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Training needs on behavioural and psychological symptoms of dementia for professional caregivers in residential homes: a qualitative study

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Abstract. The behavioural and psychological symptoms of dementia are very predominant in the disease, aggravating the suffering of people with dementia and increasing the physical and emotional burden professional caregivers are exposed to. Despite being so present in nursing homes, professional caregivers do not always have adequate training or the tools needed to deal with these situations. Objectives: to determine what knowledge professional caregivers in residential centres have about behavioural and psychological symptoms of dementia; to evaluate how behavioural and psychological symptoms associated with dementia are managed by professional caregivers in residential centres; and to know the training needs perceived by professional caregivers in behavioural and psychological symptoms of dementia. Professionals (in the fields of psychology, nursing coordination and geriatric assistance) from residential centres for the elderly were interviewed and a qualitative analysis of the interviews was carried out. The results show that most professionals do not know the behavioural and psychological symptoms of dementia or how to cope with them and have low levels of knowledge. This study highlights the need to design and provide ongoing training in the residential setting on the management of these symptoms.

Keywords. Dementia. Training needs. Nursing homes. Professional caregivers.

1. Introduction

Dementia is a major public health problem as it is considered to be the first cause of loss of autonomy in older people (Aranda & Calabria, 2019). In Spain, this pathology already affects 5.8% of persons over 65 years of age and 9.4% of persons over 70 years of age. Furthermore, the figures for this disorder are increasing exponentially and this will represent a great challenge for health and economic systems worldwide in the coming years (Leiros et al., 2018).

Residential facilities for the elderly are increasingly dealing with more elderly with dementias (Abellán et al. 2018).

At the 1996 International Conference on Behavioural Disorders of Dementia, the term "Behavioural and Psychological Symptoms of Dementia" (BPSD) was coined to designate a heterogeneous set of psychological reactions, psychiatric symptoms and abnormal behaviours

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presented by people with dementia of any aetiology. The Update Consensus Conference (Finkel & Burns, 2000), defines them as the alteration of perception, thought content, mood, or behaviour that often occurs in patients with dementia (Abraha et al., 2017).

BPDS occur throughout the course of dementia are many and highly disruptive, which increases the suffering and stress experienced by the older person with dementia, and the physical and emotional burden on professional and non-professional caregivers (Jennings, et al., 2018). Moreover, they are a major cause of institutionalization of those people that suffer with dementia (Pérez & González, 2016).

BPDS affect approximately 61.9% of people living in nursing homes (Helvik et al., 2018) and increase the prescription of psychotropic drugs in this population (Pinazo-Hernandis et al., 2019). Environmental modification and a person-centred model of care have been shown to have positive effects on these symptoms (Jao et al., 2015) by avoiding the side effects caused by the continued use of commonly used palliative drugs such as antipsychotics or benzodiazepines (Agüera et al., 2017).

For this reason, more and more authors are stressing the need to implement non-pharmacological techniques such as training professional carers to improve the quality of care for older adults living in residential homes (Sarre et al., 2018).

With this study we aim to know the training needs on BPSD of professional caregivers. Therefore, this study has three objectives: 1. To determine what knowledge professional caregivers in residential centres have about behavioural and psychological symptoms of dementia; 2. To evaluate how behavioural and psychological symptoms of dementia are managed by professional caregivers in residential centres; and 3. To know the training needs perceived by professional caregivers in these symptoms.

2. Method

2.1. Participants

The study involved nine professionals from a nursing home. Their participation was voluntary, consensual and informed. They were divided into three different groups according to their professional category and work experience.

The inclusion criteria were: for group 1: To be part of the Technical Team of the centre (TE, from now on); and to have an average of at least 2 years of experience in nursing homes; for group 2: To be an expert geriatric assistant of the centre (EA, from now on) with more than three years of experience in the sector; for group 3: To be a new geriatric assistant of the centre (NE, from now on) with less than three years of experience in nursing homes.

The sample was set up of 8 women (93.33%) and 1 man (6.67%), with an average age for the first group of 32 years, 39 years in the second and 31 years in the third. Regarding the professionals: the first group included a psychologist, a social educator and a health supervisor. The second and third groups consisted of six geriatric assistants.

2.2. Instruments

Qualitative methodology was used to evaluate the project. A semi-structured interview was carried out with open questions to the participants that aimed to evaluate the degree of knowledge about the BPSD: definition; adequate management, habitual management and type of previous training received.

To carry out the interviews and evaluate the knowledge of the professionals about BPSD, we based ourselves on the classification of these symptoms made by Cummings et al. (1994) in the Neuropsychological Inventory (NPI) which considers the following twelve symptoms as BPSD: 1.Anxiety or a state of fear, distress; 2. Depression, feelings of unhappiness, despondency; 3. Apathy or loss of motivation or interest in previously enjoyable activities; 4.

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Euphoria or a sense of optimism and extreme outward joy; 5. Emotional liability detected by fluctuations or abrupt changes in the person's mood; 6. Hallucinations or altered perception of the person; 7. Delusions, false beliefs, or alterations of thought; 8. Aggressiveness, which may cause physical or moral harm to the person with the disease and to the professional or non-professional caregiver; 9. Sleep disorfer or sleep-wake cycle disorders; 10. Eating disorders due to excess or lack of intake; 11. Disinhibition or loss of modesty; and 12. Aberrant motor behaviour, which is the term used to describe behaviour that has no clear purpose (such as erratic wandering or constant chasing after the caregiver).

2.3. Procedure

The study has been carried out in nursing home that manages residence and day centre for older adults in the province of Valencia (Spain) belonging to the business group La Saleta Colisee S.L. The centre has a total of 140 places. The interviewees signed an informed consent and the interviews were recorded and transcribed.

2.4. Analyse

Each of the project participants was tagged with an alphanumeric code to ensure the anonymity of the data. The letters ENT indicate that they are data extracted from the semi-structured interviews and the next two letters indicate the professional group to which they belong. That is, technical team (TE), new geriatric assistants (NA) or expert geriatric assistants (EA). This letter is followed by the number from 1 to 3 that has been assigned to them. For example, a sentence taken from the interview with expert assistant 2 will be coded as [ENT, EA2].

A content analysis of the responses was conducted, highlighting the most noteworthy case descriptions, ideas, opinions or attitudes that were categorized by two independent expert judges, obtaining unanimity in the analysis.

3. Results

The following are the results, which have been organized into three sections according to the objectives set out in the research.

3.1. Concept of BPSD

Firstly, the participants were asked to give a definition of each of the BPSD. In the following table, it is shown whether the answers were correct or incorrect (Table 1).

Table 1. Definition of the BSPD. Summary of responses

BPSD	NA1	NA2	NA3	EA1	EA2	EA3	TE1	TE2	TE3	TOTAL
Apathy	C	C	I	C	C	C	C	C	C	8/9
Euphoria	C	I	I	C	C	I	C	I	C	5/9
Lability/Irritability	C	I	C	C	I	C	C	C	C	7/9
Hallucinations	I	I	I	I	I	I	I	I	C	1/9
Delusions	C	I	I	I	I	C	I	C	C	4/9
Disorentation	C	C	C	C	C	C	C	C	C	9/9
Physical agression	C	C	C	C	C	C	C	C	C	9/9
Verbal agression	C	C	C	C	I	C	C	C	C	8/9
Aberrant motor behaviour	I	I	I	I	I	I	I	I	C	1/9

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Disinhibition	C	I	I	I	I	I	C	C	C	4/9
Eating disorders	C	I	I	I	C	I	C	C	C	5/9
Sleeping disorders	I	I	C	C	I	I	C	C	C	5/9
TOTAL	9/12	4/12	5/12	7/12	5/12	6/12	8/12	9/12	12/12	--

C: Correct definition; I: Incorrect definition

The terms apathy and aggressiveness were the best defined by the interviewees. A number of geriatric assistants mistook euphoria, agitation and irritability for each other. In fact, one person confused agitation with tiredness. None of the six geriatric assistants interviewed knew the term emotional lability, and they defined irritability as something similar to agitation. Neither the NA group nor the EA group mentioned emotional disorders at any time; in fact, one of the TE persons commented that the assistants "do not understand that this can occur because of the disease" [ENT, TE2], which many interpret as suddenly "going crazy" [ENT, TE2]. One of the most striking things is that only one person out of the six geriatric assistants distinguished delusions from hallucinations, and only one of the six gave a correct definition of disinhibition. In some cases they called temporary disorientation a hallucination.

Sleeping disorder and eating disorder were correctly defined, although more importance was given to lack of sleep or appetite than to excess. Only one of the EA did not know what an eating disorder was. It is worth noting that one person in the NA group, when talking about eating disorders, comments that he sometimes thinks that "users do it to get attention" [ENT, NA3]. In other words, they believe that it is not a conduct disorder but an intentional behaviour. In the case of physical aggressiveness, one of the NA added that not only is there aggressiveness towards the professionals at the centre but also aggressiveness towards other users, which could trigger other disorders. This question was also asked to the professionals of the TE, and it should be noted that one of them was also unable to differentiate between hallucinations and delusions.

3.2. Management of BPSD

3.2.1. Apathy and euphoria. In the case of apathy and euphoria, all professionals find it difficult to remember any case they have seen at the centre. Therefore, they do not recognize them and claim not to have handled them.

3.2.2. Lability. In cases of irritability, the professionals say they speak to them affectionately, carefully, let them express themselves or leave them five minutes to relax, but in general they also do not know how to describe precise examples of this alteration. One respondent associated the irritability of a woman with "wanting to be the centre of attention" [ENT, EA2]. As discussed in the previous section, it is very common for caregivers to associate intentionality with behavioural disturbances.

3.2.3. Psychotic behavior. Responses to psychotic behaviour are very heterogeneous. The ways of intervention described are very different. A large majority of assistants discredit the person's delirium or hallucination, in many cases with the intention of calming the person experiencing the disturbance. However, it is important for them to know that this has a high probability of increasing the anxiety of the person emitting the psychotic behaviour. One of the correct strategies used by one of the NA is to make sense of what they are feeling or seeing, for example, to the premise "it's winter, I'm cold", the assistant answers: "You're cold because the air is on" [ENT, NA3]. They don't deny what they feel but they give it a meaning, which will relax the person. Some geriatric assistants admitted avoiding the issue or leaving the person without offering a solution. This can also cause more stress for the person suffering from the

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hallucination or delirium because no explanation is offered for the feelings. In addition, the person may feel ignored. One of the professionals in the EA group commented: "The hallucinations I have experienced are funny; they are not aggressive towards us or other users or anything else" [ENT, EA3]. NA1 also talks about taking certain psychotic disorders "for fun" [ENT, NA1].

Two members of the TE admit to not knowing the right way to act when faced with a psychotic disorder. In the case of the visual hallucinations, the handling they described was adequate. One TE person commented that if they see the person picking up things from the floor that do not exist, to avoid risk of falling they place the person with hallucinations in a different space and therefore perform control stimulation.

It is important to note that in several interviews some professionals have commented that the behaviours of people with dementia are discussed in the third person and in front of them. Some geriatric assistants claim to speak in front of the person suffering the psychotic episode, saying, for example: "He doesn't know what he's saying" or "Look, he's hallucinating" [ENT, NA1].

3.2.4. Disorientation. In the case of spatial disorientation, patients are accompanied to where they wish to go or are told where they are. None of the geriatric assitants know how to cite specific examples of temporary disorientation, since as we have already commented in section 1, they confuse this type of disorientation with a hallucination.

In the case of temporary disorientation, a person from the TE expresses doubts about the correct way to deal with it. Furthermore, for this same professional, temporary disorientation is one of the most prevalent behaviours in the residence. According to the professionals, spatial disorientation is well-conducted in most cases.

3.2.5. Physical and verbal aggressiveness. In the face of physical aggression, most assistants step aside, giving the person suffering from aggressiveness some time to relax, or ask one of their colleagues to finish the task. The answer of EA1 is interesting when talking about a concrete case of physical aggressiveness. This professional comments that if he enters the person's room speaking in a soft tone, even though the person has a serious cognitive impairment and is likely not to understand the message, he does perceive the paralinguistic of the sentence, which avoids this person of showing aggression. This assistant adds that "there are situations in which it is more worth losing five minutes like this because you gain time later if you know how to manage it".

Another EA professional also comments that if the geriatric assistants are nervous or the residents notice them irritated, their alterations are aggravated. This worker states that his strategy is to speak to them with good words, to bring their face closer to the person's so that there is eye contact and to approach them slowly so that they gain confidence.

The members of the TE group recognize that aggressive situations often occur at times when they are not present (personal hygiene or eating, for example). Regarding physical aggression, they add that guidelines have been given by the management of the centre on several occasions because there have already been problems in this regard. For this reason, in this case they do know the correct way to act.

3.2.6. Eating and sleeping disorders. In the face of the lack of intake by older people with cognitive impairment, many professionals reported feeling unwell. Most explained that they insist the person to eat, and if they don't, they tell the nurse. All of the geriatric assistants call the nurse to carry out a control of the intake or night habits and the doctor dictates the pertinent guidelines.

3.2.7. Disinhibition. Facing with public undressing behaviour, professionals said that the usual guideline is to dress them again as often as necessary. The EA1 professional says that some geriatric assistants normalize these behaviours, especially in the room where people with

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more cognitive impairment are, where they happen more frequently. EA2 worker describes the case of a woman whom he takes to her room every time she undresses to preserve her privacy. The NA3 professional explains that he understands the reasons that lead a woman who suffers from disinhibition to urinate in public areas. This worker explains that this woman lived in the countryside with her relatives and that she had the habit of urinating in the street.

3.2.8. Aberrant motor behavior. Erratic wandering is easily recognized and correctly redirected.

3.2.9. Tools for dealing with BPSD. All of the geriatric assistants stated that if a problem or doubt arises with these type of situations the first person they ask is the nurse. When they were asked if they would tell anything to the psychologist the answers were: "Never" and "I don't have time". Only one of the six geriatric assistants answered that they may ask her for extreme cases, such as physical aggression, and always leaving a record. "We write it down in the incident book and then (the technical team) assesses whether to give them any medication" [ENT, NA2].

3.3. Perceived training needs

Many assistants agreed that their previous training focused mostly on health aspects and very little on psychological aspects. One of the professionals in the NA group stated that it is very common to offer psychological support to the elderly but that in their training they did not receive training on how to give this type of support. This worker also stated that he lacks knowledge about problems related to Alzheimer's disease and that in his professional day-to-day life it would be useful.

Several geriatric assistants highlighted the need to unify criteria. They consider important that actions do not depend on the decision or way of acting of each assistant, but that there should be a stipulation of which guidelines are correct and which are not: "There are some things in which I think I am acting right but maybe I am acting wrong" [NCD, EA1].

The TE professionals, who due to their previous training have greater knowledge on this subject, propose a training programme given to all types of professionals that work in the centre, since in many cases continuous training would be necessary. In fact, one of the people of the TE group explains: "In nursing home we need a lot of training because maybe a psychologist or a social educator is very used to everything and can redirect, but sometimes we health workers are not so used to it. They ask me questions and I don't know the answer either".

4. Discussion/Conclusions

In this research we have analysed the knowledge that professional caregivers in nursing homes have about BPSD. Many of the professionals interviewed are not familiar with the concepts and warning signs of the BPSD. They do not understand that they are caused by the disease itself and even associate them with intentionality. It is very common for caregivers (whether professional or non-professional) to view some behaviours of older people with cognitive impairment as intentional, and that this influences the stress that such behaviour causes and how the caregivers manage it. It is important to work on coping strategies with caregivers as this will affect their emotional state, increasing their feelings of overload, stress or anxiety (Tartaglini et al., 2010).

Apathy is one of the most present behavioural disorders, affecting about 50% of people with dementia according to some authors (Pérez & González, 2016), but professionals say they do not know of cases of apathy and do not consider it relevant. These behaviours are standardised in the centres. They are behaviours that cause little discomfort, do not interfere with work and are easily managed despite being annoying for the person who suffers them. Apathy is a very present alteration among older people living in residences, often related to the overcrowding

derived from the prescription of certain psychotropic drugs (Vilalta-Franch et al., 2013) and from the low stimulation that exists in some centres (García-Soler et al., 2017). It is important that this is highlighted as behaviours such as ostracism are currently considered a type of abuse of the elderly (Pinazo-Hernandis, 2013). In fact, in section 3.2.3. of the results, it is noted that some geriatric assistants claimed to speak in front of the person suffering the psychotic episode or even to take their behaviour as "something funny". It is necessary for professionals to detect these behaviours and not to normalise them.

Regarding the second objective of this work, which was to evaluate how workers handle these situations, the professionals of the TE believe that geriatric assistants have more difficulty in correctly redirecting psychotic behaviour and emotional lability. One possible explanation may be that these are delicate behaviours that require correct management, since if they are not managed properly they can trigger agitation and be very harmful to the older person and the professional (Arroyo-Anlló et al., 2001).

In reference to the management of agitation or aggressive behaviour, the importance of non-verbal communication when working with people with dementia is highlighted. The appropriate use of paralinguistic, speech cadence, i.e., melody, speed, rhythm, pauses and tone of speech is essential to reduce BPSD and treat the patients with the respect and dignity they deserve.

In one of the cases commented on in a previous section, the professional was even interested in the life history of the people, giving meaning to their behaviour and validating it, as contemplated in the validation therapy of Feil (Neal y Barton, 2003) . It is important that geriatric assistants know the principles that make up validation therapy for dementia and try to make sense of and know the previous experience of each individual in order to satisfy their personal needs.

In reference to the opinion of professionals about the need for training, the data found support that a good level of training in the adequate management of behavioural disorders will help professionals to better redirect the BPSD. Spector et al. (2013) assessed the effectiveness of conducting professional caregiver training programs on dealing with people with irreversible dementia; and in the interviews analysed, the TE and several EA spoke of the need for mandatory continuing education, updated and constant upgrading of knowledge. Among the participants in this research, we found some people who have been working for 20 years and have not received any kind of training. Care practices have undergone changes and improvements. Moreover, new techniques and models of care have been included, so the knowledge of professionals should be recycled. For example, programmes for the removal of physical and chemical restraints using non-pharmacological techniques (Briones-Peralta & Rodriguez-Martin, 2017).

Finally, we would like to emphasize that professionals should not consider non-pharmacological treatments as the only solution to these symptoms. There is a large scientific literature that underlines the effectiveness of non-pharmacological therapies to act on BPSD by multidisciplinary assessment of the causes of problem behaviour and intervention (Dyer et al., 2017).

As can be seen from the results, although the professionals on the technical team are the ones who must evaluate and design the appropriate interventions, in the daily life of a residential centre it is the professional caregivers who witness and detect these symptoms, and therefore their training is necessary. The action of these professionals must be guided by common criteria.

The study has allowed to know how the professionals of residential centres manage the BPSD and which their level of knowledge about them is. A high percentage of direct professional caregivers in nursing homes do not handle BPSD properly, and their knowledge of BPSD is scarce or confusing.

The interviews have shown the need to have common and clear guidelines for all professionals. The performance in the face of a certain problem-behaviour should not depend on the criteria of each professional.

At present we are facing a change in the model of care for the elderly in residential homes, which has shifted from a model focused on professionals to a comprehensive and person-centred care, increasingly questioning the practices that had been standardised to date (Rodriguez, 2014; Wilberforce et al, 2017).

In this changing reality, training is increasingly considered a powerful tool that companies have to renew and improve their daily practice. Various research studies have shown the need for training of professional caregivers working with older people (Coffey, 2004) and various training programmes have shown their effectiveness in increasing the level of knowledge of professionals, and changing attitudes towards BPSD (Huizing et al, 2009; Koczy et al, 2011). Training of professionals must be continuous, and companies must invest in the retraining and updating of their employees. To cite just two examples, the Ley 39/2006 on the Promoción de Autonomía Personal y Atención a las Personas en Situación de Dependencia, in Article 36 names the need to increase specific training for professionals in this sector and the Madrid Plan de Acción Internacional sobre Envejecimiento promoted by the United Nations highlights the need to train professionals (United Nations, 2002). But this training should not only be focused on training to make good beds, personal hygiene, helping to eat and drink, carrying out observations and measurements, but should also encompass aspects such as good treatment, adequate communication, interpersonal skills or appropriate management of emotions and problem behaviours of people with dementia.

The training deficiencies of the nursing home's professionals in basic aspects such as the detection of warning signs or the adequate management of the SPCD have been revealed in the analysis of educational needs carried out, although the data must be read with caution given the small sample size and this is a limitation of the study. It would have been interesting to contrast the information with other professionals. However, the strengths of this study include the fact that the professionals have talked openly about the day-to-day management of the SPCD.

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