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Conversations between persons with dementia disease living in nursing homes and nurses – qualitative evaluation of an intervention with the validation method

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Abstract

Living with dementia disease (DD) can include difficulties describing experiences of everyday lives, which can lead to withdrawal, social isolation or existential homelessness. Persons with DD living in nursing homes are mainly dependent on the nurses for establishing and maintaining relationships with those around them. It can be challenging for nurses to understand what a person with DD is trying to express and to make themselves understood in turn. The validation method is intended to facilitate communication with persons with DD, but to our knowledge, there have been no qualitative studies of how this influences persons' communication. This study aimed to illuminate the actions and reactions of persons with DD living in nursing homes in one-to-one conversations with nurses during 1 year of validation method

training, as observed in videotapes. Four persons with DD were involved in videotaped conversations with four nurses who were participating in a validation method training programme. Videotapes with at least 5 months between the first and last recording were analysed and compared qualitatively. The findings are presented in four categories that were identified to various degrees in conversations at the beginning and at the end of the programme: being uninterested in or unable to answer questions, talking about more than one topic of conversation at the same time, trying to talk about what is on one's mind and speaking more freely about what is on one's mind. In the videotaped conversations at the end of the programme, the persons had the opportunity to use their remaining communication abilities. This may have been related to the development of the nurses' communication skills during the training programme, and so it is possible that persons with DD could benefit from communicating with nurses trained in the validation method.

Introduction

The number of persons with dementia disease (DD) in the western world is expected to increase as the population grows older and live longer. In Sweden, more than 150 000 persons have some form of DD 1. Living with DD may lead to difficulties describing experiences of everyday lives, due to the communication difficulties that DD entails 1. This can cause feelings of frustration, sadness and anger, manifested in different ways, and may also lead to withdrawal, social isolation or existential homelessness 3, 4. When the DD progresses, it can be necessary to move to a nursing home. Persons with DD living in nursing homes are mainly dependent on the nurses for establishing and maintaining relationships with those around them 5-7. However, studies have shown that nurses communicate less with persons with DD who have communication difficulties than with those who do not 8, 9. Ward et al. 10 reported that persons with DD spent little time in direct communication with others, and silence was the dominant mode of caring encounter. Living in a nursing home has been described as being associated with a boring life and few opportunities to talk about significant life events, despite a need for this 11. The persons' needs for social and intellectual stimulation are not being met 12.

It can be challenging for nurses to understand what a person with DD is trying to express verbally and nonverbally and to make themselves understood in turn 13. This has been described as a perceived mutual meaning-making process, a social construct, which can be difficult for persons with DD. Fragmented and disoriented verbal expressions as well as behaviour have been described as constituting communication with meaning and relevance 14. Thus, communication incorporates both verbal and nonverbal expressions 15. Nurses' skills in supporting persons' with DD remaining abilities to communicate and in listening attentively become significant. Attentive listening comprises silencing one's own thoughts and focusing solely on the other person, with an open attitude and

sensitivity towards their expressions 16, 17. Tuning in to other persons' affective states and relying on one's own feelings of what may make sense in a situation can be one way to understand what persons' with DD tries to communicate 4, 18.

The validation method (VM) is a method aimed at facilitating communication with persons with DD. The VM presupposes that all people are unique, regardless of whether they have DD and may be disoriented 19. The VM includes accepting people's experiences of reality and being responsive to their verbally and/or nonverbally expressed actions and reactions. Empathetic and confirming approaches are used together with specific VM techniques for communication, with the aim of increasing feelings of self-worth and well-being among persons with DD 19. The VM does not include distracting persons' attention, lying or pretending to understand 20. Instead, the importance of trying to understand the meaning behind communication is stressed. It may not be the facts about what is expressed that are important, but rather the feelings behind that persons with DD want to talk about. The VM is suggested to be used in one-to-one conversations and group conversations. According to Feil 19, the VM is intended for disoriented persons with DD around the age of 80 and without a medical history of psychiatric illness or alcohol abuse.

Previous research into the VM has mainly used quantitative methods to study its impact on the behaviour, mood, depression and cognitive status of persons with DD, when used in group conversations. A Cochrane review reports that there is insufficient scientific evidence for the effects of the VM 21, and further evaluations of the VM conducted after this review have not revealed statistically significant results in favour of the VM 22, 23. However, there have been only a few evaluations of the VM in one-to-one communication. The results from a study of emotion-oriented care that included the VM showed positive effects for persons with mild-to-moderate DD in terms of maintaining emotional balance and preserving a positive self-image 24.

In previous studies within the present project, a qualitative design was used to study nurses' experiences of the VM. In these studies, nurses described improved skills in communicating with persons with DD living in nursing homes 25, which were also observed in videotapes 26. Thus, it seemed important to study how this influences these persons' communications in one-to-one conversations with nurses who were trained in the VM.

Aim

The aim was to illuminate the actions and reactions of persons with DD living in nursing homes in one-to-one conversations with nurses during 1 year of VM training, as observed in videotapes.

Method

The study has a naturalistic design. A qualitative descriptive method was chosen in order to describe the persons' communication in conversations with nurses during VM training. The participating nurses are all referred to as ‘nurses', regardless of whether they were licensed practical nurses or nurses' aides.

Study background

This study was part of an intervention project that included implementation of a 1-year VM training programme, hereafter referred to as ‘the programme', in three nursing home wards in a large Swedish city. Each of the three nursing home wards housed 24–27 residents, divided into groups of 8–9 persons with DD. The nursing care was provided by care teams, with each nurse having care responsibility for 1–2 persons with DD.

The programme included theoretical training with supervision and practical VM training integrated in the nurses' daily work [25], [26]. Twelve nurses participated and completed the whole programme. The nurses' practical VM training involved three persons with DD per nurse for conversations about 2–3 times a week. The persons involved (23 women, six men) were well known to the nurses, at different stages of DD, and with no medical history of psychiatric illness or alcohol abuse.

No specific instructions were given to the nurses regarding what the conversations should be about. During the programme, a conversation with one person with DD per nurse was videotaped once a month. The authors had no influence on the running of the programme, the persons involved or the nurses participating in the programme.

Participants

It was considered to be important to analyse the same person with DD and nurses in conversations according to the aim of the study. Of all participants, there were only four persons with DD and four nurses that had videotaped conversations with each other throughout the whole programme. Thereby, these four couples of participants were included in the present study.

Persons with DD

The four persons with DD were female and had a median age of 86.5 years (range 77–94). One person had severe visual impairment and two had some hearing problems. Their cognitive impairment as assessed with the Minimum Data Set Cognitive Performance Scale (CPS) [27], [28] was moderate (CPS 3) to very severe (CPS 6), indicating memory problems as well as difficulties finishing sentences, expressing concrete requests regarding basic needs, making themselves understood by others (e.g. due to difficulty

finding words) and making daily decisions. A very severe cognitive stage (CPS 6) also includes total dependence on nurses' assistance for eating.

Nurses

The four nurses were female and their median age was 50.5 years (range 33–60). Two were licensed practical nurses and two were nurses' aides. They had a median of 11.5 years (range 1–18) of care experience, all in this study setting. One of these four nurses had been trained in dementia care through a short course. All four nurses completed the entire VM programme.

Data material

The data consisted of videotaped one-to-one conversations between the persons with DD and the nurses, recorded for reflection and supervision during the programme. The videotapes have previously been analysed with a focus on any changes in nurses' skills in communicating with persons with DD when using the VM [26]. This study included eight videotaped conversations, four from the beginning and four from the end of the programme, with at least 5 months (range 5–8) between the first and the last video recording.

Data analysis

The structure of the qualitative analysis was based on analysis of visual data as described by Collier and Collier [29]. The basic model includes observing the data as a whole, performing a structured analysis and returning to the data as a whole. We also made partial use of other methods that have been used in similar types of analysis [6], [26], [30].

The analysis started with viewing all the videotapes several times, to get an idea of the content guided by the study aim. During this stage, brief descriptions of the first impressions of what happened during the conversations were written down. The conversations were then transcribed to text together with notes about nonverbal communication such as eye contact, touch, head nods, gestures, body posture and orientation.

Next, a structured analysis was performed. The videotaped conversations were analysed in chronological order for each person with DD. The conversations were divided into sequences that began when either the person or nurse initiated a topic of conversation. The initiative was seen as an action that accordingly was reacted upon by either the person or the nurse. A sequence ended when the next topic began. See Table [1], for a short example of a sequence.

Table 1. Example of a sequence

Actual statements		Person's actions and reactions	Nurse's actions and reactions
Start of a sequence	The person with DD initiates a topic of conversation		
Person with DD	There is someone sitting down there now	The person is looking out the window and starts talking about what she sees	
Nurse	*Yes, someone sunbathing*		The nurse is also looking out, and responds
Person with DD	(laughs)	The person laughs	
Nurse	*It's hot*		The nurse talks about the warm weather (mentioned earlier in the conversation)
Person with DD	Yes		
Nurse	*Yes*		
End of a sequence		The person starts talking about something else	

The videotapes and the transcriptions of the videotapes were kept together during the analysis [6], [26], [30] and coded with a focus on the persons' actions and reactions. The codes were compared and grouped according to their similarities and differences in terms of the persons' actions and reactions in the conversations. The analysis was performed by moving back and forth both within all data for each person and between all data for the four persons. The grouped codes were sorted into four categories describing the persons' actions and reactions in the conversations.

After the sequences had been sorted into the four categories, the videotapes and the transcriptions of the conversations were reviewed again in order to identify any contradictions regarding the categories [29]. The first and second author performed co-assessment during all analytic steps. The videotapes, the transcriptions and the analysis were continuously discussed among all the authors.

Clarifying concepts

The concept of communication incorporates both verbal and nonverbal expressions [15].

Although the analysed situations in this study included both verbal and nonverbal expressions, the concept of 'one-to-one conversations' was chosen as it was in this way the VM was used in the programme [19]. Likewise, it would have been possible to use the concept of interaction if the focus of the study had been on both persons with DD and nurses. However, the focus was on persons with DD, and therefore, we used actions for situations when persons with DD took initiative in some way and reaction for response of any kind from persons with DD during the conversations.

Ethical considerations

It is important to consider the risk of violating the integrity of those who are being videotaped, which in this study was both persons with DD and nurses. Extra attention is needed when participants can forget that they have given informed consent to participate [31]. In this study, the nurses were asked to get permission from the persons with DD every time they had conversations as part of their VM training. They were also instructed to stop videotaping if the persons with DD showed any signs of being uncomfortable; no such incidents occurred. The persons' next of kin and the nurses had received oral and written information about the study and had the opportunity to raise questions about the research before signing an informed consent form. All involved were informed of their right to discontinue participation before the analysis without giving any reason and without any influence on the persons' care, and they were guaranteed confidentiality. The videotapes were not shown to anyone other than the participating nurses and the research team and were kept in a locked filing cabinet. The study was approved by the Regional Ethical Review Board.

Findings

The four categories describing the actions and reactions of persons with DD living in nursing homes in one-to-one conversations with nurses were as follows: being uninterested in or unable to answer questions, talking about more than one topic of conversation at the same time, trying to talk about what is on one's mind and speaking more freely about what is on one's mind.

The videotaped conversations from the start of the programme lasted between three and 15 minutes, and those from the end of the programme between five and 24 minutes.

Being uninterested in or unable to answer questions

There were situations when the persons with DD took little or no initiative, and consequently, the nurses took initiative and started asking questions. This resulted in conversations that were made up of questions that the persons tried to answer, with the persons themselves having little opportunity to choose what to talk about. The persons

seemed to give reasonable answers to questions about what they had done during the day, for example whether they had slept well, or what they thought of the food. When the nurses asked questions about the past, such as about the persons' previous workplaces, people's names, or where a person lived, it seemed at times as if the persons were uninterested or unable to respond. The persons gave brief answers consisting of a few words such as ‘well, maybe' or ‘I don't know', or repeated the last few words of what the nurses had said. It sometimes appeared as if the nurses already knew the answers and were asking these questions to help the persons remember or to check what they remembered. Table 2 shows an example of such a situation, in which the person was asked about her husband's name during a conversation about her marriage.

Table 2. Excerpt from a conversation in which a person with DD was questioned to see if she remembered something

Actual statements		How this could be understood
Nurse	*Whose name was…?*	The nurse asks for the name of the person's husband
Person with DD	Well, what was his name now, actually, I don't remember	The person has trouble remembering
Nurse	*Sure you do, it starts with N*	The nurse gives a clue by stating the initial of the husband's first name
Person with DD	Nils	The person can now give the husband's name
Nurse	*Yes*	The nurse sounds cheerful
Person with DD	Yes. (laughs a little)	The person gives a laugh, which could be of recognition or embarrassment

On those occasions when the nurses seemed to ask questions to help the persons with DD remember or to check what they remembered, it was difficult to work out whether the persons actually appreciated this or whether they were embarrassed by it. When the persons were not addressed as ‘adult' people by the nurses, they at times reacted with silence or started talking about something else. For example, a person replied briefly and almost evasively when a nurse asked questions about an imaginary situation involving a teddy bear, such as finding out the name of the teddy bear. When the nurse stopped treating the person as a ‘nonadult and instead asked how the person felt at the moment, she got a clear answer. The person told the nurse about the situation with her previously

injured arm, pointed out where she sometimes felt pain and then talked about happy times she remembered having had with her brother. The person seemed to take the opportunity to talk about something of her own choice, but the nurse redirected the conversation to the imaginary situation and the person became silent.

In conversations both at the beginning and at the end of the programme, there were situations when the persons with DD took little or no initiative. However, at the end of the programme, there was more space for the persons to talk, as there were pauses in the conversation where the nurses waited for their response.

Talking about more than one topic of conversation at the same time

There were situations where the persons with DD took initiative in the conversations and initiated topics. In these situations, it appeared as if the persons sometimes talked about different things simultaneously, for example mixing up people and situations that had nothing to do with each other. When this happened, the nurses answered by questioning the reasonability of the persons' statement. There were also situations when both persons and nurses continued to speak on a topic of conversation even after the other person had changed topic. In some conversations, the persons and nurses spoke about different things, that is not *to* one another but *past* one another. These conversations became confusing; an excerpt of such a conversation is given in Table 3.

Table 3. Excerpt from a conversation in which more than one topic of conversation was discussed at the same time

Actual statements		How this could be understood
Person with DD	There comes a car that looks like the grey one that Sten usually has	The person looks out the window and changes the topic of conversation to her son
Nurse	*Who are you talking about? Is it your son?*	The nurse asks who she is talking about and if it is her son (whose name is known to the nurse)
Person with DD	Yes	The person answers in the affirmative, but somewhat hesitantly
Nurse	*Ah, he usually…*	The nurse seems to think it is the son, since the person responds positively to the previous question. The nurse then seems to try to pick up the topic of conversation initiated by the person

Person with DD	Yes, uh, I'm talking about Anderson, the one who lives in City S	Here, the person seems to continue to answer the nurse's question and to explain who she is talking about
Nurse	*City S*	The nurse repeats where the person lives
Person with DD	Yes	The person responds
Nurse	*Does he live in City S, your son?*	The nurse appears not to have listened to who the person said she was talking about
Person with DD	Yes, if, if he...	The person tries to say something
Nurse	*What's his name?*	The nurse interrupts and asks for the name
Person with DD	His name is Anderson	The person answers
Nurse	*Okay*	The nurse accepts the answer
Person with DD	But Sten, he lives out here in City V	When the person continues without being interrupted, she says where her son lives

(Names and places have been changed.)

As shown in Table 3, the conversation got out of step because the person's communication was confused and the nurse did not adapt to what the person said.

At the beginning of the programme, the persons' conversations where confusing while the nurses seemed to be occupied with judging the factual reality in the persons' statements by asking clarifying questions. At the end of the programme, this type of confused conversation became less common.

Trying to talk about what is on one's mind

There were conversations where the persons with DD appeared to be talking about things that were on their mind. These conversations could be about feelings of shortcomings or disappointments in their earlier life. In these situations, the persons

could be interrupted by the nurses, who seemingly wanted to cheer them up instead by talking about, for example, how nice the weather was. When the persons occasionally went on talking about what was on their mind, misunderstandings and confusion could occur, as the nurses continued to talk about something else. However, there were also situations when the persons appeared to be comforted by the nurses' redirection of the conversation, and smiled and laughed along with them.

Table 4 gives an excerpt from a conversation where the person with DD was interrupted when she was talking about what was on her mind and the nurse reacted by steering the conversation towards the actual reason for the person's children not coming to visit.

Table 4. Excerpt from a conversation in which a person with DD was interrupted when trying to talk about what was on her mind

Actual statements		How this could be understood
Nurse	*Your children come and see you*	The nurse starts talking about when the person's children come to visit
Person with DD	Yes but they come a little often, uh, not so often	The person's answer could be understood as meaning that she wants them to come more often
Nurse	*Yes*	The nurse appears to listen
Person with DD	I think... They think I am, uh	The person continues talking. It appears as if she wants to say something about why she thinks her children seldom come to visit
Nurse	*Not so often*	The nurse repeats what the person said in her previous utterance and appears not to have noticed what the person just tried to say
Person with DD	No	The person's answer is brief
Nurse	*They work too*	The nurse continues talking about the children and their lives
Person with DD	Yes	Again, the person's response is brief
Nurse	*They work too, they don't have time maybe*	The nurse has interpreted the situation from her own point of view and taken over the conversation

Person with DD	Yes	The person continues just saying yes or no
Nurse	*Yes, they come on weekends and so on*	The nurse continues to talk about the children and has lost the chance to find out what the person had on her mind

In this conversation, it appeared as if the person with DD had something on her mind that she wanted to talk about, but was interrupted as the nurse was not listening as open-mindedly as she should have been. Interruptions by the nurses also occurred in conversations when the persons spoke about past events in their lives, for example their parents' divorce and new relationships. Initially, it seemed as if the persons were being listened to when the nurses repeated and rephrased what they were told. However, when the persons continued talking about these issues, the nurses seemed to want to talk about something else, and then, the persons fell silent.

This kind of conversation occurred both at the beginning and at the end of the programme. However, at the end of the programme, when the persons returned to talking about what was on their mind, they were able to continue talking as long as they seemed to need to, and the nurses listened attentively.

Speaking more freely about what is on one's mind

When the persons with DD were not interrupted or otherwise distracted during the conversation, they seemed to speak more freely about what was on their mind. They seemed to be encouraged and continued talking when nurses listened attentively, repeated, rephrased and asked questions related to the topic. It was sometimes difficult to understand what the persons were talking about due to incoherence in the conversation and/or their problems with finding words. Table 5 gives an excerpt from such a conversation.

Table 5. Excerpt from a conversation in which a person with DD was speaking freely about what was on her mind at the time

Actual statements		How this could be understood
Person with DD	... So you get to see somehow what it is that you're supposed to take care of... and take care of everything (sounds upset; alternates between looking at the nurse and looking straight ahead)	The person has started to talk about something that appears to upset her

Nurse	*I'm sure you've done that in your time*	The nurse rephrases
Person with DD	Yes, I think we have done that	The person appears to accept what the nurse said
Nurse	*Yes*	
Person with DD	But it's probably... that it gets worse and worse so then should the closest you... here on the porch too it should stand so that then maybe it stands or something doesn't fit at all	The person continues to talk about what is on her mind
Nurse	*It doesn't fit*	The nurse repeats
Person with DD	No	
Nurse	*No*	
Person with DD	It doesn't	The person accepts what the nurse says
Nurse	*Where did you think it would fit?*	The nurse asks an open question reflecting the wording used by the person
Person with DD	No, I don't think it's an obstacle to that either, but it has become like that now, it is like that with everything	The person continues talking but appears not to be upset any more

The person with DD spoke freely, and the nurse seemingly was not able to make sense of the conversation. If the persons were allowed to continue in this manner, they became more talkative and wordy, which seemed to make it easier for the nurses to understand what the persons were talking about.

In this type of conversation, when the persons with DD were given space and were not interrupted, sensitive topics could arise, for example feelings of shortcomings in earlier life and loss of deceased relatives. The persons might look troubled, and their voices varied from loud to whispering. To emphasise their words, they used gestures like a clenched fist or banging a hand against their chest. At times, it seemed like the persons were struggling to express themselves.

During these conversations, several topic shifts occurred as initiated by the person with DD. The persons spoke about one topic for a while and then shifted to something else before going back to the previous topic. It appeared that some recurring topics concerned events or situations in their lives that seemed to be more important to them than others. Other topics seemingly could easily be shared with the nurses, such as specific things in the room or the view from the window. These moments seemed restful for both persons with DD and nurses. In contrast to talking about strenuous topics, both persons and nurses appeared to be relaxed during these sequences, sometimes smiling and laughing together.

In conversations at the end of the programme, some persons' condition was impaired due to deterioration of their DD. It was possible to communicate despite this, but it could take time before the persons gave any responses, and the nurses had to carefully observe any signs of interest in talking. There were pauses that lasted about 30 seconds, while the nurses waited patiently, sitting close by and touching the persons. Knowing the persons' interests could sometimes facilitate establishing contact, such as talking about birds singing outside or knowing a favourite song, as shown here:

Do you have enough energy to sing a song? ... how about if we try ... 'Härlig är jorden' (a hymn).

Yes, that one is beautiful, we should sing (inaudible) (closes her eyes).

Should we sing that?

Yes, let's do that.

The nurse started singing the song, and the person joined in and hummed the tune. After the first verse, the person continued humming when the nurse stopped singing. There was a moment of silence, and then, the person started humming again and the nurse joined in. This was repeated a few times, and it appeared to be a very close relationship as they sat close together with physical contact during the whole conversation.

At the beginning of the programme, there were few moments when the persons' acted as they were listened to. At the end of the programme, these situations could comprise the greater part of a conversation. Although the conversations seemed to be tiring for the persons, they also seemed to appreciate the opportunity to converse. This was obvious towards the end of the conversations when the nurses thanked them for the time spent together. At this moment, some persons became talkative, and the conversations went on a bit longer.

Discussion

The aim of the present study was to illuminate the actions and reactions of persons with

DD living in nursing homes in one-to-one conversations with nurses during 1 year of VM training. To our knowledge, this is the first qualitative evaluation of the VM in one-to-one conversations with focus on persons' communication.

Conversations when the persons with DD showed few actions and mostly reacted to the actions of the nurses, as described in the category ‘being uninterested in or unable to answer questions', may have had several causes. The conversational situation might have been one unfamiliar not only to the persons with DD but also to the nurses, whose everyday experience was more task-oriented. Other studies have shown how persons with DD in similar situations have few opportunities for communication, and their emotional needs as well as their needs for social and intellectual stimulation have been ignored, as nurses primarily concentrate on the persons' physical needs [10], [12], [32]. The persons' communication capabilities might have been questioned by the nurses, for example by not addressing them as adults, or asking them whether what they said was true. This can be interpreted as the persons' communication being devalued by the nurses [33] and might make persons with DD feel a lack of respect and dignity [34].

The examples in the category ‘talking about more than one topic of conversation at the same time' show how the nurses sometimes had difficulty understanding what the persons with DD were talking about. In these situations, the nurses tried to divert the persons' attention, which is not in line with the VM. The result of this was that the persons were distracted, and the conversations became more confusing. The persons became distracted when they were interrupted, while if they were given time to continue talking, it sometimes became more clear what they were talking about. Altering the topic of conversation can be difficult for persons with DD, since the situation could become stressful and more chaotic [6], [35]. In addition, when the persons spoke about shortcomings or disappointments in life, it seemed as if the nurses were uncertain how to respond, and interrupted the persons who then fell silent. According to Källerwald [36], insufficient existential support can lead to feelings of being objectified and can be experienced as a disparagement. It was sometimes difficult for the nurses to meet the persons' existential concerns, and it is possible that they did not expect the persons to be able to communicate at a deeper level [25], [37]. An important part of the VM is being open-minded to the persons' verbal and nonverbal expressions of their experienced reality. However, this does not mean lying or pretending to understand [20]. This could be a balancing act for the nurses; neither pretending to understand nor interrupting with questions when they do not understand what the persons with DD are saying.

In conversations as described in the category ‘trying to talk about what is on one's mind', the persons with DD initiated topics and talked more during the conversations. This could be interpreted as meaning that the persons felt confirmed when the nurses acted in accordance with the VM, listening attentively and open-mindedly to the persons'

expressed reality and closely following what was said. There were also situations that could be interpreted as a deep mutual relationship, together with being physically close, having eye contact and touching each other as described in the category ‘speaking more freely about what is on one's mind'. This could be likened to what has been described as communion [14] and is also similar to situations where nurses achieve understanding of persons' communication by tuning in to their affective state [18]. In these situations, there was space for persons to express themselves as well as they could and to be listened to. In nursing care, cooperation and communion have been described as valuable forms of confirmation [6]. Persons with severe DD are also in need of confirmation and conversations [38]. Cahill et al. [39] reported that persons with severe DD described a sense of abandonment and a seeking for human relationships. In the present study, the persons with DD whose communication abilities decreased was supported by being in a close relationship with the nurse who knew her favourite song, which might have helped her feel that she was in a familiar situation and at home [4]. In the videotaped conversations from the end of the programme, the persons showed signs of being confirmed in their sense of self and sense of worth, in line with previous research findings [2], [6]. This was related to the nurses' skills in having a refined attuned communication and internalisation of the VM in their approach [26].

The present study included eight videotaped conversations; the results are in line with nurses' experience of the VM as described in interviews [25]. When persons with DD can make use of their remaining abilities to communicate and nurses similarly support them, this seems to increase the persons' well-being as well as their being at ease in the conversation situation. If nurses participate in VM training programmes and integrate this knowledge, they may become more aware of the persons' remaining abilities to communicate. Similar results have also been reported from studies of intervention programmes other than the VM [6], [18]. To communicate in such situations, mutuality is necessary for a caring relationship [6].

To create caring relationships, it is important that nurses are skilled in communicating with persons with DD on the persons' own terms [40]. Communication can be described as a cyclic process, with both persons and nurses affecting each other's communication by how they act and react [15]. Initially, the persons largely reacted to the nurses' actions in the conversations. Following the programme, the persons were given opportunities to take the initiative in the conversations; this is one example of change during the programme. The reciprocity brought about by the closer caring relationships seemed to contribute to a sense of well-being for the persons and an increased meaningfulness in the work for the nurses [25], [26]. Similar results have been described by Ericsson et al. [41].

The present study shows that when persons with DD living in nursing homes have conversations as a planned care activity, it could contribute to their well-being despite

progression of the DD. Therefore, this type of caring activities should be regularly done and documented in the persons' care plans. That means that nurses need to be trained in communication skills with a training programme such as the VM. Also, other programmes have shown that training with different intervention components can develop nurses' communication skills, see for example, McGilton et al. 42 and Vasse et al. 43. In addition, it would be important with regular supervision in communication skills for nurses 44.

Study limitations

The use of videotapes provides favourable opportunities for studying what happens in a conversational situation, even though it must be considered impossible to catch and describe everything that happens. As the videotapes did not include the initiation of the conversations, we do not know how the conversation situation was presented to the persons with DD. At the start of a recording, it sometimes happened that the persons asked if the camera was recording. However, during the conversations, the persons did not appear to show any signs of discomfort at being recorded. It has previously been reported that participants get used to the presence of a video camera and act in the same way as they usually do 7, 30. Also, in the present study, it was the nurses who conducted the video recording, so the persons with DD were not confronted with an unknown person during the conversation situation.

In the present study, two conversations for each participating couples were analysed, and it is possible that other actions and reactions occurred in videotapes not analysed. Some parts of the conversations were not fully comprehensible. This article describes a single possible way in which the conversations could be understood, and other understandings are also possible. The intention was to be as open-minded as possible to what the videotapes and transcriptions were about, although it should be noted that previous studies conducted within the larger project may have affected the authors' pre-understanding 25, 26.

Conclusion

In the videotaped conversations from the end of the VM training programme, the persons with DD had the opportunity to use their remaining communication abilities and showed signs of being confirmed. It is possible that at the end of the programme, the nurses had developed their communication skills, which gave the persons opportunities to communicate what was on their mind at the time. It is therefore also possible that persons with DD may benefit from a VM training programme, as one example of a training programme targeting the communication skills of nursing home staff. Further studies are needed of persons' communication with nurses that take place during everyday care.

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Author contributions

MS, AN and GH performed the study design. MS and GH collected the data. MS, AN, BMT and GH analysed the data. MS, AN, BMT, AC and GH prepared the manuscript.

Ethical approval

The study was approved by the Regional Ethical Review Board in Stockholm No. 04-704/5.

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