5
Comparing units	4*	-	4
	5	-	-
	6	-	-
In total		12	24

*unit 4 was first a comparison unit and then an intervention unit

3.5 Data collection

Data collection was performed using video recordings and qualitative interviews. Data collection was performed in each unit over approximately a six-month period (see Figure 1, p.31). The total time period for data collection was one and a half years (September 2006 – December 2007).

3.5.1 Data collection, Study I

Video recordings as a data collection tool

Video recordings have been used and are considered to be useful for studying the interactions between nurses and persons with dementia (Cook 2002, Skovdahl et al. 2003a, Hansebo & Kihlgren 2004) and especially for examining detailed aspects of the interactions and nonverbal behaviours, such as facial expressions (Asplund et al. 1995), the effects of person-centred personal care (Sloane et al. 2004), and the interactions related to support and well-being during morning care (Custers et al. 2011). Videos were used in these studies to show nurses situations in which they had participated to help them reflect on their approaches to care and their ways of handling demanding situations (Caris-Verhallen et al. 2000, Skovdahl et al. 2004).

Videos can be useful for observing the signs and behaviours of persons with dementia, which can otherwise be complicated to understand because of their limitations in cognition and communication.

By observing video recordings, the researcher can access data from the events thoroughly, and more than one researcher can analyse the situations (Caldwell & Atwal 2005), although it is important to be aware that human observations, including video-recordings, can be incomplete because of selectivity (Caldwell & Atwal 2005). Furthermore, when many different things happen simultaneously, it is difficult to catch all aspects in the video recordings. This is especially true for complex situations in dementia care (Skovdahl et al. 2003a).

Video recordings are essential for determining what actually happened in interactions because they allow the researcher to watch the videos numerous times, freeze the picture, and focus on micro-situations and fragments (Bottorff 1994). However, a video recording is not an exact copy of the situation because atmosphere, smells, and temperature are not available (Alrø & Kristiansen 1997).

In this study, a handheld camera was used because it was suitable for changing focus as the participants moved, e.g., from the bed to the bathroom and from the bathroom to the living room. The individual holding the camera was present in the room but remained on “the periphery” of the situation and participated only when spoken to by the residents or the nurse.

In the intervention group, the video recordings of the staff-resident interactions during morning care activities were obtained prior to and at two, four, and six months after the intervention. The videos recordings of the comparing groups were done at same time and intervals as the recordings of the intervention groups. A total of ten pairs, of one nurse (in two pair two nurses alternated, see table 5) and one resident each, were included. The video recordings lasted an average of 8.3 minutes. Five hours and seven minutes of videotape were generated. In this dissertation, “a video recording” indicates one recording, i.e., from the start to the end of one interaction/encounter between a nurse and a resident.

The appropriate timing of the video recordings was defined in cooperation with the project group and the leader of all six units. The principal researcher came to the unit in the morning with the camera. A nurse (who had received detailed information regarding what to record and to stop recording with any signs of discomfort from the resident) or I performed the recordings. Time restrictions in terms of completing morning care sometimes prohibited the nurse from recording the videos; in addition, the nurses in the unit did not want to operate the camera. Morning care is a very private task, and although the researcher had been introduced to the resident earlier in all units, I am still considered less well known compared with a nurse working in the unit. Thus, we wanted to let the nurses who previously knew the resident perform the recordings. If the nurses in the unit performed the recordings, I was available to ensure that the videos were collected according to the focus of the study and to consult with the nurses concerning ethical considerations. I performed the video recordings in approximately 50% of the recordings.

The person who performed the video recording first greeted the resident and asked if he/she would allow the person to record the situation in order to study the interaction between the resident and the nurse. In some situations, the resident used words or signs to indicate that this was acceptable and it appeared that the resident enjoyed the attention from the video recording. In other situations, the resident stated that it was acceptable and appeared to ignore the video recording and the person who operated the camera.

In the beginning, the nurses were apprehensive about being recorded. Participants are commonly aware that they are being observed at the beginning of an observation study (Caldwell & Atwal 2005). As soon as the interactions with the residents started, many nurses reported that they forgot about the camera because the interaction with the resident required their full attention.

The content of the tapes consisted of greeting the resident, helping the residents out of bed, walking the resident from the bed to the bathroom, and assisting with grooming and dressing.

3.5.2 Data collection, Studies II and III

Individual interviews

The purpose of the individual interviews was to understand the personal experiences from the participants' perspectives with an emphasis on obtaining detailed descriptions (Kvale & Brinkmann 2009, Patton, 2002). In Study II, the purpose was to reveal the participants' perspectives on MMC based on their participation in the MMC sessions.

A thematic interview guide was developed with open questions that focused on the key areas of the study's research questions. The main topics in the interview guide were the experiences participating in the MMC, consequences for practical care, comparison with other types of counselling, negative experiences, and whether they would recommend MMC to other nursing home units. The principal researcher conducted the interviews. The interview was initiated with an open-ended question to the nurses concerning their experience with MMC (When you look back on the experience of participating in MMC, how was it?). This question was designed to be as open-ended as possible to encourage the respondents to provide an answer from their perspective (Patton 2002). Follow-up questions attempted to obtain more information, such as "what was the expression she / he used" or "how or why" questions based on the situation. These questions were asked to provide what Rapley (2004) refers to as "thick descriptions". If the nurses' answers were not fully understood by the researcher, the questions and answers were reformulated, and the interpretations by the researcher were crosschecked to ensure that the researcher understood what the participant wanted to convey. As the interview progressed, the interviewees were asked to provide examples of how they thought MMC might have influenced their interactions with the residents. The interview guide is presented in Textbox 4. The interviews were obtained one to two weeks after the MMC ended to obtain the participants' immediate experiences with MMC.

Textbox 4: Interview guide, individual interviews

You have participated in MMC in the unit.

- When you look back on this afterwards, how was it?
- Do you have any practical examples where this counselling was useful?
- Are your relationships with the residents in any way affected after you participated in this counselling?
 - In what way?
 - What about communication?
- Has the care to the residents changed? Has MMC affected your teamwork with your colleague? Do you have any examples?
- Has this counselling affected your contact with the residents' relatives in any way?
- Can you tell me something about the differences between this counselling type and other forms of counselling you have participated in?
 - Strengths and limitations of different counselling methods?
- Would you recommend this form of counselling for other nursing units?
 - Why/why not?
- Are there aspects in this counselling that can be/have been unfortunate?
- How many MMC sessions have you participated in?
- Have you participated in the video recording of the patient-nurse interactions?

Focus group interviews

A focus group is a group discussion that generates data from the interactions between the members when exploring a theme of common interest (McLafferty 2004, Jayasekara 2012, Malterud 2012). In this study, we combined individual interviews with focus group interviews because individual and focus group interviews are considered to be complementary and to yield different information (Patton 2002). Focus group interviews encourage the sharing of experiences and ideas, and stimulate a collective reflection process in which responding to others' ideas and statements may provide more in-depth information compared with individual interviews (Jayasekara 2012). In this study, the focus groups were held approximately 6 months after the MMC intervention. Thus, the nurses could collect experiences and reflect upon their experiences before the discussion in the focus group, and the data could yield information related to the potential outcomes of the intervention over a longer period of time (Patton 2002).

A positive group dynamic is necessary for the participants to describe their thoughts and experiences. Without a positive group dynamic, some group members will simply agree with the statements of more vocal participants without allowing their own views to surface (Morse 2012). In Studies II and III, the focus groups consisted of staff that knew each other through the working team and had participated in the same MMC sessions. This approach has both advantages and disadvantages. The advantages are that the participants refer to shared experiences and may feel secure in a group of colleagues. The disadvantages are that possible conflicts may reduce the willingness to be open and

explicit regarding differences in opinion, as this may impact future work relations. Our impression was that the participants spoke freely regarding their experiences.

The literature indicates that focus groups should involve six to ten participants (Patton 2002). In the four focus groups in this dissertation, the group size varied from four to 11 group members because there was an open invitation to participate and we included everyone who came. Because of time constraints, the interviews were carried out despite the fact that only four individuals attended the sessions. A small number of participants in a focus group interview can provide fewer perspectives, but it can also provide a more safe and comfortable atmosphere that enables each participant enough time to speak (Malterud 2012). The interviews were led by the principal researcher and a colleague who served as an assistant moderator. The structure we used for the interviews is recommended for focus groups because it allows one individual to facilitate the group and the other individual to take detailed notes and manage the tape recorder and other practical needs (Krueger & Casey 2009). The researcher listened to the conversation and asked clarifying questions if a part of the conversation was difficult to understand. To ensure the correct transcription of the focus interviews, we video recorded the focus group interviews (with permission from the participants). The interviews began with a short introduction concerning the purpose and format of the interview. The interview guide had three major themes: open experience, the value of the MMC (if any), and how to facilitate the intervention in a better way (if possible). Most participants in the focus groups had previously been interviewed individually, and a preliminary analysis of the individual interviews had been conducted before the focus group interview was conducted. This information allowed specific follow-up questions, such as “In the interviews, several of you talked about an “aha experience” – can you speak more about this?”, to be asked. The interview guide is presented in Textbox 5.

The fact that interviews were conducted both immediately after completion of the intervention and again after 6 months helped to ensure that we not only collected the immediate impressions from the intervention but also captured their perspectives six months later.

Using a semi-structured interview guide can help to ask each participant and each focus group the same question and can ensure rigor in the study. In our interview guide, there are also some yes and no questions which can allow the expectations of what I, as a researcher, wishes the participant to answer (a form of leading question) to influence the answers. In the interviews, it was included in part of the dialogue, and follow-up questions were asked if the interviewee merely stated yes or no. The interview guides provided direction and was a reminder during the interview to emphasise the importance of having a free conversation about the participant’s experiences. For example, the participants were not asked what they had learned from MMC, as an expectation about learning did not want to be suggested; however, they were asked how MMC was and what experiences they had using MMC. The findings regarding learning in study II and III resulted from the analysed text.

Textbox 5: Interview guide, focus groups

You have participated in MMC in your unit:

- How do you look at this now? How has this been?
- Was the MM counselling appropriate for you? Has this counselling had any impact on you?
- In the interview, some have indicated a gap between expectations and results in the counselling. Could you tell more about it?
- What did you expect? Has your view changed in any way after the counselling?
- Have you done anything differently after the counselling?
 - Has this counselling made any changes in the workday?
 - If so, what changes have occurred?
 - For the resident?
 - For the staff?
 - Has the MMC affected your teamwork or your interactions with colleagues?
- Is implementing MMC for staff working with persons with dementia a goal?
 - Why/why not?
- What would be necessary for this counselling to be perceived as useful and meaningful?
- Prerequisites?
- How do you consider the need for counselling and education regarding caring for persons with dementia on your unit?

- Summary of what has emerged from the moderator. Comments and feedback from the group on the summary.

3.6 Ethical considerations

The project was approved by the Regional Ethics Committee (REK project no. 4.2006.897) and the Norwegian Social Science Data Services (NSD project no. 14693). Video recording persons with limited ability to provide informed consent requires increased sensitivity, and access must be negotiated with the relevant participants. The nursing staff provided informed consent to participate after receiving written and verbal information. Participation was voluntary, and the nurses could withdraw at any time without consequence. The residents' relatives received an information letter concerning the project from the head of the unit and were asked, if they accepted, that the resident be included based on their belief that the resident would have wanted to participate had she or he been capable of fully understanding the ramifications of the study. The relatives were offered verbal information in a meeting at the unit and were informed about their right to withdraw consent at any time without consequence. Before each video recording, the nurse provided adapted information concerning the recording and asked if the resident was willing to participate. If the resident said 'no' or showed any signs that indicated discomfort, the video-recording was not initiated or was stopped immediately. The nurses were informed not to take frontal videos if the resident was undressed and to carefully respect a resident's signs of discomfort as a "no". They were asked to switch off the video recordings if the resident showed any signs of discomfort because of the recordings. We emphasised that the video recordings were to be performed with dignity and respect. The videos were recorded by the researcher or by a nurse familiar with the resident and with video recording.

After collecting the videotapes, the authors reviewed the tapes thoroughly to determine if they met the ethical requirements. One entire video and one scene from the same case were not included in the sample because the resident showed signs to stop recording that were not respected.

3.7 Data analysis

3.7.1 Data analysis Study I

This study used a hermeneutic approach (Gadamer 1975/2004, Ricoeur 1991, 2001). With respect to Ricoeur's descriptions of texts (Ricoeur 2001), video recordings can be characterised as a particularly rich text that is generated within a particular cultural and social context (Gadamer 1975/2004). In this study, a hermeneutic approach was appropriate because it enabled the researchers to analyse the small elements (micro-situations in interactions) in the context of the entire situation (the content of the specific video) and consider the environment (context) in which the video was recorded and the residents' and nurses' behaviours and speech as meaningful in the specific context. A hermeneutical approach inspired by Ricoeur (1991, 2001) (Lindseth & Norberg 2004) was used following three main steps: naïve understanding, structural analyses, and comprehensive understanding. All data were analysed in collaboration with the research group.

Naïve understanding

Initially, the authors watched the videos to obtain an overall impression of the contents and the context of each situation. The first author wrote down a preliminary impression of each video recording that aimed to catch the richness and complexity of the data. Next, the video-recordings were transcribed. The transcriptions included everything that was said and what could be seen in the videos regarding the interactions between the residents and the nurses. In this phase, we discovered that it was difficult to identify specific changes in the interactions over time by applying an open, hermeneutic analysis. It was necessary to use a more structured guide to identify the individual elements in the micro-situations. However, a structured guide for capturing the essential elements of MMC for research purposes had not been previously developed.

Preparing for the structural analysis of the text

It was necessary to develop an analytic guide to ensure consistent analysis of the video recordings. To improve validity, a preliminary analytic guide was presented to a group of experts in dementia care, licensed MMTs, and researchers with experience using video analysis in nursing research during a consultative meeting. This step was performed to obtain advice concerning how the analysis could be used to effectively and accurately evaluate the impact of MMC on the resident-nurse interactions (i.e., the ability to facilitate good interactions). During the meeting, the significance of the qualitative dimensions in the micro-situations between the residents and the nurses was emphasised. According to the expert group, what can be defined as qualitatively good interactions depends on the specific

situation. Therefore, the experts suggested that these complex, contextual considerations must be included in the analysis to avoid over-simplification and to reduce the risk of misinterpreting very complex situations. The expert group emphasised that MMC must be regarded as an approach and a “tool” rather than a pre-described “set of rules” or a “recipe” that “produces” good interactions. Function supporting elements (FSEs) are dependent on the interpretation of the staff using the “tool”.

In addition to emphasising the importance of the qualitative analysis of the data, the expert group stressed the importance of being consistent in terms of identifying any differences between the cases and over time. Based on their recommendations, we developed an analytic guide based on the FSEs. As FSEs are not easily distinguished from each other, it was necessary to define the coding labels and clarify how the different elements should be applied to ensure a consistent analysis. The definitions are shown in Table 9.

Table 9: FSEs and how they were used to code data

FSE	Descriptions of elements	How elements were used in coding
1	Prepare for a good beginning and a positive atmosphere through tone and eye contact.	The first meeting in the morning did not appear in all recordings. To create a good atmosphere, it could occur in many phases of the video recordings. This item was coded where it clearly appeared and when the start of the interactions from the first meeting in the morning between N and R* was video recorded.
2	Locate, confirm and follow the person's focus.	Used when there was a clear common contact between R and N and where R has taken the initiative and expressed a thought, feeling, or experience (pain, discomfort, joy, commitment), which was confirmed by feedback from the nurse. Used for particularly good moments (star moments), such as laughing, smiling, body contact that clearly confirms a positive interaction, or where N asks for R's experience.
3	State what is happening, what is going to happen, and what is experienced.	Used when N described what was happening / happened / will take place and / or experience; this was not included in codes 2, 4, 5, or 8.
4	Reinforce coping ability by providing help to start and/or end an activity.	Used where R first took the initiative to perform an action, N supported R to cope, and N helped R start or stop an action.
5	Help the resident to be involved in the dialogue by waiting for an answer or supporting the resident's initiatives.	Used when there was a dialogue between R and N with several "tours". "Dialogue" could be understood as an activity (dance) and/or where an activity took place along with a conversation.
6	Help or support the resident to respond to new individuals or situations in the setting.	This element occurred very rarely in these video recordings because, in general, only two persons, R and N, were video recorded.
7	Pay attention to physical contact.	Used where physical contact occurred beyond what was required to perform the personal care situation, e.g., a pat on the shoulder or a hug was used when no other element (2, 3, 4, 5, or 8) was clearly present.
8	Lead in a positive way to bring the resident to the next step in the activity (e.g., ADL).	Used when N led R in a positive way in the situation through words, signs, or body contact, and when N provided a positive confirmation, such as saying “good”, “great”, or “nice”. This item can be difficult to distinguish from 3 and 4.

*N = nurse, R = resident

Structural analysis

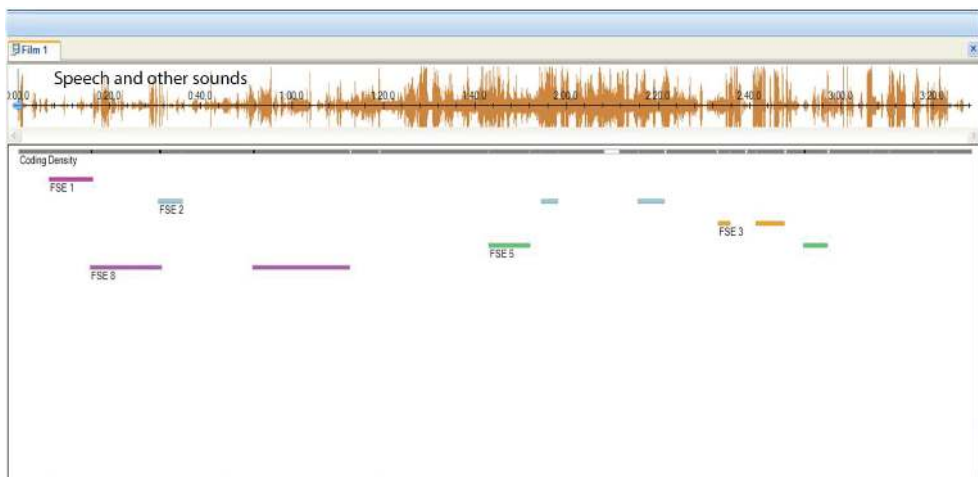
The structural analysis consisted of two steps.

The first structural analysis

The FSEs were labelled in the video transcriptions (text) by the first author, and a preliminary analysis of each case was written. The second and third authors also analysed the text while blinded to which case (intervention or comparison) and session they belonged to, using FSEs as the starting point. The research group critically scrutinised the analysis to evaluate the level of agreement of the FSE-assisted coding, which provided the initial in-depth understanding of which FSEs were present in the interactions. Even if the videos were voluminously transcribed, the written text lacked a full rendering of some significant aspects, such as the mood, rhythm, body language, and facial expressions, upon comparison of the video recordings with the transcripts. Therefore, coding of the videotapes was necessary.

The computer program NVivo 8, which is designed to assist in the analysis of video recorded material, was used; micro-situations that could be defined as positive interactions were coded using the FSEs, as illustrated in Figure 2. Figure 2 shows the coding from one video recording of one pair (a resident and a nurse) during an interaction. Every second that could be defined as an FSE was defined.

Figure 2: Structural coding using FSEs as coding labels in NVivo 8



FSE 1, FSE 2, FSE 3, FSE 5, FSE 8 see Textbox 1, point 3.2 for a description of the FSEs.

The NVivo coding performed by the first author was compared with the holistic understanding of mood and rhythm in the videos by the second and third authors, who watched the tapes independently. The second and third authors were not familiar with any of the participating units or cases and were not aware of the group assignments (i.e., the intervention group versus the comparison group). By

systematically applying the FSEs when coding the interactions, we were able to clarify the positive aspects of the interactions between the residents and the nurses. We noticed that some significant events remained uncoded. The videos showed interaction elements and fragments that could be characterised as negative and could not be considered as good care for persons with dementia. In these cases, the nurse’s statements, non-verbal expressions, or behaviour had a negative effect on the situation. To provide an accurate and complete perspective, the elements were categorised and systemised, which led to a second structural analysis.

The second structural analysis

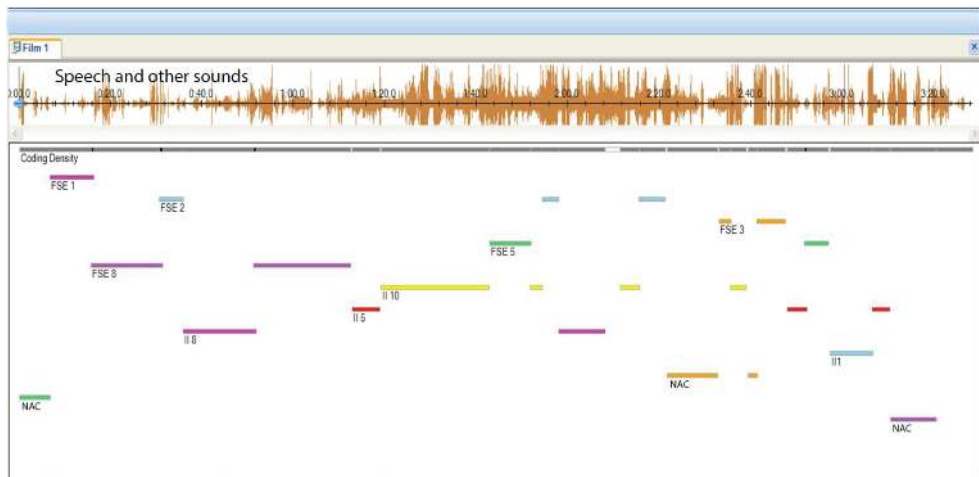
The codes were developed by considering the negative effects of the interactions in each individual video recording. The residents’ expressions and reactions in the interactions, the knowledge of the researchers, and the understanding of what characterises good dementia care and good communication were used as the basis for the assessment. The elements were characterised as inappropriate interactions (IIs) (see Textbox 6), which led to new structural coding using NVivo 8.

Textbox 6: Inappropriate interactions (II)

II 1	Information was inaccurate, unnecessary, or excessive considering the situation and the resident’s level of cognitive functioning
II 2	Memory challenge provided to the resident, e.g., asked about things that they obviously cannot remember
II 3	Nurse performed ADL that the resident was obviously/apparently capable of doing
II 4	Nurse advised the resident in a commanding tone
II 5	Nurse provided the resident with multiple instructions or performed several activities at the same time
II 6	Nurse was inattentive or ignored the signals from the resident
II 7	Pace was not adjusted to the resident’s capability
II 8	Potentially degrading comment from the nurse
II 9	Irrelevant talk (nurse discussed something that was not relevant to the context or the situation)
II 10	Resident expressed pain, discomfort, anger, or sadness without receiving a response from the nurse

It was possible to define most of the interactions as either FSEs or IIs, as shown in Figure 3. Activities in the situations that could not be defined as either FSEs or IIs were coded as neutral activity (NAC). Neutral activity included the nurse’s movement in and out of the room, retrieving objects, or any event that could not be described as an interaction between the resident and the nurse.

Figure 3: Structural coding using FSEs and IIs as coding labels in NVivo 8.



FSE 1, FSE 2, FSE 3, FSE 8 - see Textbox 1, point 3.2 for a description of the FSEs. II 1, II 5, II 8, II 10 -- see Textbox 5 for a description of Inappropriate elements. NAC = Neutral activity.

When the coding was complete, the primary researcher provided a written compilation for each pair (case), which consisted of a text analysis, an analysis of the video recordings (applying NVivo 8, Figures 2 and 3), and a description of what was positive and negative in each video recording, including a preliminary overall interpretation of each video recording. The material was reviewed individually by the other researchers, and the interpretation was adjusted based on mutual discussions. The NVivo coding of each video recording was reviewed by the authors together and was compared regarding the rhythm and the mood of the video recording. Using this method, the group achieved a common understanding of what characterised the interactions between the residents and the nurses expressed in the degree of the presence of FSEs and IIs. A high level of FSEs was consistent with a good tone (or underlying mood) and pace in the video recordings, and a high level of IIs was consistent with a poor underlying tone and pace.

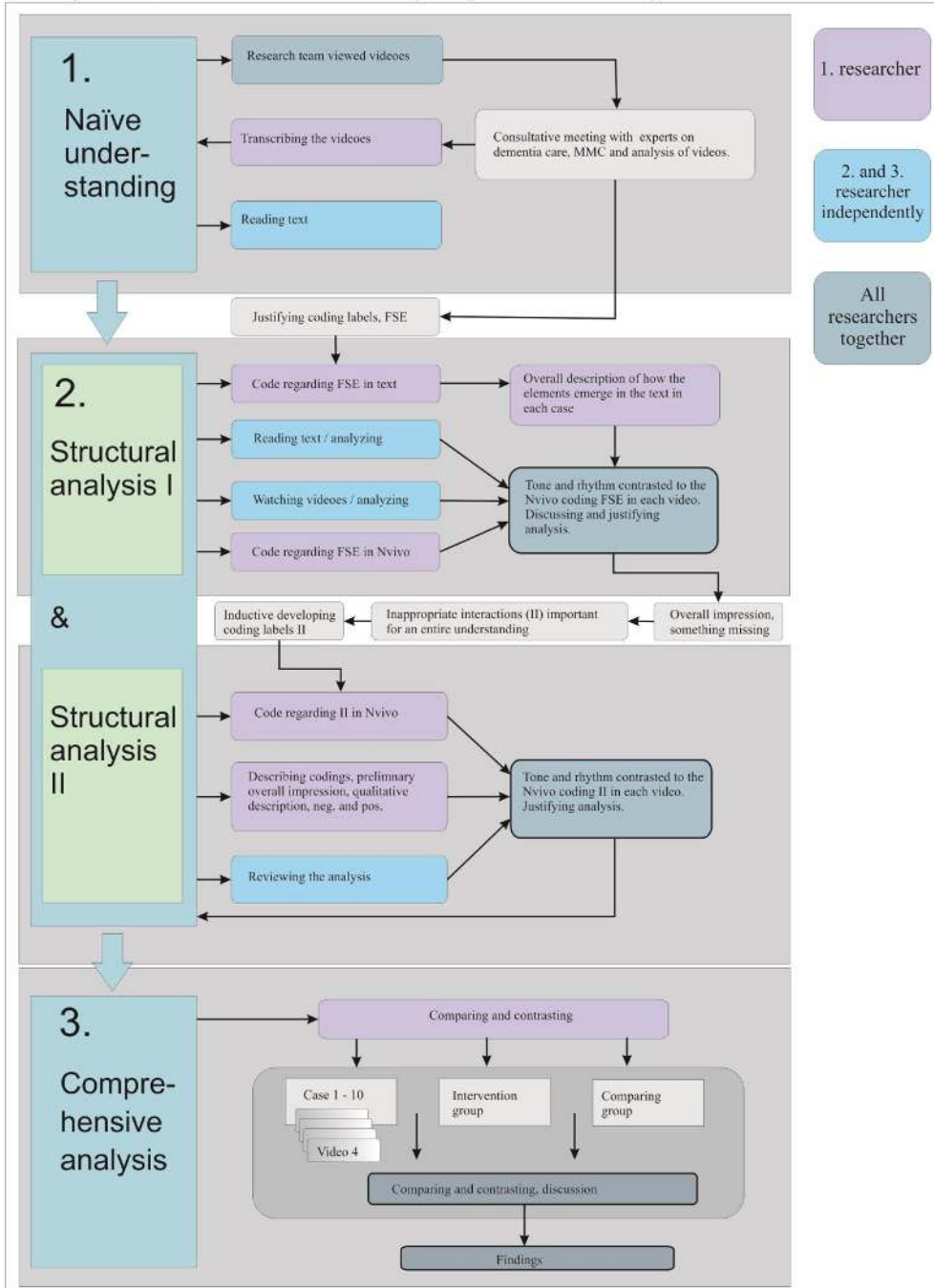
Comprehensive analysis

The proportions of FSEs and IIs noted in each video recording and in each case were plotted on a bar graph (see Figures 5 and 6, p. 63). The graphs provided us with a visual picture of the presence of FSEs and IIs in each case before and after MMC. The graph allowed us to compare cases across the sample set. Some cases were similar. For example, there was an increase in FSEs and a decrease in IIs during the data collection period, and some cases exhibited high variability. The bar graph cannot be interpreted as a complete description of the interaction elements in all situations, and a qualitative description is also required. The visual patterns provided support for our further analyses and interpretations and led to the final interpretation. After this work was complete, the second and third

authors obtained information concerning which group (intervention versus comparison group) the cases belonged to, and the two groups were compared. An overview of the steps in the analysis is presented in Figure 4.

Based on the analysis, three main categories were identified: stable cases, cases with increasing FSEs and decreasing IIs, and cases with variations in FSEs and IIs. The eight FSEs (Figure 6) and the ten IIs (Figure 7) were combined, and the combination provided an overall indication of the presence of positive interactions or interactions that could be improved (IIs).

Figure 4: Overview of the analysis process in Study I



3.7.2 Data analysis Studies II and III

A qualitative content analysis was used to systematically describe the transcribed interviews (Graneheim & Lundman 2004, Sandelowski 2010, Berg & Lune 2012) and clarify the meaning of the data (Schreier 2012). We were inspired by Graneheim & Lundman (2004), who stressed the importance of being aware of the difference between manifest and latent analyses. The manifest content analysis is concerned with “what the text says” (i.e., the “face” meaning of the text), whereas the latent content analysis is concerned with the “what the text is about” (i.e., the underlying meaning of the text).

All interviews (individual and focus groups interviews) were transcribed verbatim by the researcher. Listening to the tone and accent of the voices helped the researcher understand the meaning of the statements. To ensure that the analysis was transparent and to limit possible biases (e.g., undue influence of the researcher’s pre-conceptions and expectations), the analyses in Studies II and III were performed following the steps described by Graneheim & Lundmann (2004).

Study II

All interviews were read repeatedly in their entirety to obtain a sense of the complete interview and to gain an impression of how the different statements were connected to each other. This approach allowed the researcher to become immersed in the data and to gain an overall understanding of the interview. Notes were taken to focus on the central points in each interview.

Next, the text from each interview was organised into meaningful units, which involved separating the text into words and sentences related to each other through content and context (Graneheim & Lundman 2004). This step was followed by condensing the text by organising the meaning units in themes and sub-themes, which resulted in 12 categories and 57 sub-categories and reflected various aspects of the staffs’ experiences with MMC based on a manifest analysis. Although this process provided an initial description of their experiences, this first step provided limited precise information concerning the usefulness of MMC. However, it indicated a latent theme that the staff’s experience of usefulness was closely related to learning. In the second step of the analysis, further details were explored regarding the participants’ learning during MMC. The second step was performed by comparing and contrasting all meaning units regarding learning. The analysis yielded two new latent themes that highlighted the perceived usefulness of MMC, which included new knowledge concerning the residents and new knowledge concerning the nurses. In the third step, further questions regarding the implications of the new knowledge were applied to the text to attain a deeper understanding of the new knowledge that the nurses had gained. This final analysis generated more specific sub-themes under each main theme, such as taking enough time and the importance of eye contact. The professors in the research group critically reviewed all steps of the analysis. Whenever questions, lack of clarity,

or inconsistencies occurred, the transcripts were revisited to clarify the issues and work towards a common understanding of the text and the identified themes and sub-themes.

The individual interviews and the focus group interviews were analysed separately. One significant theme, which included increased consciousness, emerged more clearly in the focus group interviews compared with the individual interviews. Otherwise, the themes and subthemes corresponded closely.

Study III

The initial analysis showed that the individual and focus group interviews corresponded well within each unit, but that the experiences varied between the units. This finding indicated that each unit should initially be analysed separately to accurately and clearly evaluate the experiences. In the next phase, the main categories of the inhibiting and promoting factors of MMC were identified, which permitted the manifest content of the experiences to be identified. The categories (e.g., experiences during counselling, the staff's self-understanding, the video recording, the organisation of the counselling, the success criteria, and discussion during and after the counselling) recurred in all units, while the subcategories varied between the units. The manifest content analysis formed a basis for comparing and contrasting all categories across the units and by asking "what is this really about?"; one latent main theme (the underlying meaning of the text, the learning climate) and three sub-themes (establishing a common understanding of the content and form of MMC, ensuring that staff wanted and had the opportunity to participate, and providing an arena for discussion and interactions for staff) were identified. The transcripts were read by all participants in the research group, and the steps, categories, and themes were discussed by the group.

3.8 Trustworthiness

Ensuring trustworthiness in qualitative research can be challenging because of the necessity to incorporate rigor and subjectivity, as well as creativity, into the scientific process (Whittemore et al. 2001); in this way, the researcher is the instrument itself (Richards & Morse 2007). It is important to scrutinize the trustworthiness of every phase of the research process (Elo et al. 2014). The term trustworthiness can be divided into concepts such as dependability, credibility, conformability, and transferability (Schou 2011, Elo et al. 2014). It can be difficult to distinguish between these concepts, as they easily overlap, but essentially, they reflect a distinction between the quality of the study, the study's need to be credible, dependable, and confirmable, and whether it can be transferred to similar situations in similar contexts.

Dependability and confirmability were ensured in this study by conducting the intervention systematically. An emphasis was placed on providing the same information to all staff groups to ensure that the intervention was conducted in the same manner over equal time periods and with the same number of MMC sessions in each group. The therapists were approved MMTs, and the

intervention was planned in close collaboration with the MMTs, which ensured that it was conducted in the same manner at all participating units.

In study I, the interactions that occurred during the morning care between the nurses and residents were transient and complex interactions. The progress in the daily care routine occurs simultaneously with observing and interpreting the resident's signals and behaviour. Micro-analyses of short video sequences provided the opportunity to record the actual details of the interactions systematically because the same sequences could be viewed many times and because the recordings provided detailed and credible data on the care process (Bottorff 1994). The video images preserved the emotions and some of the context of the data (Morse 2012), and non-verbal communication and facial expressions could be observed. Furthermore, in analysing the interactions, each part of the micro-analysis could be understood within the context of the situation, which is a condition for hermeneutical interpretation (Gadamer 1975/2004).

The video sequences were analysed both as transcribed text and in the form of micro-analysis of the actual video recordings using the software program NVivo 8. Different perspectives could be obtained from the data using this triangulation of methods, which helped to produce a more complete picture of the situations (Williamson 2005). The triangulation of the methods provided stronger data (Patton 2002) in that the different types of data corroborated or challenged each other, which led to further analyses. Verbatim transcription from the videos was used to facilitate the analysis (Bottorff 1994). Comparisons of the video sequences (moments in a micro-analysis) with the written text were useful, as the video image moved too fast to be able to appreciate all important nuances. Through both watching the situation and reading the text that described the situation and what was said, a clearer understanding of the content was obtained. The level of detail used in this study was necessary to clarify nuances and provide a platform for assessing the recorded situations in terms of the rhythm, pace, and quality of communication.

All video sequences were first analysed by each researcher in the group, and the transcripts and video analyses were critically examined by the other two members of the team. The next step included a critical discussion of the analysis in the group until a consensus was reached as to how each individual situation in the video sequences could be interpreted. The three researchers in this study contributed different levels of experience and prior understanding to the interpretation of the data. This allowed various interpretations to be explored during the analysis. Thorough discussions were conducted until a joint understanding and consistency in the interpretations of the data and preliminary findings was reached. The two co-researchers did not know the identity of the groups (intervention group or comparison group) until the analysis was completed.

When the data were collected in Studies II and III, the dependability was ensured by using a semi-structured interview guide, asking the same questions in each interview, asking control questions in

the interview to be sure the informants were properly understood, and pursuing negative consequences of the intervention by explicitly asking about the adverse consequences. When analysing the data, investigator triangulation was used (Denzin 1989). All authors read the transcribed text and discussed and reflected upon the categories, the themes, and the steps in the analysis to ensure consistency. Dependability in Studies II and III was also promoted through the use of quotes that illustrated and supported the findings; in study II, example descriptions, which could help to portray the context and situation accurately, were also utilised (Elo et al. 2014). In the focus groups' interview six months after the individual interview, the content in the interviews was consistent with the statements made in the individual interviews, which indicated consistency in the data over time.

Transparency is important for allowing other researchers follow all steps in the studies and to ensure dependability. I have described this intervention study, the data collection, and the analysis steps of the process in detail to ensure that it is transparent.

Transferability was ensured by the selection and accurate description of the informants in the video-sequences and in the interviews (while anonymity was also assured). All six units were located in different municipalities in Norway. The units included both urban and rural districts. The diversity of the units helped to prevent factors that may be present in only one municipality from unduly affecting the results of the study. The context was described, and the findings can, in this way, be transferable to similar units. It would be advantageous if the sample size was as large as planned, but when it came to the experience of MMC, the data were heterogeneous in the sample. In studies that include persons in vulnerable situations, the investigator must be particularly attentive and ensure that the study design and methods are ethically acceptable and that the outcomes of the study justify inclusion. Conducting the study with a limited sample allowed us to learn more about the potential of MMC and how future studies should be designed prior to studying a sample that would affect a larger number of individuals.

In Studies II and III, a qualitative content analysis was used, and the nurses' statements corresponded well in the different units when they discussed the meaning and sense of MMC. These findings may indicate that the experiences of MMC, to some extent, are consistent regardless of the units and the counselling provided by the MMT and Study III showed that differences in responses regarding MMC existed in between groups with the same MMT.

To serve as an instrument for obtaining and analysing qualitative studies, the reflexivity of the researchers in all phases of the project is important. In this dissertation, the research group, the expert group (study I), and the collaboration with the project groups were critical to safeguard reflexivity in all phases of this dissertation.

4. Findings

The main findings are presented and summarised in the following order:

- Marte Meo counselling, a promising tool to support positive interactions between residents with dementia and nurses in nursing homes (Study I)
- Insights gained through Marte Meo counselling: experiences of nurses in dementia specific care units (Study II),
- The influence of the learning climate in learning outcomes from Marte Meo Counselling in dementia care (Study III).

4.1 MMC, a promising tool in nursing homes to support positive interactions between residents with dementia and nurses (Study I)

The aim of this study was to investigate whether changes could be identified in the interactions between persons with dementia and nurses during morning care following MMC.

The main finding was that the cases varied greatly in terms of the characteristics of the interactions over time and could be separated into three groups. The first group consisted of stable cases (Cases 3 and 4, see Table 5 and Figure 6 p.63). These cases were different from the remaining cases in that the nurses conducted facilitated interactions and used FSEs both before and after the MMC intervention. There were few IIs in any of the video recordings, and the nurses and residents interacted in a rhythm that created mutuality. The interactions were characterised by facilitation and dignity.

In the next group (Cases 1, 2, 5, and 6, see Table 5 and Figure 5), we found that the nurse used more FSEs after the intervention. There was a slight increase in FSEs, and there were fewer IIs after the intervention. Cases with more FSEs and fewer IIs were interpreted as “cases with positive changes”. The nurses appeared to become more focused and there were more conscious interactions with the residents after participating in MMC.

There were variations in the final group (Cases 7, 8, 9, and 10, see Table 5 and Figure 6). Some video recordings exhibited a good tone and mutuality, and other video recordings involved fewer facilitated interactions and more IIs. These cases belonged to the comparison group. The bar graph in Figure 5 shows the difference in the FSEs, and the bar graph in Figure 6 shows the IIs in all cases.

Figure 5: Levels of FSEs in the video recordings of nurse and resident interactions

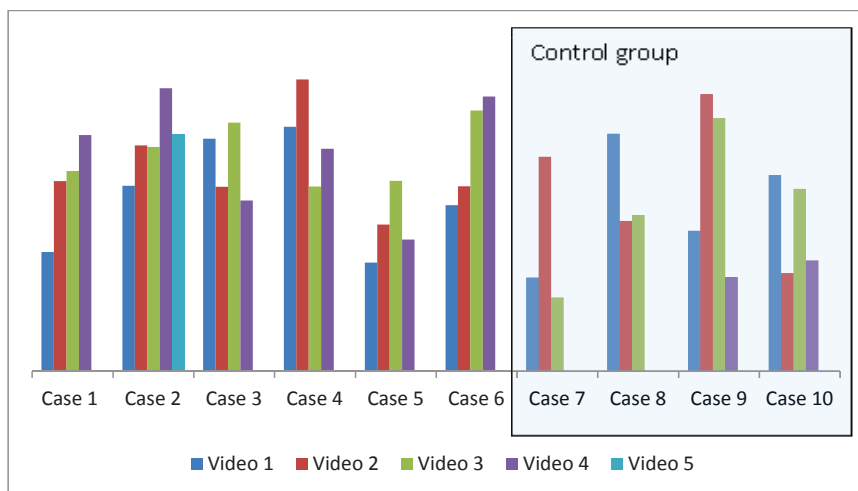
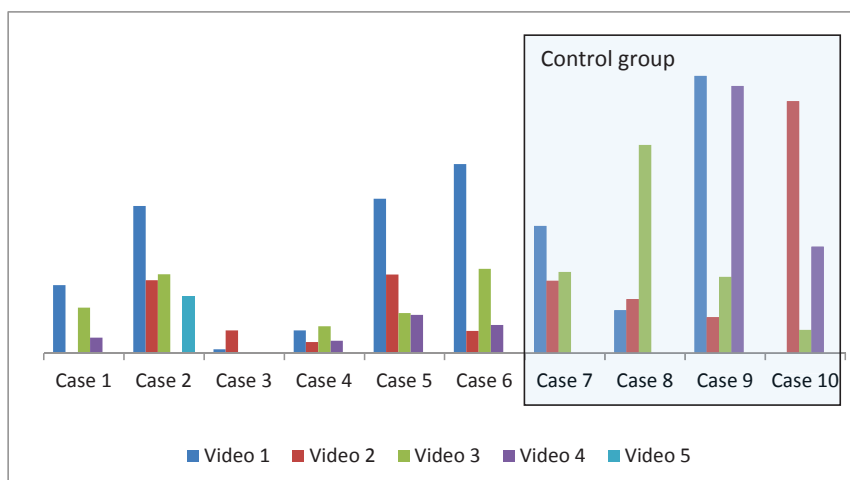


Figure 6: Levels of IIs in the video recordings of nurse and resident interactions



The patterns of the interactions illustrated in Figures 5 and 6 allowed the interpretations of the video recordings to be compared with the interpretations of the transcribed text. The sizes of the columns between Figure 5 and 6 should not be compared, but comparisons can be made within each figure.

In this small sample, it appears that MMC can facilitate positive interactions. Nurses in the intervention group succeeded to a greater degree, compared with nurses in the comparison group, in providing care consistent with promoting positive interactions during morning care routines. The nurses participating in MMC were more likely to use FSEs and made fewer mistakes during the interactions in morning care activities despite the fact that MMC did not focus on errors. Nurses in the

intervention group appeared to be more conscious in their interactions with the residents after intervention, but more research should be performed to verify these findings, because of the small sample size in this study.

We observed that video-recording can be a useful tool when studying the changes in interactions in micro-situations, such as the small elements of morning care. To study these micro-situations related to MMC, it was necessary to develop an analytical tool to provide a basis for further research on this topic.

4.2 Insights gained through MMC: experiences of nurses in DSCUs (Study II)

This study sought to discover the knowledge that the nurses perceived to have learned during their participation in video-supported MMC in four DSCUs.

The major finding was that the nurses considered MMC to be enlightening. The observation of one's own interactions or the interactions of a colleague with a resident followed by a reflection and discussion predominantly focused on the residents' expressions provided a visible and concrete understanding of the types of support that were important and useful in daily practice with the residents.

New knowledge regarding the resident

The nurses realised that the residents were more competent than they had generally believed. The MMC increased their awareness of the resident's intentions and competence. The nurses acknowledged the competence of the residents. Using video and freeze frame, they recognised that the residents could understand more than they initially assumed and that the residents' speech was more meaningful than the nurses originally thought. The nurses found that when they were attentive to the residents' subtle initiatives and provided them with the opportunity to make choices, the residents were able to make simple choices. The nurses recognised that the residents were persons with abilities and intentions and that there were reasons for their expressions and actions. MMC enabled the nurses to become aware that the residents could communicate their experiences and thoughts.

A sub-theme regarding the new knowledge about the residents was *fragile competence*. The competence of the residents was limited. The nurses understood that while the residents retained competence to understand and participate in dialogue, many residents exhibited limited ability to concentrate; trivial disturbances could make situations difficult and destroy experiences of coping. Nurses discovered that this fragile competence was closely related to the nurses' behaviour, which provided the foundation for a second main theme.

New knowledge concerning the nurses' own performance.

MMC helped the nurses realise the importance of their contributions as nurses. The speech and movements of the nurses had significant consequences on the residents' behaviour and led to emotional reactions from the residents. By viewing the video scenes and through counselling, the staff recognised how dependent the residents were on the nurses. The nurses observed that during a care-providing situation, the residents followed the nurses with their eyes. After seeing the videos and reflecting on the situation in the MMC session, one of the staff described how the nurses already attempt to adapt communication in their job: "... but now I recognised in a different way how incredibly useful we are in their lives". In this way, the nurses recognised how their behaviour and attention affected the residents' well-being.

The nurses recognised that proper communication and interactions made a difference. Another sub-theme included *knowledge about communication and interaction skills*. A main focus in MMC was to recognise what occurs during successful interactions. Using freeze-frames and slow-motion video recordings, the nurses were given the opportunity to observe and reflect on how small elements of an interaction between the nurses and the residents could affect the situation. In the interviews, the participants stressed that although they were familiar with many of the communication adjustments before the MMC, their significance became clearer during the intervention. A theme throughout the interviews was the need for time in the caring situation. The nurses experienced that through MMC, they were able to recognise that a specific resident was able to comprehend what was happening as long as the pace was slow enough and enough time was dedicated to the task. The participants focused on the importance of using eye contact along with explaining what was going on to identify the situation. They mentioned a new consciousness concerning how to speak, including the importance of using fewer and simpler words, shorter sentences, and speaking in the present tense. The nurses stated that they had gained this insight after they observed the effect and experienced the benefits it had on residents.

A small minority of the nurses questioned the significance of MMC and the usefulness of the method. They wanted greater challenges and more direct advice on how to interact with the residents. Some nurses thought that MMC was too elementary and redundant, but commented that new nurses with limited experience could benefit from it. The main findings are illustrated in Figure 7.

Figure 7: Illustrations of the findings from Study II

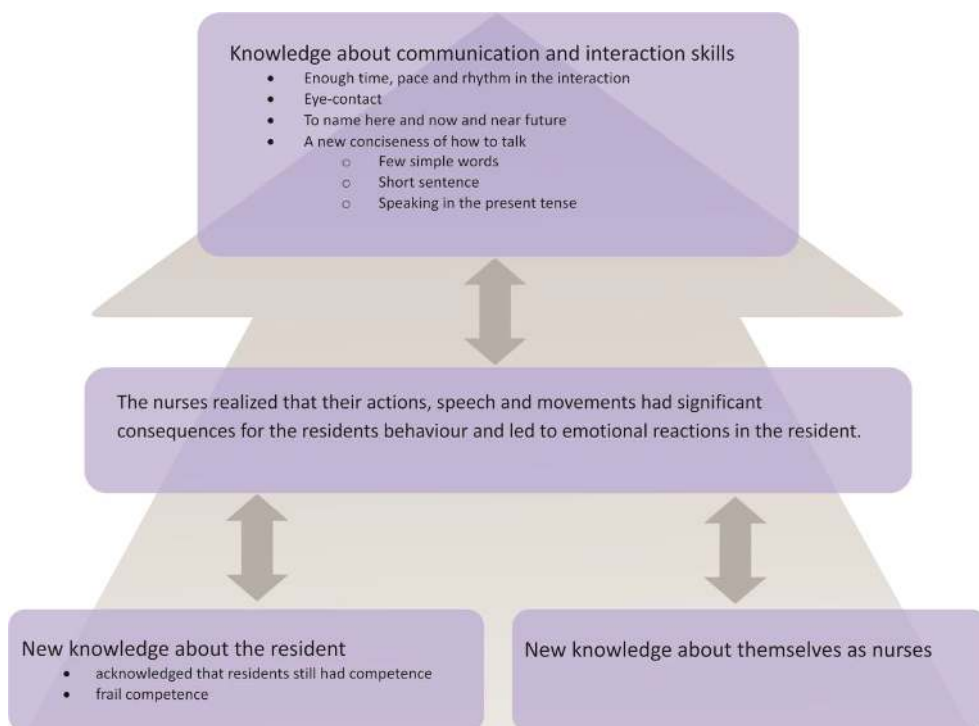


Figure 7 shows the main findings, and the arrows indicate how these findings mutually influence each other. When the nurses became aware of how they could act with the residents in a more facilitated and conscious manner, they experienced that their own way of doing things had succeeded in making the interactions with the residents mutually positive. The nurses reported that they received something in return from the residents, which allowed for enhanced mutuality.

Nurses who participated in MMC expressed an increased awareness and appreciation of the complexity of interacting with residents in the intermediate to late stages of dementia, and they discovered the importance of using FSEs when interacting with the residents.

4.3 Influence of the learning climate in learning outcomes from MMC in dementia care (Study III)

Because earlier analyses had demonstrated that nurses in different units responded differently to the same intervention, it was important to investigate the meaning of the difference. The difference became obvious especially when one of the units was characterised as having a very positive experience and another unit was very critical of the experience. In the third study, we identified the factors that affected the learning outcomes from MMC.

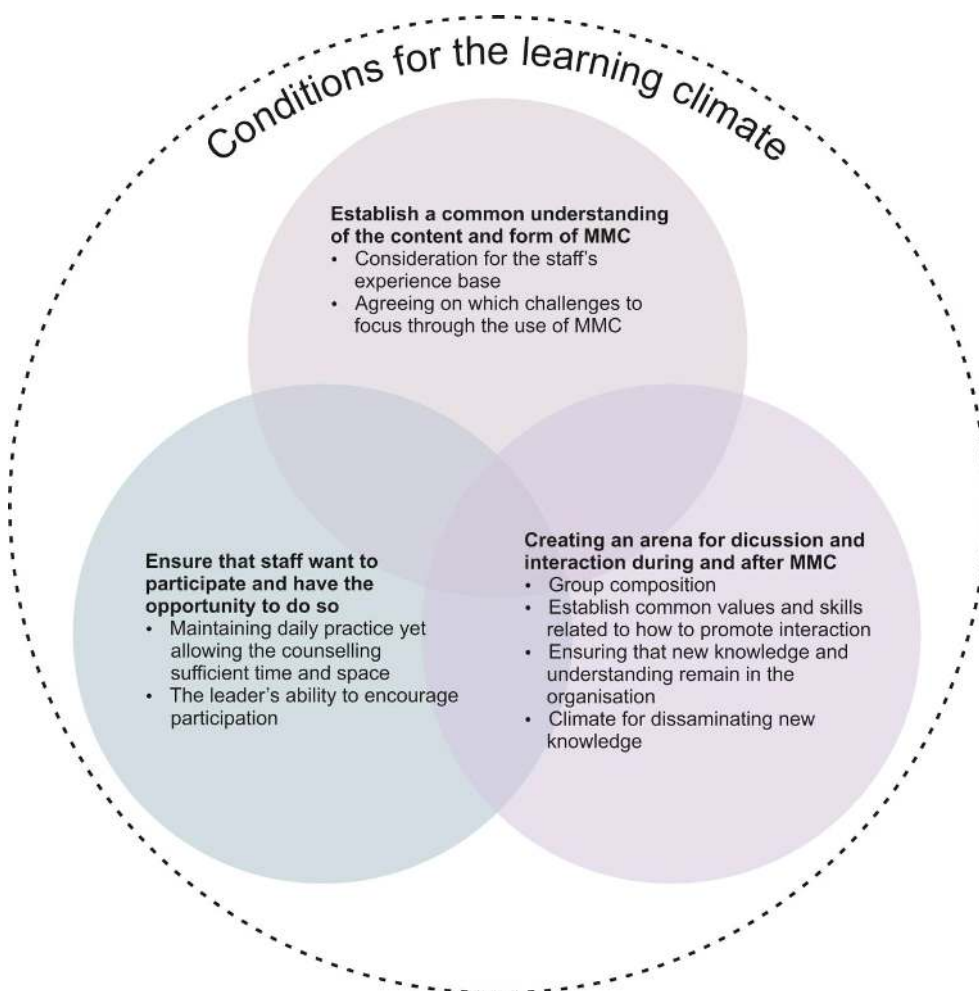
When the units were analysed separately (i.e., each unit as an individual unit of analysis), it was clear that the learning conditions and the learning climate varied. In one unit, the leader informed the staff that the intervention was important and made alternative arrangements for nurses to participate. Additional help was obtained to enable the nurses to participate in the counselling without being concerned for residents in the unit, and the nurses were provided with compensatory leave if they attended MMC after working hours. This form of leadership was appreciated. The arrangement was established as a common understanding between the leader of the unit, the MMT, and the staff.

In the other units, explicit support from the leader was not as obvious, and the leader did not participate in the meetings or hire substitutes to support the staff. When support from management was not present, the nurses questioned the intervention and were critical regarding their leader for lacking clarity on the organisation of the intervention.

In all units, the staff reported that they could have spent more time discussing their experiences from MMC, especially after ending the counselling. In the interviews, they asked themselves and the leader how they could further discuss how to establish effective interactions with the residents. The nurses asked for arenas/forums to hold discussions to better use the knowledge they had gained and to increase the utility of the new understandings and the new awareness in terms of improving patient-nurse interactions.

In all units, the nurses agreed that it was difficult to inform a colleague that his or her interactions with a resident were not effective. A new nurse (i.e., a vacation replacement) could easily be informed how to interact consistently using the new skills or learned behaviours, but informing colleagues was more difficult. We determined that an intervention, such as MMC, requires a climate in the unit in which reflection on the working teams agrees with new understandings from joining MMC and can occur outside the time dedicated for MMC. Figure 8 illustrates an overview of the findings regarding the learning climate and the prerequisites for learning.

Figure 8: Conditions for the learning climate



The learning outcomes from MMC in DSCUs appear to depend on the learning climate that exists or has been established in the unit. The learning climate depends on the ability of the MMT, the leader, and the staff to establish a common understanding of the content and form of MMC. The counselling must be considered legitimate by ensuring clarity in the relationship between the intervention and the organisation's objectives. Suitable conditions must be created to ensure that the staff is interested and is able to participate in MMC. Furthermore, an arena or forum must be provided to discuss how to facilitate interactions during and after counselling.

4.4 Summary of the findings

Study I aimed to investigate whether changes could be identified in the interactions between persons with dementia and their nurses during morning care activities following MMC. The nurses who participated in MMC succeeded to a greater degree, compared with the nurses in the comparison group, in providing care that was consistent with promoting positive interactions during morning care, and the IIs were reduced after participation in MMC. This study indicates that MMC can facilitate positive interactions and reduce IIs. However, the sample size was small, and further studies are necessary.

Study II aimed to explore the staff members' experiences participating in MMC with a particular focus on their learning experiences. The nurses who participated in MMC acquired new knowledge regarding the residents and new knowledge regarding themselves as nurses. They recognised how their actions entailed consequences for the interactions. They expressed increased awareness and appreciation of the complexity of the interactions with residents who suffered from dementia as well as the importance of consciously incorporating FSEs when communicating with the residents.

Study III aimed to identify factors that affects the learning outcomes from MMC in a nursing home context. The findings indicates that the learning outcomes from MMC in DSCUs depend on the learning climate that exists or has been established in the unit. The learning climate depends on three conditions: establishing a common understanding of the content and form of MMC, ensuring the staff's willingness to participate and that they have the opportunity to do so, and securing an arena in the unit for discussion and interactions.

Further research is however warranted to evaluate the effectiveness of MMC.

5. Discussion

In this chapter, I first discuss the relevant methodological and ethical issues encountered in this study. Then, I discuss if MMC can change the interactions between nurse and resident in positive ways. I will also discuss how nurses' learning can be understood in light of the concept of self-efficacy and discuss necessary conditions to successfully implement MMC in nursing units. Next, how training in interactions in dementia care best be accomplished and finally, I highlight the potential consequences and the need for further research.

5.1 Methodological and ethical considerations

5.1.1 The use of video recordings to study the interactions between nurses and persons with dementia

To acquire knowledge of the changes in the interactions between the nurses and the resident after MMC, it was crucial to perform a detailed study of the interactions in daily practice situations. The interactions between persons with dementia and nurses are transitory, ambiguous, dependent on the situation, and therefore difficult to study. We decided to use video recording as the best appropriate method to collect data. Other studies of nursing interactions have successfully used video recording as an observation tool (Kihlgren et al. 1994, Bjørk 1999, Skovdahl et al. 2003a, Sloane et al. 2007, Kelly 2010). This study was based on experiences and knowledge gained from the methods used in some of these studies (Kihlgren et al. 1994, Bjørk 1999, Skovdahl et al. 2003a).

Video recordings were considered well suited for the purpose of this study because the recorded situations could be replayed as many times as required to obtain maximum clarity regarding the interactions, and the video recordings provided access for all researchers in the group to the studied situations (Santiago et al. 2008). It is not possible to repeatedly observe all nuances in micro situations of interactions without the support of video recordings.

Previous studies on MMC have not developed tools for the analysis of video recordings based on MMC, but we were familiar with earlier analyses of other situations that demonstrated that video recordings are accurate and detailed and enable researchers to identify and define key elements in complex situations (Kihlgren et al. 1994, Asplund et al. 1995, Ekman et al. 1995, Bjørk 1999, Ragneskog 2001). In these studies, video sequences were coded manually either inductively, through the traditional qualitative analysis of transcribed text (Bjørk 1999, Skovdahl 2003b); deductively, according to a theoretical model (Ekman et al. 1995) or a pre-developed coding system (Ragneskog et al. 2001); or both inductively and deductively (Asplund et al. 1995). In our study, we combined a qualitative analysis with inductive and deductive approaches to the video recordings, consistent with a hermeneutic interpretive perspective (Ricoeur 1991, Lindseth & Norberg 2004). The data program Nvivo, which was used in Study I, was initially designed to analyse qualitative text data. The

possibility of analysing video recordings was first introduced as part of the program in the spring of 2008 using NVivo 8 (Edhlund 2008). This launch occurred at approximately the same time that the video recordings for this study were ready for being analysed. We considered the program to be suitable because it had a reasonable user threshold, which made it possible to systematically code and analyse the video recordings. NVivo 8 enabled us to adequately define each individual second of the video sequences because the screen image simultaneously showed the recording and the tool bar for coding. Throughout the video-sequences, we were able to define each function supporting elements (FSE) and inappropriate interaction (II) in addition to neutral activities. This method allowed us to observe, critically discuss and summarise the events that characterised each recording and provided a basis for comparing video recordings in the same case and across cases.

The request to video record interactions in nursing home units initiated discussions. Concerns were voiced regarding video recording of patients and nurses. In the interviews, some nurses stated that they experienced participating in video recording was scary in the beginning. After participating in MMC, however, they experienced that the focus was on how the situation went well and on the interactions rather than on them as persons. This made them more confident. When they saw how the video recordings were used in the MMC session, they accepted the video recordings as a tool that could help them improve their interaction skills. During the intervention period, the focus on the video recordings decreased, and the focus on what the video recordings and counselling could improve was increased.

5.1.2 Limitations

In Study I, the comparison group was referred to as the control group. The more correct term is comparison group (as used in this dissertation) because randomisation was not performed. In exploratory designs, the strict demands regarding identical characteristics in major variables between a control group and an intervention group cannot be ensured.

In Study I, we collected data from a limited sample size, and there were fewer participants in the comparison group than in the intervention group. We originally recorded three pairs in each unit, but a greater number of participants dropped out of the comparison group than in the intervention group. In both groups, several requirements had to be fulfilled to include the participants: the nurses had to consent to being video recorded, the residents had to accept the video recordings, and the same nurse had to be present and care for the resident in a similar care situation on four different occasions. These requirements were difficult to arrange because of shift work and illnesses in the residents and nurses. In addition, some video recordings had to be deleted because the resident showed discomfort or provided other negative signs during the video recording. These recordings were excluded for ethical reasons. More pairs from the comparison group were excluded than from the intervention group, which resulted in four pairs in the comparison group and six pairs in the intervention group. It would have strengthened the dissertation if the size of the sample in the comparison group was similar to that

of the intervention group in Study I. Nevertheless, the data material was rich and allowed us to conduct a thorough analysis based on the video recordings and uncover important differences between the two groups.

With the exception of two nurses, all nurses who participated in the individual interviews and in the videos were members of one of the project groups (i.e., responsible for organising and conducting MMC in their units). The nurses were asked to participate in the project group by the unit leader of their nursing home. The method the leaders used to select the nurses for the project group is not known, but because experience showed that there was some stress concerning being video recorded, the most confident nurses or the nurses that the leader regarded to be most competent were likely asked to join the project. Therefore, the participants may have been systematically different compared with other nurses in the units, and perhaps the selected nurses were more confident in their roles compared with the staff in general. This difference could represent a possible explanation for the small variations in Study I. Furthermore, being assigned the responsibility for the intervention in their unit might also have made them more positive to MMC, which might have impacted their responses in the interviews in Studies II and III. We did not receive sufficient information concerning all nurses to enable us to draw any firm conclusions. Nevertheless, the findings suggest that MMC increased the level of FSEs and decreased the level of IIs in the interventions.

The studies could have been strengthened by conducting video recordings from the MMC sessions. This approach could have generated more data regarding what the nurses and the MMT discussed in the counselling and how the MMT and the nurses commented on the videos. It would have also clarified whether there were any important differences between the MMTs' counselling.

5.1.3 Ethical considerations

Thorough ethical assessments must be conducted in all clinical studies before the study is conducted, including informed consent, confidentiality, privacy, and participant burden and safety (Lauren et al. 2008, Morse 2013). The ethical requirements pose a challenge in studies that focus on persons with dementia because the ability to provide informed consent may be limited. It is particularly important to protect the interests of the individuals when they are placed in vulnerable situations, such as being video recorded. In a review of the current literature available on instrumentation and procedures for capacity assessment of cognitively impaired individuals, Simpson (2010) concluded that universal guidelines regarding obtaining informed consent to participate in research do not exist, but that the consent process must be as transparent as possible.

Obtaining informed consent from persons with moderate to severe dementia is complicated, and cognitive skills may be too limited to enable the patients to completely understand the extent of the study in which they have been invited to participate. Great efforts were made to inform the potential participants and their relatives prior to the start of the study and while the study was being conducted

(see point 3.6). Although they understood the question concerning being video recorded, they could have quickly forgotten the information they had received once recording began (Dewing 2007).

Each time a video recording occurred, the residents were provided information by the nurse or by the researcher after first greeting the residents and asking if it would be acceptable if the researcher or the nurse recorded them along with the nurse. We explained to the resident that the reason for the study was to learn how good interactions could be achieved or how we could talk and spend time together. In some cases, the questions needed to be simplified considerably and were limited to asking permission to video record, while simultaneously showing them the video recorder. It was important to practice what Dewing (2007) called “on-going consent”, which involved constantly evaluating the residents’ verbal and non-verbal expressions regarding how they experienced and interpreted the situation when the video recording was performed. Some residents expressed distress, which showed that the residents who were suitable for inclusion in the study were also competent enough to refuse participation. In these cases, we stopped recording. In a few instances, we discovered afterwards when reviewing the video recordings, that the residents expressed reluctance in terms of the video recordings. In these cases, we excluded the video recordings, in order to honour what we interpreted to be their wishes of not being part of the study.

According to Dewing, (2007) the individuals who obtains consent should be aware of how the particular individual consents to activities, and the process must be conducted according to the individual’s preferences and personhood (Dewing 2007). In the cases that I recorded, I spent time in the living room observing and becoming acquainted with the residents before recording. In the cases where the nurses performed the recording, nurses who already knew the residents conducted the recording. The residents’ relatives consented verbally and signed a form which indicated that they were aware that the resident was participating in the study and that they had no objections to the participation. The relatives were requested to assess whether the study was something the resident would have consented to, prior the onset of dementia, based on their previous knowledge of their next of kin.

This type of research includes persons in a vulnerable position because of their diagnosis and the conduct of personal and intimate care. Therefore, Study I challenges *confidentiality* and *privacy*. Consequently, the utility value must be assessed against the *participant burden and safety* (Lauren et al. 2008). In a comment to Study I, when it was published, Hoe (2011) questioned the necessity of conducting research that involves video recordings of vulnerable persons in vulnerable situations and stated that “The dilemma that this raises is how do you evidence improved practice for the delivery of personal and intimate interventions for vulnerable adults and what alternative methods could be used” (p.435). Determining whether this type of research is consistent with good research ethics and ensuring that the well-being of the patients in vulnerable situations is not compromised is difficult. We

carefully judged the pros and cons of conducting the study using video recordings. Our decision to use video recordings was based on the assumption that it may be equally unethical to avoid this type of research because we know that situations associated with the morning care routine can be very problematic and entail demanding interactional situations (Skovdahl et al. 2004, Eggers et al. 2005). It is well known that morning care situations frequently trigger NPSs (Enmarker et al. 2011, Isaksson et al. 2011), which may signal distress and despair. It is important to develop additional knowledge regarding how to promote good interactions in morning care and in other challenging everyday situations (Skovdahl et al. 2004). In order to contribute to this goal, we chose to conduct an intervention study.

Using video as an instrument for acquiring a basis for counselling in practice places considerable demands on its implementation. Video recordings can be considered as “strong” tools that must be handled in an ethical manner and with a continuous dialogue with those participating in the video recording, including both residents and staff. Only certified MMTs can be supervisors in MMC (Aarts 2008). Video-supported counselling must satisfy the confidentiality and privacy of the residents and the staff. Participant burden and safety must be assessed in situations in which a video is used in counselling. There must be procedures in the unit to ensure how to store a video recording before counselling occurs and to ensure that it will be deleted after the MMC session.

5.2 Discussion of the findings

5.2.1 Can MMC change the interactions between nurse and resident in positive ways?

In study I, we identified a positive change in that FSEs and less IIs were observed in the intervention group than in the comparison group. This can indicate an approach to care that is consistent with person-centred care because the FSEs in the interactions are connected to each resident’s special needs and their ability to master a task or an interaction situation.

Through focusing on FSEs, elements in small interaction situations were shown to the nurses. They understood that by following the residents’ statements and paying attention to the resident, they could reveal the residents’ competence, be in contact with the resident, and establish a common focus for the interaction (FSE 2) (Study II). The establishment of trust and attachment is fundamentally important for persons with severe dementia because they require constant reassurance concerning how to perceive and understand situations because of memory loss (Kitwood 1997, Potkins et al. 2003, Langdon, et al. 2007, SBU 2008). Reassurance can support their experience of being able to cope with situations, which is crucial for maintaining selfhood and a sense of value (Steeman et al. 2007). By discovering the residents' dependence on them as nurses, the nurses became more aware of their own importance and the significance of how the interaction was handled.

Persons with dementia can easily be interpreted as less competent than they actually are (Normann et al. 2002, 2005, Sabat 2005, SBU 2008, Moos 2011), (see point 2.2), MMC seemed to help the nurses to discover the concealed personhood. Still pictures (from the videos) of the resident's face and body shown during counselling allowed the nurses to interpret small signs that were difficult to interpret. The staff members' ability to interpret signals as meaningful is critical to ensure good care consistent with the residents' needs and values. Through watching the video recordings, the nurses observed that the residents experienced pain through small verbal and facial expressions or that they struggled to comprehend what the nurse said or did and had limited ability to concentrate. In the same video sequences, they also observed how important their support was to residents. They realised the importance of recognising and name the residents' pain or other feelings and how this helped the resident to be able to handle the situation, e.g. walking over a floor despite the fact that they had some pain in the hip.

Through the image on the screen, the nurses observed how their touch and proximity influenced the residents, and based on this evidence, they were able to be more sensitive regarding how the person wanted to be touched and how much personal space the resident needed. The nurses stated that they brought this new knowledge of the resident with them when they met the resident in new care situations (Study II), and based on this knowledge, they were able to be more secure in how to interpret the resident. They stated that they came to know each resident in a new and better way. To know each individual resident well is necessary to person-centred care and to provide care in a manner that respects the resident's remaining competence and dignity.

Levinas indicated that the face is the starting point for ethical reflection (Lévinas & Aarnes 2004). As humans, we are affected by the facial expressions of others (Lévinas & Aarnes 2004). To interpret facial expressions requires a higher degree of empathy with the residents (Asplund et al. 1995), and proper interpretation can help the nurse to see the situation from the resident's perspective, which is one of the core elements in person-centred care (Brooker 2007). Thus, their ability to identify ethical challenges was also improved. Research has shown that there is a need for ethical reflection when caring for persons with dementia (Norbergh et al. 2006, Terri et al. 2006, Solum et.al. 2008) and ethical challenges are related to understanding the world from the perspective of the residents (see point 2.2.1). In Study II, one of the nurses explained how she, through the videos, recognised the resident's vulnerability and the painful feeling of losing control and that she was able to experience the vulnerability along with the resident through watching the video. The others nurses expressed similar thoughts. Vik & Hafting (2009) found that using MM for mothers who suffer from depression during pregnancy led to greater sensitivity and emotional touch in their contact with their child. To understand the resident as a person (Buber, 1958/2004, Kitwood 1997), one has to be sensitive to the signs she/he conveys. Feeling sympathy for patients and having the ability to sense their pain are crucial characteristics in care work (Nordtvedt 2008, Martinsen & Kjær 2012). This is a starting point

for acting in a way making the care person-centred (Kitwood 1997) and for prioritising the relationship as much as the care tasks.

MMC became a concrete tool for the nurses given that after counselling they understood how to act to ensure good interactions. Some nurses knew this well before the MMC, but their knowledge was confirmed, and some obtained improved understanding regarding why the situation went well, i.e., by taking their time and following the resident's pace. The nurses stated that they learned a lot about "time" through MMC (Study II). In a workplace with many demands, it can be difficult to stop and be aware of each encounter. MMC helped the nurses to become aware of how to "take their time" and the resulting advantages. Previous research has pointed out that morning care can be rushed in nursing homes (Cohen - Mansfield et al. 2006, Sloane et al. 2007). In this way, our findings suggest that MM counselling can contribute to greater awareness of the importance of concentrated presence, and the use of enough time in encounters with the residents.

5.2.2 MMC, learning, and self-efficacy

Considering Studies I and II together, positive changes occurred with respect to the nurses' interactions with the residents and their experiences of learning. In the next section, I will relate these findings to the theory of self-efficacy (Bandura 1997).

The theory connected to MMC is sparse, but a basic question from Aarts (2008), when she started her work, was "How could I transfer the necessary information to the mother [with an autistic child, (my amendment)] in such a way, that she would comprehend it in a way that enabled her to put it into practice?" (Aarts 2008, p. 31). Her answer to this question was that it is essential that individuals become aware of their own competence. This concept is underlined through the name MM, which means "of one's own strength". The idea that individuals can influence what they do can be grounded in the theoretical framework of social cognitive theory described by Bandura (1997), which is related to his concept of self-efficacy.

The concept of self-efficacy is defined as the confidence an individual has in his/her own ability to handle specific situations (Bandura 1997): "To transfer new skills into actions people must experience sufficient success when using what they have learned in order to believe both in themselves and the value of the new ways" (Wood & Bandura 1989, p.364). There are four main resources for achieving self-efficacy: *positive mastery experiences*, which involve performing a task and experiencing success; *vicarious experiences*, which involve witnessing others with similar backgrounds and experience master a task; *social persuasion*, which entails gaining support from others that results in overcoming self-doubt and focusing on performing the task to the best of one's ability; and *strengthening physical and affective state*, which involves how one interprets one's own emotions in certain situations (Bandura 1997).

Positive mastery experiences

The findings in Study II showed that MMC provided nurses with positive experiences in mastering interactions in morning care. What the nurses learned from being more aware of the residents' signals and the importance of their facilitating skills can be described as positive mastery experiences. In Study II, the nurses described their own skills, such as using eye contact and waiting for an answer from the residents, as the reasons why the interactions went well. They discovered that they were in a position to affect the outcome of the interaction and that it provided them with positive mastery experiences. When the nurses realised that the interactions were important for the outcome of the patient's experience of the interaction, this strengthened their intentions to implement these actions, as underlined by Bandura's theory of self-efficacy (Bandura 1997).

Vicarious experience

Vicarious experience through MMC (as witnessing colleague making qualitative good interactions) can be facilitated using videos through modelled attainment. The nurses who were recorded could see their own skills in action and become their own role model if the experience was positive. The colleagues could see that a person with a background similar to theirs had mastered the task, which according to Bandura (1997), can help individuals acquire greater faith in their own mastery. Because MMC focuses on what functions well in the interactions between the resident and nurse, this can be a positive mastery experience for the nurse and provide positive social modelling for the entire nursing group. The nurses were given the opportunity to watch a model example). According to Benner et al. (2010), this type of modelling is a very important method of learning nursing practice because the situations in nursing practice are complex and difficult to learn without the learner being located in a relevant context. This is also in line with Aarts' original idea (2008).

Social persuasion

Using MMC, the nurses acquired knowledge regarding each other as nurses from a new perspective and were provided the opportunity to offer positive feedback. The feedback that was expressed to the nurses who were exposed in the video sequences during the MMC sessions was of considerable importance for them because it reassured them that they were performing actions that supported the functioning of the residents when interacting with them (Study II). This can also help to create a culture where social persuasion and providing feedback to each other in the working group can be appreciated. For the nurses, confirmation and the opportunity to feel valued can create greater confidence in their own ability to handle (Bandura 1997, Severinsson 2001, Zimmermann et al. 2005b).

Strengthening physical and affective states

Caring for persons with dementia can be challenging (Edvarsson et al. 2009). Being able to handle complex situations, such as morning care situations (Enmarker et al. 2011, Isaksson et al. 2011), is very important for preventing strain in nurses (Edberg et al. 2008). The nurses in Study II stated that it gave them satisfaction when they discovered that they were able to establish contact with residents they assumed to be difficult to reach because of limited speech and few understandable signs. The finding that the nurses were able to establishing contact with the residents with challenging behaviour represented important experiences that influenced them psychologically and encouraged them to apply these approaches more consistently in their encounters with the residents.

In conclusion, it appears that MMC can positively affect nurses' self-efficacy.

5.2.3 Important conditions for the implementation of MMC in nursing home units

In Study III, we found that the nurses experienced participation in MMC in different ways. Most nurses experienced that they learned something important. However, a smaller group stated that participation in MMC was not helpful or valuable to them because they knew the interaction skills from before. The latter nurses were not significantly different from the other nurses in terms of their level of education and experience in dementia care.

This raises the question of which conditions must be in place in order to facilitate implementation of MMC in nursing home units. To address this question, theories on social cultural learning may be helpful. Social cultural theories emphasise that learning is always situated and influenced by the context in which it takes place (Lave & Wenger 2003), and that organisational learning (Argyris & Schön 1996, Senge 1999, Klev & Levin 2009) is necessary to succeed in implementing change.

To meet the changing demands on long term care institutions to provide timely and effective treatment during care, it is strongly emphasised that health organisations should be "learning organisations" (HOD 2012-2013, Morgendagens Omsorg 2020). Senge (1999) emphasised that shared values (i.e. that colleagues agree on what is of most importance in their work) and team learning (i.e. creating the conditions for collaborative learning in work teams) are important characteristics of learning organisations. Gjerberg & Amble (2009) noted that a learning organisation is an organisation that offers its employees opportunities for learning in everyday practice and can create positive results and innovation through continuous and critical reflections in their daily work. In Study III, we argued that to facilitate MMC in nursing homes, a learning climate is required. This implies motivation in the staff (i.e., that the staff wants to participate), common understandings between the staff and leaders, arenas for discussions, and clear leadership.

The nurses in one unit (Study III) questioned why they were chosen for MM counselling, as they believed they were skilled in communicating and interacting with persons with dementia. These nurses raised the question of why they were chosen to be the “victims” of video recordings, which suggests that they experienced participating in the intervention as an assigned duty rather than an opportunity to learn and develop their skills. When the nurses asked “why them”, this highlighted that an intervention such as MMC will not be automatically welcome in all units. The ground must be prepared. When offering counselling, the first step is to clarify the expectations among all relevant staff involved to develop a common understanding of why the counselling is being offered (Egan 2002). This group, who did not experience MMC as useful, wondered whether their nurse leader considered their competence inadequate because they thought that MMC focused on simple elements of communication, such as “eye” contact and “using simple language”. They reported that they had not received clear information from the leader concerning the purpose and goal of the MM counselling. Consequently, MMC was experienced as one more thing they had to do (Study III). They did not see any connection between the MMC and the core values of the organisation.

Developing common understandings in collegial groups

The staff in some units developed a common understanding of how they could promote interactions with persons with dementia (Studies II and III) through reflections in MMC sessions and by working together when helping the residents. This understanding led to discoveries by the staff that affected their basic assumptions concerning the necessity for participating in the interactions with the residents with dementia. A thorough understanding of the reasons for one’s own actions is referred to as double-loop learning and is considered necessary to change organisational culture (Argyris & Schön 1996). The staff in one of the four units underscored this point by stating the importance of the staff “being on the same page”(that is understanding situations the same way). This point was underscored by both the RNs, the ENs, and the NAs. When the nurses watched the same video-sequences and were at the same counselling sessions, they experienced that it was easier to collaborate when caring for a specific resident together, because they both knew the importance of e.g. pace and timing when interacting with the resident. In this way, the nurses developed a common understanding of the situation (Senge 1999) and shared values regarding the importance of providing enough time for interactions and developing the skills and knowledge to enable good interactions in morning care.

Building a culture for disseminating new knowledge

Although they learned new skills in interactions and some units developed a “common understanding”, the nurses found it difficult to convey the new knowledge to colleagues who were not members of the same nursing team and who had not participated in MMC. It appears that the new insights they gained were difficult to disseminate and share with colleagues who had not participated in the counselling (Study III). To tell a colleague how to act in order to improve the interactions with

the residents was a difficult task for the nurses. This experience can be related to the culture in the units, including which actions are “permitted” in the environment. Studies have demonstrated the benefits of clinical nursing supervision and reflection groups in nursing homes on job satisfaction and well-being in nurses (Bègat et al. 2005, Begat & Severinsson 2006, Gjerberg & Amble 2009, Edvardsson 2009). Nevertheless, peer counselling is not common practice in Norwegian nursing homes. In order for such sharing of knowledge to be acceptable, establishing a culture of learning, trust, reciprocity, and common vision is necessary. Changing the patterns of communication and the interactions with the residents also changes social practice and depends on what is accepted in the situation and the culture (Lave & Wenger 2003).

New understandings and values can be difficult to share. This concept was demonstrated in a qualitative study that assessed how systematic mapping and observations (DCM) provided a basis for reflection in practice and could be used to develop cultures in nursing homes in a more relational direction (Jøranson & Hauge 2011). The group that conducted the most mapping, observation, and reflection had the greatest learning outcome, and they changed their model of care towards relation-oriented care. In the other group, the content was communicated by the unit leader and did not impact the care culture in the same way. The staff retained their previous culture and understanding. The study shows that inclusion of the entire working group is essential for changes to occur (Jøranson & Hauge 2011).

To build cultures where nurses can share values and learn in team and e.g. be able to discuss how to facilitate interactions in caring situations, arenas for reflection are necessary. Even in the units where the staff was primarily positive regarding MMC, they experienced a lack of “arenas” for reflection regarding the topics from the counselling. The nurses were informed about the intervention and how it developed at staff meetings, but there was little opportunity to reflect and discuss the process openly and emphasise how it could contribute to better care. The dissatisfaction in some of the nurses suggests that they realised the need for converting their new insights and skills into common knowledge in the entire unit in order to ensure consistent good interactions between the residents and the staff. Nurses depend on their nursing leaders to develop organisational structures that allow this type of cooperation, e.g., by planning and supporting regular reflection sessions in which the entire staff can participate (Gjerberg & Amble 2009). Gjerberg & Amble (2011) argued that systematic reflections in peer groups are central to the development of learning in practices in long-term care. This may lead to increased awareness and coping for persons who work in emotionally oriented service work (Gjerberg & Amble 2009, 2011). The findings from Study III show that reflection in groups beyond the MMC sessions is necessary.

Clear leadership

The nurses in Study III asked for clear organisational conditions for MMC. The attendance in the MMC varied in the groups, and the outcome also varied, depending on how many members of the staff participated in the MMC sessions. The potential for frustration occurred when there were no clear rules regarding which nurses should participate in counselling and who had to be in the unit taking care of the residents while the MMC sessions took place. The nurses in Study III emphasised that knowing that the residents were well cared for when counselling occurred was important in order to be fully present at the counselling. Therefore, how MMC is organised will affect the staff's motivation to participate.

In a nursing home in Denmark, the staff experienced conflicts between the residents and the staff that were both undignified and inconsistent with good dementia care. The management for the institution decided to introduce MMC in all units in the nursing home (Horsted et al. 2007, Gudex et al. 2008). They reported that after participating in MMC, the staff was better able to understand the residents' needs, the violent episodes decreased, and the staff experienced increased work satisfaction. Horsted et al. (2007) and Gudex et al. (2008) underscored that leadership must be a driving force. They must understand what MMC entails and the resources that are needed in the institution to succeed. In a study that investigated the role of leadership in nursing homes that implemented DCM, Rokstad et al. (2013b) found that the role of the leader in terms of including all staff and formulating visions is a core factor for the intervention to succeed. This finding is also emphasised by Røsvik (2012) and consistent with our findings in Study III.

When practicing MMC, it is important to create an understanding of why the counselling should take place in a specific unit and how it is related to the central values of the unit. This information must emerge through joint efforts and reflection in the whole organisation (Klev & Levin 2009). The leader must facilitate an environment on the unit and in the nursing home in which the development and dissemination of knowledge occurs every day. In such units, an intervention such as MMC can succeed.

5.2.4 How can training in interactions in dementia care best be accomplished?

We found in our studies that training in interaction and communications skills can increase positive interactions in dementia care settings. As outlined in 2.2.2, research has shown that the training and education of the caregivers of persons with dementia improve the quality of life of the residents and the staff. Nevertheless, there have been discussions regarding which approaches are preferable to promote the integration of knowledge and skill in nursing practice. The following section will outline how MMC can answer the challenges that are raised in reviews.

Levy-Storms (2008) review based on studies related to therapeutic communication training for nurse aides, show that training should emphasise simple, concrete, verbal, and non-verbal communication behaviours, focus on the psychosocial aspects of long-term care, and present strategies in “real-life” examples. In another review, Eggenberger et al. (2013) identified interventions aimed at promoting communication with persons with dementia. They found, in agreement with Nolan et al. (2009), that there was a strong need for creating organisational conditions to promote interactions and that communication training by itself was insufficient without follow-up sessions (Vasse et al.2010, Eggenberger et al. 2013). Furthermore, interventions must be embedded in practice to facilitate translation (Graham et al.2006, Levy-Storms 2008, Vasse et al.2010).

Based upon findings in this dissertation, an advantage of MMC is the possibility of receiving direct feedback on skills as they are practiced. To some extent, skills can be communicated through examples or role playing (Caris-Verhallen et.al. 2000). However, the use of actual video recordings in the counselling situation can connect the learning directly to the “real situations” that nurses encounter. Study II emphasised the usefulness that the nurses experienced by observing the interactions as they unfolded and discussed them in collegial groups.

The use of video in the counselling situation is the most striking difference between MMC and other counselling methods in dementia care nursing (Lunde & Munch 2012). The recorded sequences revealed that the situations the nurses were required to handle were very complex and demanding (Study I). It is extremely difficult or even impossible for the nurses to keep track of everything that occurs in such situations. Watching themselves or their colleague in the video sequences provided an opportunity to stop and reflect on what had actually happened, on what functioned well in the situation, and on what could have been improved. A video can provide the opportunity to study a skill in more detail than would be possible through a description of a situation in words or text without actually watching what was going on. What is difficult to name, the way of acting in a concrete situation, how to interpret signs and actions, and the use of tacit knowledge and body language (Polanyi, 1966/2009) can be observed and shared.

In counselling groups, there tends to be discussion regarding how to interpret a situation. By using video sequences, there is less room for interpretation, i.e., the staff sees what actually happened and can thus agree more quickly on an interpretation of the situation. This was also stated by the nurses in Study II, when they stated they “saw it”, which suggests that communicating after MMC is easier. However, it is important to be aware that watching the video also results in interpretation, and it is not a “truth”, but how it is perceived at the time.

Based on the discussion above, I will argue that MMC largely answers the challenges that were raised in the reviews by Levy-Storms (2008) and Vasse et al. (2010), i.e., that the training should be embedded in practice and that it provides opportunities for individual feedback. The review of

McGilton et al. (2009) emphasised communication interventions, which considers the complex interaction between the nurse, the resident, and the environment. MMC is one answer to this challenge through reflections upon micro-situations in real life in a nursing home. The reviews also suggest follow-up or refresher sessions, i.e., “boosters” (Vasse et al. 2010, Eggenberger et al. 2013). This was not embedded in our intervention (Studies I, II, III), and there are no studies on the long-term effects related to MMC in dementia care, except from the report that described how MMC was used on an ongoing basis for the entire institution for approximately three years (Horsted et al. 2007).

Based on the previous discussion, it may be concluded that MMC can be an important supplement to other training methods for promoting communication and interaction skills in staff focused on dementia care. However, more research is needed to explore the benefits of MMC compared with other training methods.

6. Conclusions and implications for further research

This dissertation suggests that MMC may positively influence the daily interactions between persons with dementia and staff in DSCUs. The nurses acquired new knowledge regarding the residents and new knowledge regarding themselves as they underwent training.

MMC may accomplish the following:

- assist nurses in developing increased sensitivity and skill in observing the signs and behaviours of the residents
- help the nurses to develop their interaction skills with persons with moderate and severe dementia
- may be able to change the nurses ability to interact in a more person centred way.

The nurses' experiences with MMC can be interpreted as the development of self-efficacy, which implies that the nurses became more confident in their role as nurses for persons with dementia.

However,

- MMC must be conducted in a supportive learning climate with adequate arenas to build a culture for disseminating knowledge and developing common understandings for reflection
- creating a supportive learning climate requires clear leadership.

Implications for further research

Because MMC is commonly used in dementia care and because this study is one of the first studies on its utility, it is vital to conduct additional research in this field. This study represents one small step, and demonstrates that the focus on micro-situations in interactions can provide valuable information on the challenges of the interactions and on the possibilities of success. It is important to conduct additional research on the micro-situations in interactions between persons with dementia and staff to be able to identify how the interactions from staff can support the development of relationships with residents with moderate and severe dementia. It is also necessary to more closely examine if MMC can promote self-efficacy in nurses working in dementia care.

Further studies should include larger samples and should use controlled designs that include suitable outcome measures to more extensively evaluate the possible effects of MMC in dementia care.

Knowledge of how new knowledge and insight become common knowledge in a nursing home organisation is important for implementing future interventions and training programs such as MMC.

This study examined one method of conducting MMC in a nursing home unit. This study did not have the necessary data to explore what would be the "ideal" number of MMC sessions required to ensure

positive changes in the interactions with the residents; it also did not examine the long-term effects of MMC on the interactions between the staff and residents. We did not collect data on the residents' experiences of the care provided before and after the intervention or the quality of life, thriving, pleasure or functioning. Nevertheless, this study will hopefully serve as a foundation for further studies that will contribute to a solid knowledge base to further develop MMC in dementia care.

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