

MARIANNE MUNCH, MSc

Marte Meo Licensed Supervisor; Manager of the
Education and Training Unit; Geriatric Nurse;
NKS Olaviken Alderspsykiatriske sykehus,
Bergen, Norway

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Marte Meo Film Counselling

A Supportive Communication Approach Towards Elderly With Poor Communication Skills



Abstract

I have worked with the Marte Meo method for the last 13 years and would like to share some of my experiences. I will make an attempt to convey the need for interactive skills in approaching persons with dementia with poor communication skills and unintelligible behaviour. I will describe the elements of supportive communication through examples of interaction in daily life situations that we focus on, while reviewing film clips in counselling sessions. Focus will be on the caregivers' learning process in the counselling session as well. Further more results, future challenges and obtaining consent will be mentioned.

The terms patient, resident and person with dementia are used indiscriminately.

1. Introduction

The term caregivers in long term care, in Norway, covers a variety of staff such as graduate nurses, nursing assistants, social educators, and unskilled staff.

The term challenging behaviour is used instead of Behavioural and Psychological Symptoms of Dementia (BPSD).

The caregivers in dementia care in particular need to develop skills in how to interact and communicate in a way that defends the dignity and integrity of the person with dementia. Reduced capacity to communicate and to interpret perception through their senses, makes the persons with dementia vulnerable in interaction situations.

During the last years, there has been a demand on solution oriented teaching methods with attention on strengthening the caregivers' interaction skills. Attending different courses may increase the caregivers' knowledge about dementia, but does not always ensure that the caregivers apply their knowledge. The Marte Meo method is an approach that focuses on the good interactive moments. This seems to enhance and strengthen the caregivers' relational and communicative skills. When the caregivers become more aware of, and trained in applying the supportive elements of communication in interacting situations, it seems to increase the patients' initiative and coping behaviour. Reduction of challenging behaviour is observed as well.⁽¹⁾

By strengthening the caregivers' interaction skills, we expect that they will develop an individualised or person oriented care.⁽²⁾ A person oriented care as opposed to task-oriented care, renders a more human care of persons with dementia. Hopefully this leads to a better quality of life during the course of the disease.

1.1. Impact Of Dementia

Dementia is composed of a series of brain diseases, Alzheimer (AD) constituting the major part. The term dementia is in this article used about all the forms of dementia. Dementia is a chronic disease and progressive reduction in cognitive, psychological, emotional and motoric functions, are characteristic.⁽³⁾ The disease has an enormous personal impact. In the subjective perspective, the consequences for the individual are tremendous. The loss of ability to communicate verbally, as the disease advances, is a challenge for the person with dementia, for the family and for the caregivers. A woman with advanced dementia, in the process of losing her ability to speak expresses this experience by saying:

»...No. I can... what was I going to... no, I have forgotten what I was going to do. I have this thing that I forget what I am going to say.«⁽⁴⁾

Caregivers, on the other hand, describe disruption in communication as one of the four most strenuous factors in dementia care.⁽⁵⁾

1.2. Costs Of Dementia

In Norway, 40% of persons with moderate to advanced dementia live in long-term care.⁽³⁾ The caregivers' competence in dementia care in general and skills in communicating with dementia patients in particular has implication for each of the around 26.000 persons with dementia living in long term care, individually. Health care to elderly persons with co-morbidity is a very demanding work.

In Norway only, it is stipulated that the direct dementia care cost more than 2 million Euros per year. Globally the medical cost in treating dementia worldwide is about 159 billion dollars according to the findings Winblad et al.⁽⁶⁾, presented on the 20th of June 2005, at the Alzheimer's Association International Conference on Prevention of Dementia, in Washington, DC. Further more, according to Winblad et al.⁽⁶⁾ dementia care is the most costly disease in our society, costing more than cardiovascular diseases and cancer put together.

Providing for an effective use of these resources, by ensuring that the patients receive a human as well as a professional care, should therefore be in the interest of the society as a whole.

2. The Marte Meo Method

Our experience with the Marte Meo method at NKS Olaviken Alderspsykiatriske Sykehus, a gero-psychiatric hospital, started around the year 2000. Even though Marte Meo is being applied in a variety of sectors, up to the year 2000, the method was not yet employed in the treatment of persons with dementia in Norway. The pioneer project involved one unit in our hospital and six dementia units in long-term nursing homes. The results were promising⁽¹⁾ and in the year 2003 it was decided to direct more effort on implementing the method in the institution. The education and training unit would start their own Marte Meo education programs.

2.1. Developmental Supportive Elements

Marte Meo is a counselling method based on developmental psychology and studies on elements of communication that are a part of natural parent-child interaction, using film-footages as working tools.⁽⁶⁾ Marte Meo is derived from the Latin *»mars martis«*, meaning *»on one's own strength«*. The method is developed by Maria Aarts in the Netherlands.⁽⁷⁾

By studying in detail how well functioning parents

support their children's development in daily life situations, she managed to formulate certain basic elements in communication. »Natures recipe« is the name given by Maria Aarts to the developmental supportive elements present in natural and normal parent-child interactions (Developmental Supportive Dialogue). When using these elements, which she claimed existed in her interaction with the autistic children, the effect was astonishing.⁽⁷⁾ A simple fashion of introducing and imparting this information in an intelligible manner to parents and caregivers became one of her objectives.

The method was introduced in The Netherlands around 1980 and has since been spread internationally, leading to a variety of Marte Meo programs and centres being developed in countries as far apart as India and Norway.⁽⁸⁾ ⁽⁹⁾ Some of the centres have consultancy functions on governmental level.

In Norway the method was introduced around 1989, through the University of Bergen, Institute of Psychology. In Scandinavia it is being applied in a variety of fields. These are Maternal and Public Health Care Centres, Child Care Department, Juvenile Authorities, kindergartens, schools, services for persons with developmental disturbances, family therapy, marital counselling, mental healthcare, and lately also in the dementia care field.

Theories of infant and children's development, as well as research on infant development, give support to Maria Aarts' work, even though she herself does not integrate the method on empery or theory.⁽⁸⁾

In their book, »The Marte Meo Method and Developmental Supportive Dialogues«, Hafstad and Øvreeide⁽¹⁰⁾, describe the Marte Meo model as built on the idea of a natural, prototypical, developmental and supportive process between parents and infants. They describe the method as being a particularly constructed guide to *»make visible the natural developmental model and the natural developmental supportive dialogue's potential. It is tailored to activate the adults dialogical resource in the relational everyday situations with the child – at meals, in bedtime situations, in games, in everyday 'crises', in tuition, in special education situations; that is in any interaction between adults and children.«*⁽¹¹⁾

2.2. To Maintain The Remaining Resources

The developmental supportive dialogue is split into some basic elements, or principles of communication. These basic elements constitute the communicative action on the part of the parent or the adult. The elements are used individually or together, depending on the needs of the child at the specific interaction situation. As the relation between parent and child is oriented towards the development of the infant or the child, dialogue is both developmental and supportive. In the dementia care, however, our main objective is not a developmental perspective, but rather to maintain the remaining resources of the person with dementia by supporting his/her coping behaviour, strengthening the experience of his/her identity, and by supporting the weak communicative initiatives shown in everyday situations by persons with dementia.

The caregivers often find it challenging to interpret and to understand what persons with dementia are trying to express. When one is vulnerable and totally dependent on the help of others, even in the most personal and intimate way, in an interaction situation, the sensitivity of a person with dementia will be directed towards the quality of the interaction signals. It is the nuances of the voice, the pace and timing of the caregiver's actions: an impatient glance, an absent-minded expression, the handiness; these are the behaviours a person with dementia is susceptible to.⁽⁴⁾

2.3. Behaviour / Speech Of A Person With Dementia Might Become Understandable

When the persons with dementia do not have the ability or the possibility to express what they want, and how they want it, and when they are not able to react in a constructive manner, when they feel ill treated, they have few options in which to express their experiences. This may lead to verbal or physical aggression. Challenging behaviour is not uncommon in the dementia process.⁽³⁾

In spite of their speech and their cognitive impairments, most persons with dementia give a strong impression of a wish and a will to express and experience meaningfulness.⁽⁴⁾ In an interaction situation this means that the caregiver meets the patient with an expectation that whatever behaviour the patient shows, it has an intentional meaning. Incomprehensible behaviour and speech can be defined as symptoms or unintentional behaviour. With the right look,

with the ability to share feelings and experiences and with patience, the behaviour and the speech of a person with dementia might become understandable.⁽¹²⁾

2.4. *Not An Easy Task In Nursing Homes*

It is crucial to have information about the patients own experience in having dementia when it comes to individualising the interaction between the caregiver and the patient. It gives the caregiver the opportunity to experience the patients' despair, anguish, resignation and isolation. This is not an easy task in nursing homes where the caregivers have to comply with the high demands on productivity. The caregivers are often pulled between their conscience and the ward's need for »getting on with the job«. In this situation, the caregivers may blame the patients by attributing the disruptive behaviour to the patient's personality.⁽⁴⁾ The appreciation of the true value of the patients' own experience needs more attention.

How do persons with dementia experience a situation where the caregiver does not understand? What do they say or express?

Expressing themselves non-verbally with their bodies and with facial expressions is often their only option of conveying their own experience to the caregivers. On the other hand, the caregiver in a busy dementia unit may have a series of tasks that has to be done. In spite of the heavy workload many caregivers experience, most of them we encounter when giving courses and during Marte Meo counselling, show a sincere wish to take good care of the patients. The caregivers point out that they often have to split their attention on many things at once. To interpret several patients' behaviour and needs simultaneously is not an easy task.

2.5. *Marte Meo: Monitoring In Detail*

In the Marte Meo counselling, a patient's facial expression or behaviour can be monitored in detail. Film reviewing opens up for the possibility of reading the patient's non-verbal expressions and reflecting upon the patient's behaviour. It also allows for viewing the patient's responses to the caregiver's action in a specific situation (interaction analyses), in other words, what is the meaning of the patient's behaviour.⁽¹¹⁾ The basis for interpreting the needs of the patient in the specific situation, and how these needs are met, are the Elements of Supportive Communication (ESC). Giving the caregivers the opportunity to dwell and to reflect upon the patient's facial expressions, responses and behaviour, seems to encourage

a curiosity on their part, as to what they can do to improve the patient's situation.⁽¹²⁾

3. Elements In The Supportive Communication

The basic Developmental Supportive Elements in Communication applied in working with children, can be transferred to Elements of Supportive Communication in interaction with persons with dementia.⁽¹³⁾

3.1. *Creating A Structure And A Positive Atmosphere Enhances The Patients Coping Behaviour And Contributes To A Sense Of Prediction And Security*

Arranging the environment surrounding the patient in order to increase the patient's possibility to understand what is going on is important. As an example: to let the patient sit by the sink while brushing his teeth, instead of lying in bed, increases the patient's possibility to recognise the tooth brushing situation, and thereby make the situation more understandable. Before starting an activity, the caregiver approaches the patient with a smile or a friendly face. This contributes to secure the patient emotionally.

3.2. *The Caregiver Seeks To Locate And To Confirm The Patient's Attention Focus*

The caregiver gets information on what needs the patient has by following the patient's attention focus. The patient's attention focus can be directed towards the caregiver, towards another patient, towards an object outside the relation, or towards some inner emotional experience or need.⁽¹⁴⁾

When the caregiver confirms the patient's attention focus verbally or non-verbally, this contributes to a feeling of acknowledgement, which may lead to a response from the patient. When the patient responds, he directs his attention towards the caregiver. This leads to a moment of common attention, and a sense of expectation on the side of the patient, giving the caregiver an opportunity to introduce an activity.

For example: during a meal, one of the patients stops eating and looks at something on the floor. The caregiver follows the patient's gaze and discovers that the patient's napkin has slipped to the floor: »I see your napkin is on the floor.«

When the patient looks towards the caregiver, she has the patient's attention and can continue: »You can take it up«, or »I can take it up for you.«

Whereas had she insisted on making the patient eat instead of building a common focus of attention, the patient may have grown angry, and shown aggressive verbal and non-verbal behaviour.

Lone Bakke⁽¹⁵⁾, a Danish Marte Meo licensed supervisor with considerable experience in applying the method in dementia care, emphasises the importance of common attention focus between the patient and the caregiver before starting an activity. She argues that when the caregiver tries to impose an activity on a person with dementia, either by giving the person an instruction or by starting an activity without making sure that they have a common focus of attention, this may lead to challenging behaviour. The person with dementia has not had the occasion to understand what is about to happen. This may unleash an experience of being threatened, particularly if it affects the person's intimacy zone. According to Bakke⁽¹⁵⁾ and Aarts⁽⁷⁾, the collapse of common attention focus, the bad timing of actions, the lack of naming up-coming and on-going actions and the lack of voice intonation are some of the key relational factors that contribute to challenging behaviour.

3.3. The Patient Receives Help To Be In Rhythm When The Caregiver Supports The Patient's Initiatives, And Waits For The Patient's Responses

The rhythm of action and reaction in a dialogue, and the turn taking between persons without cognitive impairment usually last for as long as the persons involved find it convenient.

When the caregiver has named the patient's attention focus, in an interaction situation this may well, lead to a response from the patient. By giving the patient time to respond, the caregiver creates a space for further communication. When the caregiver immediately reacts on the patient's response, either verbally, or with sound or just by nodding, the patient can experience a sense of affirmation.

This support may give the patients sufficient confidence and energy to make a new initiative and so forth. The form this dialogue takes and the process of turn taking has a value of its own. It has more value than the verbal content of the message.

In a dialogue the meaning may sometimes be difficult to understand, because the patient's utterances may be unintelligible. By repeating the patient's sounds, words or movements, the caregiver confirms the patient's initiative.

A resident in a nursing home, Carl, shows aggressive behaviour during the morning toilet, when the caregiver wants to help him to wash himself. Carl is sitting on the bedside. The caregiver is standing in front of him and asks: »Do you want to wash your face? Do you want me to wash your face?«

Carl says »Yes«, but draws back when the caregiver starts to wash his face. His facial expression indicates that he is angry and he shows signs of not wanting to co-operate. The caregiver does not stop washing and Carl starts to shout and hit the caregiver.

Asking questions to persons with advanced dementia with speech difficulties, confronts the patient's cognitive functions, which are impaired. Another way of putting it is that by asking questions the patient does not understand, the caregiver defies the very part of the organism that is ill. To not ask questions seems to be a challenge for the caregivers. »What do you want to eat? Do you need to use the toilet?«

To ask questions is an integrated part of many caregivers' general communication pattern. In cases of severe dementia, however, having to respond to questions may be challenging. The option of having to choose often leads to confusion. The patient understands by the tone of the voice that a question is being asked, but often does not understand the contents of the question or does not have the ability to make choices. When a patient experiences that he does not know what is expected of him, he may well react with frustration and a disruption of communication.

A Nurse's Idea Concerning Marte Meo Counselling Sessions:

One of the nurses has an idea she wants to try out, while reviewing the film clip of the bedside situation with Carl, in a Marte Meo counselling session. We agreed that she should try out her ideas during the next filming.

In the next film clip we can observe the effect of using some of the supportive elements in the same interaction situation. Carl is again sitting on the bedside. The caregiver is sitting in front of him on the same level, allowing the patient to see her facial expressions. The fact that she is sitting on his level instead of standing above him, may influence the patient's experience of power, or of control.

Is it possible that a caregiver in a standing position challenges the patient's experience of power and of

control? Is it possible that it is easier for the patient to interpret the caregivers' expressions and intentions when the caregiver is at the same height level as the patient, and at arm's length?

The caregivers share some of their reflections during the reviewing of the film clips during the counselling session. We see how the caregiver names up-coming action by saying: *»Carl, you have something under your eye. Let's take it away!«*

The caregiver carefully wipes away 'something' on his right cheek with the washing cloth. Carl does not draw back, he sits quite still, and the nurse says: *»Yes, and on your left cheek.«*

Carl continues to sit still. The caregiver says: *»Uuumh, feel how good it is.«*

Carl moves his face towards the caregiver's hand with the cloth, he closes his eyes and says something unintelligible. The caregiver confirms that she has heard him by saying: *»Yes«,* while she continues to wash his face thoroughly.

Carl says: *»This is something else.«*

The caregiver repeats: *»Something else.«*

Carl says: *»Do it every day.«*

The caregiver confirms: *»Yes, you do it every day.«*

During this dialogue Carl sometimes closes his eyes and sometimes opens them and looks at the caregiver. The rest of the activity continues in the same kind of rhythm, without any episodes of challenging behaviour.

3.4. The Patient Receives Naming Of Upcoming And On-going Actions And Events. The Patient Receives Stepwise Confirmation During The Course Of Action

Adding words to actions, both the caregiver's own actions as well as the patient's actions, gives the patient a chance to understand what is happening. It is easier for the patient to concentrate on what is happening when naming of on-going actions is made stepwise, instead of in long sentences containing several instructions. Otherwise he may get lost in all the instructions. To balance between leading and following and to maintaining the patient's attention to the situation here and now, appears to prevent confusion. To split a course of action into small sequences, to add words to the actions, and finally to affirm the patient when he has carried out the actions, seems to give the patient sufficient self confidence and energy to proceed.

For example the caregiver can say: *»Ann, here is your fork.«*

When Ann looks at the fork, she says: *»You can hold it.«*

When Ann takes the fork she continues: *»Good. Now you can butter your bread.«*

While Ann butters her bread the caregiver confirms her behaviour by saying: *»Yes. Fine.«*

Or she can say: *»Now you are buttering your bread, good.«*

If Ann stops by herself when the task is completed, the caregiver says: *»Fine, now you can cut the bread.«*

While she is cutting the bread the caregiver can nod approvingly, smile encouragingly and say: *»Yes, that's right.«*

In reviewing film footages we see the patient's facial expressions and non-verbal responses when she experiences coping. The caregivers see the patients smile when they receive confirmation. For the caregivers this is a confirmation that what they are doing is the right thing at the right moment.

To develop a sense of compassion towards and understanding for the patient, it is important to dwell on the still pictures in the film clips, which clearly illustrate the patient's emotional responses. It gives the caregivers the opportunity to reflect upon what the patient is feeling right *at this moment*. What is it like to be Ann, right at this moment when she is smiling? Or, what is it like to be Carl, right at this moment, when he is shouting and looks angry?

If the caregivers close their eyes when reviewing the film clips of the patient when he looks angry and shouts, they will hear emotional intonation on the patient's voice. They will discover, and they will realise that the patient's shouts possibly expresses his anxiety and his fear.

The patient's body language gives the caregiver an indication on whether her approach has been successful.

3.5. The Patient Receives Help To Start And To End An Activity

In social situations there is continuity between the start, the exchange and the end of the interaction. In advanced dementia the ability to know when to start and when to stop is reduced. To support the patient in this process, the caregiver has to let the patient finish one activity before starting the next. To signal the start and the ending of an action, the intonation and the timing are essential. When an action is near

the end, the caregiver signals this by using a lower tone of voice. To signal the start of an action, caregiver uses a lighter tone of voice.

3.6. *The Patient Receives Support To Introduce Himself To Others By The Caregivers Naming The Patients And Co-Patient's Actions And Reactions*

In long-term care we often witness certain patterns of communication that are distinguished by the caregivers' one-to-one communication with the patients. Patients with advanced dementia and with poor communication skills, lack the initiative to converse with each other. When the caregiver introduces the patients to each other and links the introduction to specific circumstances in the situation, this encourages the patients to participate in social interaction. The caregiver encourages the social interaction by saying: »Mrs. Wilson...«

The caregiver pauses; when the caregiver has her attention she continues: »Mr. Carr, sitting beside you, wants some more coffee.«

The caregiver waits to see if Mrs. Wilson takes the initiative to pass the coffee. If she does not, the caregiver says: »The coffee pot is on your right hand side.«

To reinforce the message she can point to the coffee pot while she is saying it. When Mrs. Wilson is passing the coffee pot to Mr. Carr the caretaker can say: »Mr. Carr, Mrs. Wilson is passing you the coffee pot.« Mr. Carr may say: »Thank you.«

If he does not, the caregiver can confirm Mrs. Wilson by saying: »That was kind of you Mrs. Wilson. I see Mr. Carr is very grateful.«

3.7. *The Patients Need For Physical Contact*

The patient may need guidance to cope with the task when he does not understand verbal instructions. Furthermore, some persons with dementia have an increased need for physical contact. A caregiver sitting close to the patient and holding an arm around him or holding his hand may possibly increase his experience of safety. To other patients this closeness feels wrong. Awareness of each patient's individual necessity for physical contact is a way of sustaining the dignity of the patient.

4. Reviewing Film Footages

During the counselling sessions we review short film footages of about five to ten minutes of interaction between patients and caregivers in daily life

situations that the caregivers describe as demanding. When reviewing the film footages the Marte Meo counsellor seeks to highlight the moments where the patient's response to the caregivers actions leads to solutions, instead of focusing on the moments that exposes the caregiver's lacking skills.

Supporting the caregiver's adequate interaction moments seems to increase her relational and interaction skills. In the interaction analysis we focus our attention on the patient's verbal and non-verbal expressions. What is the patient trying to convey to us? What does the patient's behaviour express?

We try to interpret the patient's needs and how to comply with these needs in light of the elements of supportive communication. We highlight the patient's coping behaviour, and signs of satisfaction when the patient's needs are being met.

When evaluating the effect, we look for changes both in the caregivers and the patient's behaviour.⁽¹³⁾

Usually there are three reviewing sessions to each interaction problem, but sometimes the solution and the way of handling the problem is feasible after one reviewing session. At other times, more than three reviewing sessions are needed.

4.1. *Positive Response Of The Caregivers*

The effects and the results come clearly through in the film footages. There is an increase in naming upcoming and on-going actions, and fewer questions are being asked. The caregivers express increased feelings of coping when interacting with the patients with dementia. They transfer the use of the elements in supportive communication to other patients. They say they are more aware of and curious about the patients' responses and needs. We observe a reduction in the patients' challenging behaviour, and the use of coercion documented through the film material, as well as by the registration of his behaviour. The caregivers report that the patients take more initiative in social interactions and that some of them eat more during the meals.

4.2. *Securing The Quality Of Interaction*

According to the head nurse of one of the long-term care units that has been applying the method systematically since the year 2002, her staff has integrated the supportive elements of communication in such a way that they use them in most interaction situations. Each patient that has special communicative needs has a written care sheet describing which elements in supportive communication are most use-

ful in the specific situation, and how to apply them. They do not feel the necessity of reviewing the film footages whenever they discuss the patients' needs, because all the regular staff members have developed an awareness of the patients' responses. Before summer vacations, the film footages with the solutions are reviewed together with new caregivers to secure the quality of the interaction.

Whenever the caregivers are not loyal to the directions on the care sheet, certain patients start to show challenging behaviour, or to show other responses that indicates communication disruption.

One of the graduate nurses in this unit is a certified Marte Meo counsellor, and the head nurse is at this moment participating in a Marte Meo education program. Both nurses use the method to develop and to maintain their staffs' attitudes and interaction skills. When evaluating the effect of the Marte Meo method or other interventions to cope with more challenging interaction problems, the unit documents the patient's behaviour a week before and a week after intervention.

5. Obtaining Consent

Our hospital has developed a special consent sheet in cooperation with the lawyer of the Chief Health Administrative Office. The patient's next of kin gives the consent on behalf of the patient, as persons with severe dementia often do not have the competence to understand the consequences of being filmed. The person's physician assesses the person's consent competence. The films are highly sensitive material and are therefore kept in the patient's medical record.

6. Future Challenges

So far scientific research on the effects of the method is rather limited. There are, however, a few studies.⁽¹⁶⁾ ⁽¹⁷⁾ There are three published articles about the use of Marte Meo in dementia care in nursing home by *Rigmor Alnes* at the University College in Aalesund, Norway. The articles are part of her PhD project.⁽¹⁸⁾ ⁽¹⁹⁾ ⁽²⁰⁾

More scientific research on the effects of the method is necessary on all the different areas where it is being applied. There is a need to study the effect of the method on children or persons with dementia level, on parental and caregiver level, on ways of implementing and maintaining interaction skills, and

finally on an economic level. Doing the right thing at the right time can be effective for the person with dementia needing care, as well as being cost effective. The humanization of the environment surrounding the residents in long-term dementia care is a noble and a necessary goal, if the concept of dignity is to carry any weight in a longevity perspective.

- *Maria Aarts marginalia* (April, 2013): This article has been written by Marianne Munch in 2005. However the books »Marte Meo – Basic Manual« (2nd edition, 2008), and in particular »Marte Meo – Ein Handbuch« (2nd edition, 2009⁽²¹⁾ and 3rd edition, 2011⁽²²⁾), and several Marte Meo Magazine articles⁽²³⁾ show, that the field of research and publications regarding the Marte Meo Method noticeably has changed since 2005.

Until the mid of the 2000-decennium research publications on the effects of the Marte Meo method was rather seldom. Though various European studies were conducted, access to them was not an easy task.

In the meantime several research projects are available and with »Google Search« it's not a heavy job anymore to find interesting publications.

Especially I like to mention the important study of *Colette O'Donovan* at Dublin City University: »Public Health Nurses' Experiences of Training in Marte Meo Communication Skills«.⁽²⁴⁾ ⁽²⁵⁾ ⁽²⁶⁾

And furthermore, several research projects are in progress, like:

- Australia/Melbourne, DEAKIN University: Project leader is Keith R. McVilly (BA GDipPsych MPsych (Clinical) Tas., PhD. Syd., MAPS), Professor and Principal Research Fellow at DEAKIN University Australia, School of Psychology, Faculty of Health, Medicine, Nursing and Behavioural Sciences. John Lord (ADHC) organised the Marte Meo Project on behalf of ADHC.⁽²⁷⁾
- Denmark/Aarhus University: Ingeborg Hedegaard Kristensen (RN, MPH, PhD Student, Section for Nursing, Department for Public Health Aarhus University) commenced a extensive research on »The relations between infants and vulnerable first time mothers - Does video guidance with the Marte Meo Method promote the process?«⁽²⁸⁾
- Germany/Paderborn: Project's subject: Marte Meo video facilitation regarding interaction of traumatised mothers and their children during the first two year's of their life. Researcher: Prof. Dr. Albert Lenz, Catholic University North Rhine-Westphalia, Faculty Welfare, Paderborn, Germany.⁽²⁹⁾

• *Marianne Munch's Epilogue* (April 2013): **Norway 2013:** There is an increased attention and curiosity in the dementia field on using the Marte Meo counselling. NKS Olaviken is with the Norwegian Centre for health and aging, and Sykehuset Innlandet, assigned responsibility for a dementia care program initiated by the Norwegian Health Ministry. NKS Olaviken contributed with a Marte Meo practitioner course. The main objective of the project was to examine the effect of the Marte Meo practitioner course of dementia caregivers communication and relational skills; the ability to give person-centred care. A total of 30 caregivers from four different nursing homes participated (mean age 43,4 years). The participants completed a two self-report measures, The Person-centred Care Assessment Tool (P-CAT), and a measure regarding the psychosocial work environment, before immediately and after, as well as six months after the Marte Meo practitioner course. Focus group interviews of 12 participants in three of the groups, as well as depth interviews of three of the leaders was carried three to six months after the intervention.

The participants reported significantly higher total score on both self-report measures after completing the course. The caregivers participating in the focus group interviews report: change in their own behaviour when approaching persons with dementia, increased attention on and discussions of care approaches, the importance film footages to create change in their own behaviour and the consequences for the psychosocial environment. They reported changes in patient behaviour as well; from resistance and helplessness to cooperation and initiative, as well as a change from a negative to more positive body language.

The results showed an effect of the Marte Meo practitioner course on care giving experience and behaviour, on perceived contentment with psychosocial work-environment and perceived patient behaviour.⁽³⁰⁾ ⁽³¹⁾

As the results from this project are so promising, the Norwegian Health Ministry wants to build up expertise on four environmental method including Marte Meo in each county. This means that the education of Marte Meo therapists in the Specialist Health Services in the psychogeriatric care is being subsidised by governmental funding.

There are today about 60 Marte Meo certified therapists, about 25 are being educated, there is one

Licensed Marte Meo supervisor, three supervisors and five in education in the dementia field. The Marte Meo method in dementia care is in a solid growth in Norway.

To promote the method further we have started a Nasjonal Marte Meo in dementia care biennial conference. The next one will be commenced in Oslo, the 5. and 6. of June, 2013.⁽³²⁾

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Abbreviations:

AD	Alzheimer's Disease
ADHC	Family & Community Services / Ageing, Disability & Home Care (Australia)
BPSD	Behavioural and Psychological Symptoms of Dementia
ESC	Elements of Supportive Communication
MSc	Master of Science in Clinical Research
P-CAT	Person-centred Care Assessment Tool
PhD	Doctor of Philosophy

MAIN KEYWORD:

Dementia

SUB KEYWORDS:

- Communication
- Communication challenges
- Communication, supportive
- Care, Person centred
- Care, Relation oriented
- Interaction in daily life
- Filmcounselling

Further Information:

MARIANNE MUNCH, MSc | Supervisor Manager of the Education and Training Unit; Geriatric Nurse;
NKS Olaviken Alderspsykiatriske sykehus, 5306 Erdal, Bergen | Norway
Marte Meo Licensed Supervisor

Tel.: (+47)-56 15 10 00

E-mail: marianne.munch@olaviken.no

Website: www.olaviken.no

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