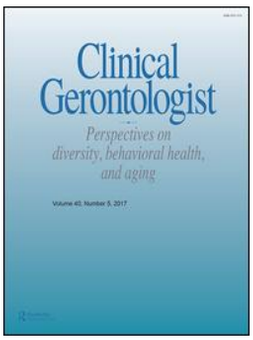

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Feasibility of Training and Delivering Compassionate Touch in Long-Term Care

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ABSTRACT

Objectives: Limited evidence supports the use of therapeutic touch for people with dementia (PWD). Interventions incorporating a person-centered approach to touch delivered by staff may benefit PWD and staff in long-term care settings. The Compassionate Touch® (CT) program provides skilled human touch and a compassionate presence following a person-centered approach and touch protocol. The purpose of this study was to determine the feasibility of training and delivering CT.

Methods: An online survey was sent via email to 112 staff who attended the CT coach training. Descriptive statistics and thematic analysis were used to analyze closed-and open-ended questions of the survey.

Results: Twenty-four staff members completed the survey and reported positive perspectives about the training, use of the program, and benefits for PWD and themselves. Five themes emerged, including (1) benefits for residents, (2) challenges in using CT, (3) when to use CT, (4) training staff, and (5) needed support.

Conclusions: Preliminary findings from the present research show potential benefits of using the CT program for residents, challenges participants faced in using the program and training other staff, and support needed to overcome these challenges.

Clinical Implications: Programs such as CT may benefit PWD and staff in residential care settings.

KEYWORDS

Alzheimer's disease; caregivers; dementia; long-term care; massage therapy; surveys and questionnaires; therapeutic touch

Introduction

With the increasing number of people with dementia (PWD), more people will care for PWD, either as unpaid or paid caregivers (Alzheimer's Association, 2017). The majority of PWD living in residential care settings have behavioral and psychological symptoms, such as agitation, apathy, and depression, and are in the later stages of dementia, with limited ability to communicate verbally (Selbaek, Engedal, Benth, & Bergh, 2014). Antipsychotic medications to manage these symptoms are more likely to be used for PWD living in residential care settings such as nursing homes than for those living at home (Jacquin-Piques et al., 2016). Due to potential side-effects of antipsychotic medications, use of nonpharmacological treatments has been preferred as much as possible to manage behavioral and psychological symptoms of PWD (Azermai et al., 2012). Research has found positive effects of different nonpharmacological treatments on PWD (i.e., Livingston et al., 2014).

Therapeutic touch or massage is one type of nonpharmacological treatment. Limited evidence supports its use for PWD for decreasing agitated behaviors and stress levels (Holliday-Welsh, Gessert, & Renier, 2009; Moyle, Johnston, & O'Dwyer, 2011; Suzuki et al., 2010). One systematic review suggested the need for more rigorously conducted research because the majority of published research articles regarding touch or massage are of poor methodological quality, thus making it hard to judge effects of such an approach on PWD (Moyle, Murfield, O'Dwyer, & Van Wyk, 2013).

How touch or massage is delivered may make a difference in how a PWD responds and feels connected with the person who provides the touch or massage. To be therapeutic, touch should be more than massage techniques, a way to interact with PWD by being connected through human touch. One possible way is to incorporate a person-centered approach when providing touch or massage by being carefully aware of and respecting each

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person's verbal and nonverbal responses to decide when to start touch and whether the person is okay to be touched or the person is not comfortable with touch at all (Tuohy, Graham, Johnson, Tuohy, & Burke, 2015). Research is needed to evaluate the effects of an intervention using touch combined with a person-centered approach for PWD and caregivers.

The Compassionate Touch® (CT) program was developed by Ms. Ann Catlin (a registered occupational therapist and licensed massage therapist) in the AGE-u-cate Training Institute as a way of relating to PWD, especially in residential care settings. The CT program provides skilled human touch on hands, back, or feet, and a compassionate presence, following a person-centered approach that focuses on each resident with dementia. The program was designed to be used for reducing behavioral symptoms of PWD and unnecessary use of anti-psychotic medication. Generally, PWD having sensitivity to touch or conditions that can misinterpret touch (i.e., delirium) are not good candidates for CT. The person who gives therapeutic touch should engage the resident's attention by asking, "Can I join you?," and being sure it is okay to touch by paying attention to any nonverbal reaction of the resident. Staff in residential care settings who attend a two-hour CT coach training through the AGE-u-cate Training Institute are prepared in using the CT program and in training other staff in their own settings. The CT coach training covers: understanding about PWD and their behaviors as expressions of their unmet needs; skilled touch vs. other forms of touch used in dementia; evidence of therapeutic touch; verbal and non-verbal communication techniques to make a connection with PWD; how to initiate the CT session and get permission to touch; non-verbal positive and negative responses to touch; and skilled touch protocol on hands, back, and feet, and focused touch techniques. However, it is unknown whether and how staff who attend the CT coach training use the program for residents in their own settings, whether and how they train other staff in their own settings, and what potential benefits and barriers they encounter while using the program for residents and training other staff. To fill these gaps in knowledge, the present study was designed and conducted.

The purpose of this study was to determine perspectives of staff who attended the CT coach training. More specifically, we aimed to understand the trainees' opinions about the feasibility of training and delivering CT, along with perceptions of potential benefits for PWD. Insights gained from the present study will be used in designing a further intervention study that will assess the efficacy of the CT program for residents and staff in residential care settings.

Methods

Participants

Table 1 describes characteristics of 24 staff members who attended the CT coach training and completed the online survey. A total of 112 staff members who attended the CT coach training through the AGE-u-cate Training Institute were invited for study participation through e-mails. The potential participants received an e-mail with the electronic survey link posted on PsychData, saying that, "Completion of this survey constitutes your consent to participate in this research study." PsychData is specifically designed to meet or exceed the standards set by academic IRBs, and PsychData's online surveys are more secure than paper-and-pencil research. The survey was open for about three months (around the first quarter of 2017) and emails with the survey link were sent to the potential participants three times during the period to remind people who had not completed the survey. There was no incentive given for the survey respondents. The present study was conducted with IRB approval from Texas Woman's University (Protocol # 19332).

Survey instrument

A survey asking about staff perspectives about the CT program experience was created by the authors of this article, who have expertise in dementia research. The survey included 18 closed-ended questions (Table 2) rated on a 3-point Liker-type scale where 1 = "strongly disagree" and 5 = "strongly agree," and nine open-ended questions (Table 3).

Data analysis

Descriptive statistics using PsychData were run to summarize responses on closed-ended questions. Thematic analysis was used to analyze responses on

Table 1. Characteristics of Survey Respondents

Categorical variable	*n*	%
Gender		
Male	0	0.0
Female	24	100.0
Job/discipline		
Community life/activities	12	50.0
RN (Registered nurse)/certified nursing assistant (CNA)	7	29.2
Caregiver education	3	12.5
Hospice chaplain	1	4.17
Exercise physiologist/fitness director	1	4.17
Use of the CT program with the residents with dementia after training		
Yes	23	95.8
No	1	4.2
Frequency in use of the CT program		
Never	0	0.0
Almost never	1	4.2
Sometimes	11	45.8
Fairly often	6	25.0
Very often	6	25.0
Training your staff about the CT program		
Yes	20	83.3
No	4	16.7
Numerical variable	Mean (SD); Range	
Age	50.75 (11.94); 29–73	
Years of experience in working at long-term care facilities	15.94 (8.62); 4-31	
Years employed at the current facility	10.07 (7.97); 3-31	
Number of hours per week working in the current facility	39.77 (5.92); 20-50	
Number of staff you have trained in CT program so far	27.63 (41.65); 0-200	

Note. CT= Compassionate Touch

open-ended questions of the survey, by using NVivo 11 software (QSR International Pty Ltd, Melbourne, Australia). NVivo 11 software is a computer-based tool that is helpful in organizing and analyzing qualitative data quicker and more efficiently than manual coding. The auto coding function was used to start coding under each of the open-ended questions because the survey asked the same open-ended questions. Thematic nodes were created and reviewed and then thematic nodes were reorganized for final themes. Coding was done by the first author, who went through individual training in using NVivo 11 software and through training in qualitative data analysis including thematic analysis. Having another independent coder was not necessary in thematic analysis of open-ended survey responses. Instead of coding by a second coder, themes with all relevant responses were documented and sent to the second author to check if themes were well-grounded and represented in the survey responses.

Results

More than 95% used CT with residents with dementia after training and 50% used CT fairly or very often (Table 1). About 83.3% trained other staff in their settings after they attended the CT coach training.

Results in closed-ended questions of the survey

Table 2 displays results of closed-ended questions of the survey, as a frequency table (N = 24). All or almost all participants agreed/strongly agreed with all the statements, except for Statements 15, 16, 17, and 18. Participants reported that the CT program was easy to learn and use and that they felt confident, comfortable, satisfied, and pleasant about using the program. Also, they found that using the CT program was beneficial for residents with dementia and themselves; and they felt connected and interacted better with residents with dementia than before using it. Overall, the participants recommended using the program. About two thirds of the participants (65.2%) disagreed/strongly disagreed with Statement 15, meaning that no more training is needed. Almost all respondents (95.7%) disagreed/strongly disagreed with Statement 16, meaning that they would use the program in their settings. Nearly two thirds of

Table 2. Open-ended Questions of the Survey.

Question
1. When and how do you use the CT program in your setting?
2. What are the benefits of using the CT program for residents with dementia?
3. What are the challenges/barriers of using the CT program for residents with dementia in your setting?
4. Which residents would benefit the most and the least from the CT program?
5. What are the needed supports to use the CT program for residents with dementia in your setting?
6. What alternative ways can be used in providing the CT program for residents with dementia in your setting?
7. How did you train the other staff in your facility about the CT program after you attended the coach training?
8. What are the challenges/barriers of training staff in the CT program in your setting?
9. What further comments do you have regarding being trained in, giving training to other staff, and/or using the CT program for residents with dementia?

CT = Compassionate Touch

participants (60.9%) found the program beneficial (Statement 17), and an overwhelming majority (83.3%) felt ease in training others (Statement 18).

Results from open-ended questions of the survey

Five themes emerged from participants' responses on open-ended questions of the survey. These themes include (1) benefits of using the CT program for residents, (2) challenges of using the CT program, (3) when to use the CT program, (4) training staff, and (5) support needed to use the CT program.

Theme 1. Benefits of using the CT program for residents

Almost all participants mentioned at least one or several benefits of using the CT program for residents. These reported benefits included calming and redirecting residents, decreasing residents' behavioral issues, and improving residents' mood (Subtheme 1a); and increasing connection between residents and staff (Subtheme 1b). Also, participants regarded residents who would get the most benefit from the CT program as those who are not sensitive to touch and those who have behavioral symptoms, challenges with activities of daily living (ADLs), or little human interaction (Subtheme 1c).

Participants reported that the CT program calms residents (15 responses), decreases residents' agitation and anxiety (five responses), redirects residents (three responses), and improves residents' mood (two responses). Examples of these participants' statements include the following: "It helps to calm them," "I find the program lessens anxiety," "I have seen residents who were in distress become calm and able to engage after slowly introducing and using the program with them,"; and "When residents are isolating themselves or depressed, it helps to alleviate some of their sadness." Increased connection between residents and staff through the use of the CT program is another benefit reported by participants (seven responses): "It establishes connections and aids in relationship building. It provides much-needed physical contact in an appropriate, easily accepting manner," and "We have seen residents, who are unable to

Table 3. Results of Quantitative Analysis of Survey as Frequency Table (N=24).

Questionnaire Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. It was easy to learn how to use the CT program.				11(45.8%)	13(54.2%)
2. I am confident in using the CT program.			1(4.3%)	11(47.8%)	11(47.8%)
3. I feel comfortable in using the CT program.			1(4.2%)	11(45.8%)	12(50.0%)
4. The CT program is simple to use.				12(50.0%)	12(50.0%)
5. Providing the CT program to my residents with dementia is useful.			3(13.0%)	12(52.2%)	8(34.8%)
6. I am satisfied with using the CT program for my residents with dementia.			4(16.7%)	13(54.2%)	7(29.2%)
7. It is pleasant to use for the residents in my setting.			1(4.2%)	13(54.2%)	10(41.7%)
8. It works the way I want it to work.			2(8.3%)	15(62.5%)	7(29.2%)
9. I would recommend using the CT program to others.			1(4.2%)	11(45.8%)	12(50.0%)
10. It is accepted by the residents.			5(20.8%)	12(50.0%)	7(29.2%)
11. Using the CT program is beneficial to me.			4(16.7%)	13(54.2%)	7(29.2%)
12. Using the CT program is beneficial to residents with dementia.		1(4.2%)	2(8.3%)	15(62.5%)	6(25.0%)
13. I feel connected with the residents with dementia when using the CT program.			4(16.7%)	11(45.8%)	9(37.5%)
14. The program helps me interact with residents with dementia better.			6(25.0%)	11(45.8%)	7(29.2%)
15. I need more training in using the CT program for the residents with dementia.	4(17.4%)	11(47.8%)	7(30.4%)	1(4.3%)	
16. I would rather not use the program in my setting.	10(43.5%)	12(52.2%)	1(4.3%)		
17. I think it is beneficial for the family members/friends of residents with dementia to learn and provide the program to their relatives/friends with dementia.	1(4.3%)		8(34.8%)	8(34.8%)	6(26.1%)
18. Training the other staff after the coach training was easy.		2(8.3%)	2(8.3%)	15(62.5%)	5(20.8%)

Note. CT= Compassionate Touch

speak, tear up at the end of the session because of the human touch they are receiving."

Almost half of the participants believed that any resident who is not sensitive to touch will get the most benefit from the CT program (13 responses). Others, however, identified more specific residents who benefit the most from the CT program. These include residents with behavioral symptoms and challenges with ADLs (four responses), and residents who are lonely and want human interaction (two responses): "Residents who have issues with ADLs will have the most benefit because they can often be soothed by it," and "It is most beneficial to residents who want time and touch from another person and are lonely or bored."

Theme 2. Challenges of using the CT program

Some challenges in using the CT program in their settings were experienced by participants. These include the difficulty of knowing when to use it for the right resident at the right moment (Subtheme 2a); staff hesitation and discomfort about using the CT program (Subtheme 2b); and difficulty in finding and having the time for it (Subtheme 2c).

Participants realized that the CT program should be used for the right resident at the right moment (Subtheme 2a; 11 responses) because it did not work well when residents were too agitated: "If they are extremely agitated, they often don't want anyone touching them." Some mentioned that it is important but … challenging to try to catch them at the start of agitation and not later." Also, some residents did not like to be touched, or some residents' reactions were different day to day. It was challenging to "… understand residents' desires to receive the CT program from day to day" for some participants because some residents were not able to express themselves, and their reactions to the CT program were different on different days: "You could have a really good session one day; then they don't want to receive CT the next time you offer it. You have to respect their wishes."

Staff hesitation and discomfort about using the CT program (Subtheme 2b; 4 responses) and difficulty in finding and having the time for it (Subtheme 2c; 3 responses) are other reported barriers in using the CT program in their settings. Some participants addressed the staff belief about added duties and discomfort about having to go through the training and practice: "Staff tend to think it is going to take time away from their duties and give more work for them. Some staff are uncomfortable with the hands-on training and practice." Also, some staff seemed to feel uncomfortable about using the CT program because residents might not like to be touched: "It can be hard for some staff to feel comfortable doing it and/or getting permission from residents, either verbal or nonverbal. Some people just don't want to be

touched, either all the time or in certain instances."

Theme 3. When to use the CT program

Participants stated that they use the CT program when residents have behavioral issues, or need some calming (Subtheme 5a; 16 responses), during any one-on-one interaction with residents or unstructured time (Subtheme 5b; 10 responses), and at a specific care time when touch comes naturally to residents (Subtheme 5c; four responses). The majority of the participants used the CT program on purpose when they believed that it was needed. Such situations were when residents had some behavioral issues and needed some calmness: "I use it when someone is upset or restless," and "We use it if we notice that residents are becoming agitated or just need to relax." Some participants used the CT program more flexibly during any one-on-one interaction with residents or at certain care times when touching residents comes naturally: "I use it when I am doing manicures," and "After morning stretches they enjoy the back massage."

Theme 4. Training staff

Staff who attended the CT coach training reported that they trained their staff by doing hands-on practice and using video-recorded CT training material and handouts (Subtheme 3a), and that they faced some challenges in training staff in their settings (Subtheme 3b).

Participants who attended the CT coach training did hands-on practice with staff and used video-recorded CT training material and handouts to train their own staff (Subtheme 3a; 16 responses). Some participants did the staff training just as they were trained in the coach training and had the staff practice with residents: "I provided the same training to staff as the coach training and then had them practice with residents and report back." Some participants used the video-recorded training material with hands-on practice: "We used the CD and paused to try the technique on each other, then continued to the next step." To promote staff's new learning and refresh CT techniques after training, some participants gave handouts to staff or made the binder that they received from the coach training readily available in their setting.

Challenges in training staff in their settings (Subtheme 3b) were reported, including staff's uncomfortable feelings and reluctance (eight responses) and scheduling issues (six responses). A training challenge was noticed by some participants because of staff "resistance to another thing being asked of the staff to do" and "fear of making the initial approach to the residents." Some staff's uncomfortable feelings when touching other staff during the hands-on practice or residents after training were also reported. Reluctance and resistance about being trained in CT also seemed to come from the staff belief that this is not part of their job: "Some staff don't understand the need and don't feel that it's part of their job." Scheduling time for training staff was another challenge because staff have other duties, and it was hard to make a schedule work for getting staff together who work in different departments or have different work shifts. A few participants mentioned some strategies they used to overcome scheduling issues by asking staff to come on their day off and paying them for attending the training or by setting up the training as a monthly training for newly employed staff and an annual refresher training for staff who had already completed the initial training.

Theme 5. Needed support to use the CT program

Participants reported needing support to better use the CT program in their settings, including not forcing but encouraging staff to incorporate the CT program into current care (Subtheme 4a; nine responses), and providing continuing education for training new staff and refreshing CT techniques for the rest (Subtheme 4b; four responses). Because some staff felt that time was an issue in using the CT program in addition to their duties, staff needed to be supported by guiding them to incorporate the CT program into their current care schedule and rewarding staff for use and positive outcomes: "Time appears to be a staff concern. Leadership staff must lead by example, show staff how to incorporate the CT program into the day, incentivize staff to use the program, and then reward positive outcomes." Some participants also emphasized not forcing staff that are

not comfortable using the CT program, although reinforcing the benefits of the program may encourage some other staff: "Not forcing the issue with certain staff. If they are not comfortable giving CT, then it will not be a good experience for those receiving CT," and "Keeping it top of mind for staff and reinforcing the benefits of this type of touch." Providing continuing education for training new staff and refreshing CT techniques for the rest were regarded as another needed support: "Continual training is needed for new staff and refreshing current staff."

Discussion

Our preliminary findings from the present research show potential benefits of using the CT program for residents, challenges participants faced in using the program and training other staff in their settings, and support needed to overcome those challenges. Although the reported benefits, such as calming residents and decreasing agitated behaviors of residents, were not objectively measured but merely perceived by the participants, these benefits of using therapeutic touch are partly supported in the literature (Holliday-Welsh et al., 2009; Moyle et al., 2011). Neuropsychiatric symptoms such as agitation and depression and antipsychotic drug use have been found to be related to poor quality of life in PWD living in residential care settings (Klapwijk, Caljouw, Pieper, Van Der Steen, & Achterberg, 2016; Wetzels, Zuidema, De Jonghe, Verhey, & Koopmans, 2010). It is, thus, important to identify evidence-based nonpharmacological treatments that can help in managing neuropsychiatric symptoms and antipsychotic drug use.

Increased connection between residents and staff also was reported by participants in the present study. Residents with dementia in residential care settings may have low social engagement, and relationships and connectedness with others including staff may positively affect residents' quality of life and psychosocial well-being (Bradshaw, Playford, & Riazi, 2012; Nakrem, Vinsnes, & Seim, 2011; Van Beek, Frijters, Wagner, Groenewegen, & Ribbe, 2011). Providing a positive social environment and improving the quality of the relationships between PWD and caregivers are important aspects of person-centered care to fulfill psychosocial needs and promote psychosocial well-being of PWD (Dementia Initiative, 2013; Edvardsson, Fetherstonhaugh, & Nay, 2010). Staff in residential care settings are important team members in dementia care because of their day-to-day interactions with residents with dementia, which allow caregivers to have positive social contact with residents, depending on their attitudes and care approach.

Some challenges in this study were related to staff reluctance about being trained in a new care approach and using, it as they believe that this will take up their time for other duties and that is not their job. Staff busy routines can be a barrier hindering them from building close rapport with and providing social support to residents with dementia, although staff may value interventions that help them better understand and connect with residents with dementia (Lung & Liu, 2016; Rapaport, Livingston, Murray, Mulla, & Cooper, 2017). To overcome this challenge, it can be important to encourage staff to use the program by guiding them in ways to incorporate the program into routine care and rewarding staff when they use the program with residents. A systematic review found important elements of nonpharmacological interventions delivered by care home staff to PWD, such as provision of posttraining support and interactive training, building the intervention into routine care, and aiming to train most staff (Rapaport et al., 2017). Modifying training so that it provides clear insights as to how to incorporate the CT program into the day-to-day care routine without increasing their workload might increase staff motivation to use the program. Also, educating staff about providing emotional social support to residents with dementia may change their attitudes about being trained in a new care approach focusing on emotional support to residents. Staff positive attitudes toward PWD and stronger motivation to implement a person-centered care approach may give a greater sense of competence to provide care and reduce job strain, as PWD also decrease behavioral symptoms from the positive interaction with staff (Edvardsson, Sandman, Nay, & Karlsson, 2008; Mullan & Sullivan, 2016). Further study is needed to examine whether using the CT program decreases staff burden in caring for residents with dementia and increases their competence in caring for PWD.

Findings of the present study should be interpreted with caution because of its preliminary

nature due to several limitations. These include a small sample size (response rate: 21.43%) and selection bias. The response rate of the present study seems to be low, but an average response rate for external surveys is 10–15% and an e-mail survey response rate of 15–20% is considered good (Fryrear, 2015; "What Is a Typical," n.d.). Opinions of participants who responded to the survey might be different from the opinions of those who did not respond to the survey, so there is a possibility that the participants of the present study do not represent the whole sample that attended the CT coach training. Also, characteristics of survey respondents and non-respondents could not be compared as we only collected demographic information of survey respondents who entered their demographics while completing the survey. The present preliminary study, however, shows a potentially positive experience in and potential benefits of using the CT program by staff with residents with dementia. Gained insights from the present study will be used in designing and conducing a further larger-scale study with a higher-level research design, modified training materials and support for staff, and the most appropriate and validated outcome measures to examine impacts of the CT program on PWD and staff in residential care settings.

Clinical Implications

- Programs such as the CT program may benefit PWD and staff in residential care settings by calming residents, decreasing agitated behaviors of residents, and increasing connection between residents and staff.
- To encourage staff to use a new program for residents, training

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