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Reciprocity and caregiver competencies. An explorative study of Person-Attuned Interaction in dementia care

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Despite the impact of dementia, people's needs to connect with others and their environment remains. With progression of a dementia disease, a person will gradually be more dependent on assistance and care. In this study, we aimed to conceptualise our understanding of person-centred dementia care, theoretically based on Tom Kitwood's ontology of personhood. A hermeneutic constructivist approach with four explorative phases allowed for a metaphorical way of working with implicit knowledge related to professional caregiving. We used Lego Serious Play™ for data collection and as a method for exploring, articulating, and conceptualising how we understood caregiver interactions. Based on our analysis, we developed a co-created, condensed model suggesting an ideographic understanding of person-attuned interactions in caregiving, emphasizing knowledge about personhood and reciprocity. We unfolded how professional caregivers represent an essential value in dementia care by providing a feeling of safety through person-attuned interactions, introspection and mentalisation. We found that caregiver competencies depend on resources, culture, and interdisciplinary collaboration, which puts a strong demand on continuous training and supervision and for political and societal priorities.

Keywords: Dementia care, Interaction, Attunement, Caregiver competencies, Lego Serious Play

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Introduction

Dementia and person-centred care

Dementia is an umbrella term for several diseases affecting cognitive and functional abilities, and impacts on the person's ability to perform everyday activities (WHO, 2019). As dementia progresses, communication and self-regulation skills are compromised, including sense-perception and the ability to sustain attention. For persons with moderate to severe dementia, there is an increasing demand for care in all aspects of daily living, for the use of non-verbal communication, and for changing the ways of sharing time together with friends and family (Cheston & Bender, 1999; Pedersen, 2018). Tom Kitwood is described as "One of the most radical thinkers to have addressed the subject of dementia care" as he accords an ethical status to an absolute value of the person (Davis, 2004, p. 375). Kitwood worked from the premise that the person with dementia remains as a person, also in the late stages of dementia, and therefore maintains personhood. Personhood is when the self continues existing in the context of relationship and social being (Kitwood, 1997). According to Kitwood, the aim of person-centred care is to nurture personhood and to increase wellbeing though positive person work. Following Kitwood, Dawn Brooker strengthened the importance of person-centred care by defining four essential elements that support personhood. They are guiding principles – the VIPS principles – for caregivers about the absolute value (V) of all humans in an individualised (I) approach where the perspective (P) of the person and supporting (S) psychosocial needs are key (Brooker & Latham, 2006). A person-centred approach to care including Brooker's VIPS principles is recommended by the British NICE guidelines (2018) and the Danish clinical guidelines for the prevention and treatment of behavioural and psychological symptoms in persons with dementia (SST, 2019). Person-centredness is complex, and even with a clearly defined framework, such as the VIPS, there is a need for knowledge and research about *how* caregivers interact with the person with dementia and which competencies this would require. Therefore, evidence-based dementia caregiving interventions should be translated into practice (Gitlin et al., 2015), and, simultaneously, research should inductively be grounded in practice. Following the recommendations from the Center for Innovative Care in Aging (Gitlin et al., 2015), dementia caregiver interventions need to obtain conceptual clarity and consensus to improve clinical relevance and implementation potential of evidence. This puts specific demands on research on caregiver competencies.

Objective

The objective of this study was to explore, articulate and conceptualise professional caregiving from a person-centred perspective and to identify essential components and their implications of positive person work between caregivers and persons with moderate/severe dementia.

Caregiver interactions based on competencies and value co-creation

Actions, that a caregiver carries out with a person with dementia as part of daily care, can be observed, recorded, and mapped. However, the underlying intentions of the actions are not visible and therefore difficult to grasp. To gain in-depth knowledge about the underlying and implicit understanding of actions, Duggleby and Williams (2016) state that we need to develop methodologies that expand the subjective domain of human action and interaction. An act can never be isolated to a simple output but will always be understood as part of systemic principles. The German psychologist and business economist, Timo Meynhardt, who studies individual competencies and their link to the core competencies within organisations, has described systemic principles of value co-creation, defined as synergetics of value and service ecosystems (Meynhardt et al., 2016). In this perspective, caregiver competencies may be regarded as values; values that emerge through value co-creation. In the service ecosystem, which we here define as the nursing home context, knowledge and skills are the primary resources for exchange. The society at a macro-level as well as the person with dementia at a micro-level benefit from the competencies of professional caregivers. The care, provided by the caregivers, is catalysed by mutual value co-creation, and therefore, the caregivers “together constitute a self-adjusting, self-contained service ecosystem” (p. 2982).

According to Meynhardt and colleagues (2016), value is situated in the social environment, as, for example, *the culture of care* forms the daily life for the person with dementia in the nursing home context. This culture of care is expressed through the way the caregiver acts in each single situation, but is also expressed at a macro level where certain patterns of interaction form similarities between various cultures of care. As an example, Kitwood (1997) termed a specific culture “malignant”, and in his research strived to define the opposite culture – a new culture of care – created by positive interactions. He rejected the overall paradigm that was characterized by the ignorance and stigma associated with dementia. As such, he critically questioned the malignant culture of care. Critical questioning may lead to destabilisation, continuing to a point where the parameters of the system break free and a new order can emerge (Meynhardt et al., 2016).

Dementia care at Kitwood’s time happened in a “context of relative deprivation” (Kitwood & Bredin, 1992, p. 286), and he therefore suggested twelve positive interactions, among these; validation, holding and facilitation (Kitwood, 1997). He observed that such interactions served at building up positive relationships between the person and the caregiver and played an important role for the quality of care. Positive relationships, for instance between a couple, parent/child, or friends, are characterised by a higher degree of temporal coordination and more interpersonal synchrony than in other interacting dyads (Koole & Tschacher, 2016). Interactional and communicative patterns happen intuitively and lay the ground for social cohesion. Interactions are also a result of culture and social forces (Giddens, 2006), which means that positive interactions may be developed or changed at an individual level and/or by changing the culture that is forming them. A first step in this direction is to explore and describe these interactions at a micro-level.

Applying a person perspective on dementia implies a “broader lens that incorporates citizenship and sociological ideas about agency and structure” (Barlett & O'Connor, 2007) and is integrated in the ontology of personhood (Kitwood, 1997). Our focus is on persons with moderate to severe dementia living in nursing homes or care facilities, and therefore, to understand their interactions with professional caregivers. We have noticed a tendency in scientific journals to term professional and paid care providers as, and the informal, spouse, filial or family care providers as *carers*. A way to understand this distinction is that the family carer *cares* and is confronted with the carer role from a private perspective, whereas the professional care provider is in a situation of *giving* care as defined in a formal contract. A caregiver, who only *gives* the expected services, is in risk of not *taking* care. Thus, a reciprocal dimension exists in the ethics of caregiving (Holm, 2001; Nortvedt, 2001) which further puts a demand on the training of caregivers in a way where the teacher is a “facilitator of knowledge co-creation” (Dinkins & Cangelosi, 2019, p. 6).

Methods

This explorative study was part of an ongoing four-year study: Person-Attuned Musical Interaction in Dementia Care funded by the Velux Foundations, Denmark (PAMI, 2019). The research group consisted of four music therapists with long experience of working in dementia care who in a joint research project focussed on person-attuned musical interaction as an overarching theme.

We applied a hermeneutic constructivist approach, embracing knowledge creation at an ideographic level (Peck & Mummery, 2018). According to Peck and Mummery (2018) hermeneutic constructivism concerns “providing a nuanced and more idiographic understanding and representation of human being for qualitative research.” (p. 392). Peck and Mummery distinguish between expressive and designative theories of language. For expressive theories language is a medium through which human experience transpires and allows a view of the world to be made manifest (p. 390). In contrast, for designative theories of language words are considered meaningful as a function and are an instrument of thought. This understanding entails that thought must occur prior to language itself (p. 390). The view of hermeneutic constructivism is that language is the medium through which the world comes to understanding and that the notion of meaning represents “what it is that goes on in *making something of* the world” (395). Meaning is explained as a dialogical iterative movement of seeking understanding, and understanding is a fundamental component of being which again is conditioned by meaning.

We used Lego Serious Play™ (LSP) as a method for exploring, articulating, and conceptualising how we understood caregiver interactions. LEGO® is in fact small building bricks for children to play with, however, the LSP was launched as a strategic planning tool for business settings with the overall idea to create an innovative and experiential process for organisations. The aim was to deepen reflection processes and support effective dialogues (LEGO, 2019). The LSP has been further developed for play therapy supervision (Peabody, 2015) and for engaging doctoral students creatively in emotion work and hereby providing them with reflective tools to enhance wellbeing and resilience (Brown & Collins, 2018). The process of creative and playful exploration facilitates conceptualisation and externalisation, and makes it possible to dive into implicit knowledge, intuitive and non-verbal acts, and cultural practices. Using LSP as a hermeneutic constructivist approach to research enabled us to foster creative thinking and reflection by hands-on construction and the use of symbolisation, and hereby to explore our experiences at a deeper level of abstraction.

Triangulation implies measures, researchers take to assure that the findings are credible and valid (Farmer et al. 2006; Lincoln & Guba, 1985). Triangulation methods were used by including multiple investigators at different stages of the process, and by allowing their critical reflection as a necessary way of learning about and integrating different perspectives in the process of collecting and analysing data and in the discussion of findings.

The study was registered at The Danish Data Protection Agency through Aalborg University and followed The Danish Code of Conduct for Research Integrity. Ethics exemption was granted from the regional ethics committee for Nordjylland.

The study consisted of four phases: 1) Data collection, 2) Data extraction, 3) Data analysis and synthesis, and 4) Triangulation and dissemination.

1. Data collection

The LSP was applied as a data collection method where a panel of six people took part. The panellists were the four music therapists forming the research group and two invited nurses and researchers; one with long experience and expertise knowledge in person-centred dementia care, and one with expertise in aesthetic and creative learning processes and also an LSP-instructor. Prior to this, the research group had met over a period of time on eight one-day research seminars and a four days' research retreat. During these research seminars the group had from various perspectives discussed person-centered dementia care and the interplay between caregiver and music therapy competencies. Thus, initial ideas and concepts were beginning to be defined and iterated, which were then explored and conceptualised using LSP.

The research group formulated a working definition which Peck and Mummery (2018) would describe as a prejudice and is regarded "a temporal and yet essential precondition of understanding that represents the initial position from which an understanding originates" (p. 394). For the working definition, attunement was placed as a core concept within a person-centred approach and with a reciprocal dimension of interactive performance. The group synthesized this to interactions attuned to persons with dementia and used the concept *person-attuned interaction* as a working title. LSP facilitator (Dr Julie B. Jensen) guided the panellists into a creative playing mode with a series of simple and engaging exercises and exemplified the basic rules for how to work exploratively together as a group and how to construct and co-create. Next, the panellists dived into exploring person-attuned interaction in dementia care individually and then to build the individual constructs together. The final and merged Lego construct was then presented to and discussed with an expert group of three senior researchers (I.N. Pedersen, C. Lindvang, and S. Storm) with expertise in facilitating therapeutic learning processes.

2: Data extraction

A summary (364 words, including six pictures) of the key findings from the LSP process was carried out by the second author, based on the immediate notes written by each participant, including those by the LSP instructor and the expert group when the merged construct was presented. Audio data consisted of five recordings of three hours. In the transcription process, the precise wording and formulation was captured, but with repeated words and sentences omitted. The final transcription was 36 pages (16,714 words) with the verbal dialogues about the Lego constructs including nine pictures. The first author carried out a pre-analysis, and the findings were discussed and then presented by the research group at a national conference on dementia, and at a music therapy world congress. For these presentations, focus was on the caregivers' interactions, responsibilities, relational competencies, and structural requirements. The on-site or mail feedback was afterwards discussed in the research group and integrated as new understandings in the hermeneutic process.

3: Data analysis

An in-depth analysis of the transcripts was now carried out by the first author using the Nvivo-12 software to structure the process and carried out through the lens of the preceding process. Nvivo is a multipurpose tool that allows qualitative researchers to handle a multitude of textual and audio-visual material in numerous ways (Mortelmans, 2019). The aim of the analysis was to meaningfully understand person-attuned interaction from the LSP and to conceptualise how caregivers carry out person-attuned interactions; what these interactions consists of; and what fosters them to happen. The analysis was an attempt to conceptualise the exploration and articulation of the panellists, carried out through the following six steps:

1. Inductive coding of transcript
2. Inductive coding including code-by-list
3. Reading codes and the related text parts to further organise codes, sub-codes and relationships
4. Creating structure by ordering codes chronologically
5. Using the *Coding Summary By Code Report* to reorganise structure
6. Integrating text parts in order to provide meaningful abstractions

Example of a construction

In the direct process of the LSP, the panellists first constructed and then co-constructed their prejudices and understandings of person-attuned interaction with bricks and various LEGO-products (e.g., windows, flowers, doors, figures, wheels). As part of the analysis, each of the constructs were given a title that reflected the wording used by the panellist when they described the construct. For example, panellist C’s construction was titled “Entering door to mood & arousal ladder” (for picture, see Figure 1). The construction consisted of a blue baseplate with an open door: “Person A has entered the room and stands in front of person B with a face in each hand. Person B is orange and sits on a ladder. At the side there is a mirror and a bush.” (Transcript, p. 1). The panellists explained their constructions after which the other participants commented or asked questions. As an example, panellist C explained:

> “There is a door here, because you go through a door into somewhere, where someone is sitting. So this (B) is the resident, for example, and this (A) is the caregiver. The caregiver enters the door into the room of the person, and then the

> task of the visitor (caregiver) is to attune themself to the person in the room. This comprises two things. First of all, the person in there has a face; he has an expression on his face, and the caregiver needs to pick a face that resonates or is kind of the same. So, he needs to attune his expression to the being of the person. So that is why there are several faces to choose between. And secondly, the caregiver also needs to adjust to the emotional arousal ladder of wherever the person is. He needs to adjust himself. Person-attunement is about being able to adjust yourself to the other". (Transcript, p. 1)

Figure 1. Example of LEGO-construction explaining person attuned interaction

Data synthesis

The transcript was clustered into units consisting of one to 27 sentences and hereafter integrated into meaningful abstractions. In this interpretation process, we intended to carefully respect the individual understandings although articulated metaphorically as illustrated with the following examples:

- "You also have to steer" (p. 14):
  "be able to lead"
- "You have to find the keys to the person" (p. 14):
  "be curious"

- "This is like grass or something, you need kind of safe ground to be able to do that" (p. 17):
  "be grounded" and *"create a safe and protective space for oneself"*
- "And about attunement, I think it is very necessary to – when you open the door as C was talking about, that you are very aware of how you are going into, and how you are meeting the person with dementia and are going into relation together with the person. And if you have to do that in a really good way, so the person can flourish …" (p. 4):
  "Enter the space of the person with dementia" and *"Attuning to the person is how personhood is enhanced".*

Gradually, a meaningful structure of categories and sub-categories emerged after being repeatedly adjusted and restructured.

4: Triangulation and dissemination

Throughout the process, the research group critically discussed the meaning and relevance of the concepts that emerged. As a group, we felt that we agreed about what we wanted to convey, but that we did not necessarily agree on how to explicate our understandings. All were experienced clinicians, presenters and/or teachers and regularly discussed video clips, clinical papers, or our own research in progress. At each stage of the study, preliminary findings were presented to clinicians and researchers specialising in person-centred care to ensure the rigour of the data analysis and synthesis. It was an important part of the triangulation process that the research group took part in seminars and conferences, presenting the research in progress. In preparing presentations and in the discussions with audiences, we developed our understanding by learning from the perspectives that we met. Especially the critical opinions gave us a push to be clearer about our ontological standpoint and theoretical background. This was an on-going reflective exploration and reality-check aiming to deal with the particularly high-level abstraction that, following a hermeneutic constructive approach, is the very condition of understanding. Further, publishing and sharing ideas, concepts, and approaches with a broader audience allowed for dialogical encounters in an effort to achieve a closer appreciation of our experiences – in alignment with a hermeneutic constructivist position according to Peck and Mummery (2018).

Findings

The coding process and the subsequent abstraction and synthesis led to five categories and their subcategories. These are presented in Table 1. The categories suggest the research group's understanding of person-attuned interaction in dementia care and which elements that are understood as vital for person-attuned interactions to take place. In the following, each category is presented in its summarised form as it emerged from the interpretation process.

Table 1. Categories and subcategories of person-attuned interaction in dementia care

1. Resources and caregiver competencies		
2. Culture and interdisciplinary collaboration		
3. Personhood and reciprocity	3.1. The person with dementia attunes to the caregiver	
	3.2. The caregiver's task: to attune to the person	
4. Caregiver interactions	4.1. Entering the space of the person	4.1a. Observing and listening to the person
		4.1b. Observing oneself/introspection
	4.2. Assuring warmth and safety	
	4.3. Attunement	4.3a. Attuning to arousal level
		4.3b. Attuning to functional level
		4.3c. Attuning according to the person's preferences
		4.3d. Attuning to mood and emotions
		4.3e. Making room for breaks
	4.4 Helping the person attune to inner resources	
5. Manualising Person-attuned Interactions		

Category 1. Resources and caregiver competencies

The panellists expressed that relatives and other carers are a great support to the person with dementia, and further, they have important information for the professional caregivers for them to understand the person with dementia and their background, life story, interests, resources, preferences, and reactions. When it comes to carrying out positive person work with persons with moderate/severe dementia, caregivers must possess many qualities. Among these are patience, creativity, ability to listen, and to observe. Further, caregivers are in a position where they need to be able to cope with stress, to create a safe and protective space for themselves and for others, use qualifications and competencies to establish positive interactions, break isolation, and make use of professional judgement. They must be willing to seek knowledge, learn new skills and techniques, and learn how to develop competencies. In summary, caregivers are expected to be personally stable, reflective, and resourceful, and to possess a high degree of interpersonal competencies in order to carry out positive person work with persons with moderate/severe dementia.

Category 2. Culture and interdisciplinary collaboration

According to the panellists, dementia care happens within complex systems with fragile cultures that on the paper follow principles for person-centred care, but that sometimes does not emphasise personhood, positive person work, or the VIPS definition (Brooker & Latham, 2006. See also the introduction of this article). The professional team forms the culture of care, but it is also formed by the management, leadership, and how group dynamic processes are promoted between professionals. The culture is under pressure from health services with under-resourced staff, time pressure, demands for efficiency and SMART goals, and is lacking opportunities to exchange experiences and learn from each other. The culture of care forms the daily structures and the structure of the working place. This influences how caregivers attune to the person with dementia, and how the professionals attune to each other. Good collaboration depends on each caregiver to be attuned to themselves, their life situation, their position, and their practice. In a good-enough culture of care, the team works together in a flexible and creative way, reflect on and learn from processes where they succeeded or failed, and are open to new ideas, results, and methods and to learn from these. The team will benefit from including various professions as each profession brings in new perspectives. Attunement processes are important for caregiving, but in a different way as in a music- or psychotherapy treatment settings. However, the music- or psychotherapists may contribute with perspectives about how to include sensing, feeling, and thinking in musical, art-based, and bodily interactions and how to shift between these modalities. This underlines the importance of collaboration, knowledge-sharing, and/or situated learning.

The panellists described that there are caregivers with profound knowledge and experience, which is essential to acknowledge and integrate. In addition, they explained that caregivers are not only under pressure as part of the working conditions. They are also under pressure if the persons, they work with, are suffering, depressed, tense, stressed or aggressive. It is not the responsibility of the individual caregiver alone to find ways to deal with this pressure from working with a population who is highly challenged; this must be dealt with in the culture of care and in society. The demand on caregivers to collaborate, exchange, learn and reflect in their team, and to understand attunement as a tool for interaction, can for some be experienced as yet another (impossible) demand and further pressure.

Category 3. Personhood and reciprocity

The panellists described how personhood involves experiences of self-identity and connecting with *inner resources* manifested through values such as family, work, spirituality, memorable moments in life, hopes, and dreams. With dementia, the person may have difficulties with being connected to these values and may feel detached and disconnected. Such disconnection may lead to depression or aggression. Relatives and music therapists can assist in informing about such inner resources of the person with dementia, so the entire culture of care is considering these perspectives of the persons with dementia. It is a co-creative process to value the person and see the world from their perspective; each time you meet the person, the situation is created anew and must therefore happen through reciprocity. Reciprocal processes involve relationship-building and attunement to each other.

3.1. The person attunes to the caregiver

The panellists expressed that in daily life, we are usually unaware of how we attune to other people, and that we for example unconsciously attune our tempo to the way another person walks and talks. Following this, they found that the person with dementia may attune to the caregiver, but maybe with delayed response. Caregivers are often not conscious of how the person with dementia attunes to them. Therefore, there is a need to pay more attention to such reciprocal attunement and integrate this knowledge in the professional work. If caregivers are supported to acknowledge reciprocal attunement more frequently, this will help increase self-awareness of the person with dementia and strengthen their sense of self.

3.2. The caregiver's task; to attune to the person with dementia

The panellists agreed that person-centeredness is professional, and that it therefore is the responsibility of the caregiver to observe and pick up cues from the person with dementia, and, based on these, attune to the person. Attunement happens through many small acts, and, importantly, in a reciprocal process that may be more mutually equal than we are aware of. The small acts are about how you lower the volume of your voice, a change in facial expression, or the pace of movements. When the caregiver intends to attune to the person, the first step is to attune to oneself and to be aware of one's own role in the attuning process. It is a role where the caregiver is subjectively involved. The caregiver needs tools to carry out attunement and to repair broken attunement processes. The tools are not something external, but actions that the caregiver already uses (e.g., expressed through voice and body). Such tools need a language for the caregiver to be able to share observations and reflections and to evaluate care practices. Attuning to the person with dementia is how personhood is enhanced.

Category 4. Caregiver interactions

Caregiver interactions are, according to the panellists, expressed through different musical parameters; tune, timbre, tempo, dynamics, and volume, and in a somewhat chronological order as presented in the following.

4.1. Entering the space of the person with dementia

The caregiver must be aware of *the space* of the person with dementia and be conscious about how they enter this space, meets, and relates to the person.

4.1a. Observing and listening to the person

Before interacting, the caregiver observes the person with dementia and picks up cues about mood and arousal by observing position, expression, muscle tonus, what the person expresses or says, how this is said, and if in a tensed or relaxed manner. The caregiver also observes the responses and arousal level of the person and how the person attunes to the caregiver. For persons with severe dementia, the cues could be subtle and only visible to the trained eye. The caregiver may get important information about the person from *listening* not only with the ears, but also with the body, emotions, and senses. In addition, the caregiver needs to observe and listen to the environment and be aware of stressors that affect the person with dementia. Sometimes we see and hear with our expectations and pre-understandings, which could lead to a wrong picture of a situation. To avoid this, a high degree of reflectivity is necessary, as well as the ability to step back and to see things from other perspectives, putting aside one’s own agenda, and act according to the overall goals.

4.1b. Observing oneself/introspection

Before interacting with the person with dementia, the caregiver may get important information about a situation by introspection; by observing one’s own appearance, emotions, sensations, arousal level, and reactions. This information may help figure out how to adjust and act. Such subjective observation represents another modality, which may be particularly important when observing little responsive persons. How much one’s own reactions has to do with the person with dementia is an interpretation, and therefore needs careful consideration to avoid over-interpretations. In order to be transparent about the observations and the choices based on these, a vocabulary is needed to describe the introspection, including help to reveal implicit knowledge, and with a culture where this information is shared and integrated.

4.2. Assuring warmth and safety

The panellists expressed that feeling safe and warm (relaxed, comfortable, at ease) is essential for living and brings motivation and life. Safety allows for resources and competencies to come to the front for the person with dementia.

4.3. Attunement

4.3a. Attuning to arousal level

The arousal level of the person with dementia fluctuates naturally, but with too high levels as an indicator of stress and too low as an indicator of freeze reactions or burnout. The caregiver needs to adjust to the level of arousal of the person and may for example lower arousal by regulating with tone of voice, facial expression, and pace.

4.3b. Attuning to functional level

For collaboration to happen, the panellists found it necessary to attune to the resources of the person with dementia, to the person's way of thinking and acting, and to cognitive disorders. If the person has limited cognitive functions, it is necessary to adjust in order not to overwhelm the person. In contrast, if the person still has preserved cognitive functions, they need to be challenged and stimulated to the right level.

4.3c. Attuning according to the person's preferences

For the person with dementia to feel acknowledged, it is important to take the person's preferences into account and adjust to these, for example to be aware of the habitual way of reacting to touch, music, or other sensory stimulation.

4.3d. Attuning to mood and emotions

The person with dementia may communicate with emotional expressions instead of verbal language, therefore the caregiver must attune to the mood and emotional state of the person, resonate with this, and adjust own expressions to the person.

4.3e. Making room for breaks

The panellists expressed that dementia often leads to a lowered stress threshold, and the person with dementia could need a break to withdraw to avoid being overloaded. Also, for the caregiver, continuously being attuned is not possible, and there is a need for time for self-contact, pausing, and taking a deep breath. Steadily attuning to others and being aware of when to tune in and when to tune out is a life-long learning process. If tuning-in is applied professionally, there must be measures for tuning-out as well.

4.4. Helping the person to attune to inner resources

With dementia, it might be difficult to connect to inner resources; resources that normally entail growth, warmth, richness, flourishing, and spirituality. According to the panellists, the caregiver can step in and help building a bridge to these resources. The person with dementia is still a person, and to be attuned to the self and inner resources is empowering. The aim for the caregiver is to attune to oneself and to the person with dementia, and then to facilitate the person’s attunement to inner resources, to time and space, and to others.

Category 5. Manualising person-attuned interactions

The complexity of person-attuned caregiver interactions is linked to implicit micro-processes of mutual engagement. Attuned interactions have an ideographic quality that are incompatible with generalized guidelines. However, the panellists suggested that there is a need to learn and develop the how-to of caregiving, and therefore, for ways of manualising elements of person-centred care. In this process, it is important to acknowledge existing resources of caregivers and to develop and expand from their reality as a starting point. With the suggestion of attempting to manualise elements of person-centred care, the panellists found it important that the complexity of real-life interactions are integrated, that they are kept realistic, and consider the personal, physical, and practical limits of all involved. They also stated the importance of providing perspectives that are innovative and go beyond perceived limits. They formulated that the outcome of a manual on person-attuned interactions should not be a fixed set of tools but present a way to guide daily care interactions flexibly and creatively.

Discussion

In this hermeneutic constructivist study, four phases (data collection, extraction, analysis, and triangulation) provided knowledge of how to understand the background, mechanisms, and practices of person-centred care following the VIPS-principles. The data collection process using the Lego Serious Play™ (LSP) allowed for a metaphorical way of working with symbols and forms in the exploration of the panellists' understandings. Based on the analysis, we suggest a condensed model of person-attuned interactions in dementia care, including elements that are vital for them to take place. The model provides an understanding of the complexity of person-attuned interactions and consists of the following five categories: 1) Resources and caregiver competencies, 2) Culture and interdisciplinary collaboration, 3) Personhood and reciprocity, 4) Caregiver interactions, and 5) Manualising person-attuned interactions. The caregiver plays an essential role by providing a feeling of safety and by attuning to arousal and to the functional and emotional level of the person with dementia. This happens by means of reciprocal interaction and introspection.

The goal of the study was to explore person-centred caregiver interactions and the essential components of positive person work between caregiver and person with moderate/severe dementia. However, in the process it became important for the panellists not only to describe the interactions between caregiver and person with dementia, but also caregiver competencies and responsibilities as well as macro-level aspects of care.

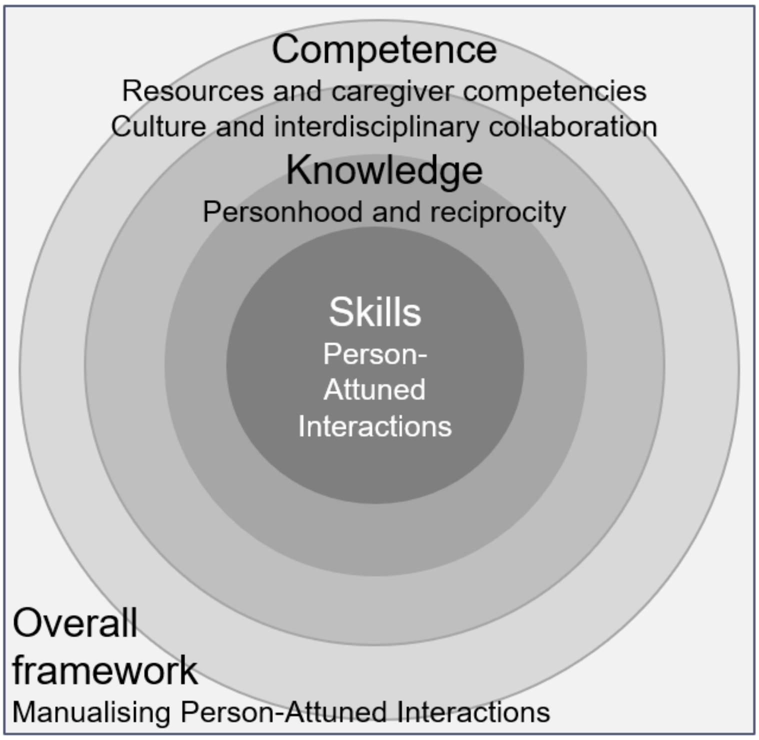
The research group used the term *person-attuned interaction* as a working title but kept coming back to this wording and the term attunement. Peck and Mummey (2018) would describe this as a prejudice, which in their understanding is the condition of our internal qualities of experience (p. 404). In hermeneutic constructivism, prejudices are our inner outlooks and the way we understand the world. By creatively constructing understandings, the panellists expressed their meanings in language and through dialogical encounter came to nuanced understandings of person-attuned interaction. They explored and articulated their understandings of interactions carried out in a person-centred approach and related these to synchronised, reciprocal ways of being. There is only a small number of research studies investigating reciprocal relationships between people with dementia and their caregivers, as shown in the review by Krøier, McDermott & Ridder (2020). However, recommendations that correspond to the panellists' understandings are presented in a literature review by Fazio and colleagues who highlight to: "Build and nurture authentic, caring relationships" (2018, p. 18). Caring relationships are nurtured when the caregiver is present and concentrates on the interaction, rather than on the task. Therefore, caring, supportive, and mutually beneficial relationships are about "doing with" rather than "doing for" (Fazio et al., 2018, p. 18). Such "doing-with"-actions are mostly part of unspoken practices, and as such ways of interacting that are difficult to change, unless they are consciously observed. The process of observing and understanding own actions and interactions is in psychology termed mentalisation which we find relevant to integrate as a perspective on the findings.

Mentalisation is a key concept of human social functioning; it is a reflective function that enables us to read ourselves and other people, and to give a plausible interpretation of own and others' behaviour, believes, and emotions (Fonagy et al., 2002). Caring relationships are developed through mentalisation, but when caring becomes difficult due to specific dementia symptoms, the caregiver must show advanced mentalisation capacity. It is a demanding task to observe tiny and ambiguous cues, carry out introspection, and then further to use this information professionally. The panellists expressed that highly skilled caregivers use their receptiveness, so we suggest that they integrate mentalisation intuitively in their work, but that learning to do so, and even be demanded to do so, could be tiresome and stressful. Caregivers are already under high pressure (Chen et al., 2015) and therefore we agree that aims for training caregivers must be realistic and empowering. With this perspective on the findings, we suggest that the integration of mentalisation as a professional capacity is only possible in a professional and supportive culture of care where each caregiver feels safe in a way that allows personal availability. It is a conclusive question whether the culture of care allows for a subjective and personal engagement from the professional, and how caregivers develop mentalisation capacity in an empowering way. Fine-tuning introspection and strengthening mentalisation is also about how you learn to cope with stress in everyday life. For this, the panellists explained that caregivers must be aware of when to ask for help or take a break, or how to regain balance – which is to take a moment to attune to inner resources. Thus, the model points at the high responsibility caregivers have towards persons with dementia and the need for extensive caregiver competencies and mentalisation capacities. From a macro-level perspective, this puts a strong demand on the need for education, training, and supervision of caregivers so that those who have these competencies are supported in their work, and those who need training, are given this. As person-attuned interactions consist of micro-level interactions and interpersonal processes that mostly happen intuitively, we assume that the training must include other means of learning than theoretical lecturing. Therefore, the need for training curricula should include an account of relevant learning models and be supported and enforced by public policy as described by Thornhill and Conant (2018).

We find it important to stress that reciprocity and emotional attunement is not about imitating or mirroring another person. Imitating an angry face or sound could lead to increased anger and make the person with dementia feel unsafe or attacked. The caregiver must attune to the emotional state of the person and be aware of the way it affects oneself and others, and how to validate the expression without taking over the emotions of the person. To work consciously at a non-verbal level is a “tool” used by psychodynamic therapists and is needed when caring for persons with severe neuropsychiatric symptoms. However, caregivers are seldom trained in such interpersonal competencies. This leaves them to find out themselves how to act, how to bring the person in a balanced emotional state, and how to acknowledge and validate the person’s feelings. Such demands on the caregiver profession are extremely high. The caregivers must be able to mentalise and have access to inner resources. At a societal level, there is a need to question how the system can attract the most competent caregivers for this work, and how they are trained and supported in daily practice. This stresses a focus on the culture of care, working conditions, education, supervision, continuous professional development, and ethics.

Several interventions address the need for dementia caregiver training, for example The Communication Enhancement Model (Ryan et al, 1995), ICDP for dementia (Hundeide et al, 2011), Attuned Pedagogy (Ertmann et al, 2015), and Adaptive Interaction (Ellis & Astell, 2018) (see also Anderson-Ingstrup & Ridder, 2020). These models stress the need for competencies that expand the functional tasks of caregiving and include sensitivity, nonverbal communication, and reciprocal interactions. Neuroaffective approaches integrate an understanding of sense perception and feelings of safety (Porges, 2017) and reciprocal and emotional interaction (Hart & Jacobsen, 2018). Approaches like these may contribute to a future direction for person-centred dementia care where interpersonal competencies are highlighted and supported from a societal and political point of view, not leaving it to each individual caregiver alone to learn skills and develop competencies. For this to happen, we want to highlight that political decision making must support professional development as part of caring cultures, wherefore elements of daily care practice must be described and/or manualised, and learning outcomes defined. The European council on the Qualifications Framework for lifelong learning describes "learning outcomes" as statements of what a learner knows, understands, and is able to do on completion of a learning process, defined in terms of knowledge, skills and competence (Eurospace, 2008). We suggest that the learning outcomes for caregiver training would cover *knowledge* about personhood and reciprocity (category 3, Table 1), *skills* defined as caregiver interactions (category 4), and with *competencies* dependent on resources, culture, and interdisciplinary collaboration (category 1 and 2). Finally, the overall theoretical framework would need to be explicated in detail and included in manuals or guidelines (category 5), which should be tailored to suit the caregivers and be flexible enough to allow for adaptations of the content to fit the heterogenous arena of person-attuned interactions as well as make use of appropriate dissemination elements (Anderson-Ingstrup, 2020; Krøier & Ridder, 2020). These learning outcomes cover all five categories included in table 1 and are summarized in Figure 2.

Figure 2. Summarized learning outcomes for caregiver training



This explorative study is based on, and therefore also limited to, an ideographic and inductive process. Hence, what we have lost in breadth, we have gained in depth. The study has allowed us to dive into the exploration of implicit understandings, tacit knowledge or prejudices that the panellist have integrated through long practice experience in dementia care. The hermeneutic constructivist approach called for an analytical co-creation process where pre-understandings were explored and brought new levels of understanding through iterative dialogical encounters. For future research, we suggest a process where the ideographic co-created in-depth knowledge is expanded to a wider perspective. This should include the voices of caregivers as well as persons with dementia, to allow for consensus at a broader level, and even for a certain level of generalizability by developing and testing training manuals and curricula.

Conclusion

Using a hermeneutic constructivist approach, we explored professional caregiving from a person-centred perspective. Six panellists explored their experiences of person-attuned interaction in dementia care by co-creating Lego-constructs and using these to articulate their understandings in a dialogical process. We analysed what they articulated with the aim to conceptualise their knowledge creation. Based on the analysis, we suggest an understanding of the complexity of dementia caregiving in a condensed model. From this we propose a need for caregiver training that covers knowledge about personhood and reciprocity and trains caregiver interaction skills, and which finally nurtures competencies in a process that is dependent on resources, culture, and interdisciplinary collaboration. We suggest an overall theoretical framework that acknowledge the essential role of caregiving for providing safety, and for attuning to levels of arousal, emotion, and cognition of the person with dementia by means of reciprocal interaction and caregiver introspection. Person-attuned interactions are described as reciprocal, and the competencies necessary for engaging in such interactions may be explained by mentalisation capacity. Our goal was to explore person-centred caregiving, however it turned out to be important not only to describe the interactions between caregiver and person with dementia, but also to describe the values of caregiver competencies and how these are nurtured and developed. This points at the necessity for a political dimension with a macro-level aspect of dementia care and caregiver training.

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The authors declare that there is no conflict of interest with respect to the research, authorship, and/or publication of this article.

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