

Sonas aPc

**Activating the potential for
communication through
multisensory stimulation**

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Quality of life has become a predominant issue in the care of older people in hospitals and homes. Shifts in health care philosophy in the past 50 years have placed the issue firmly in the centre of health care delivery and the development of the health care environment. While previous models of care management focused strongly on the physical, medical and functional dimensions of care, quality of life management also focuses on social and psychological dimensions of well-being. Consequently, maintaining and developing quality of life for older people – their social and psychological functioning – will increasingly shape the agenda in health care delivery in the coming years.

In Ireland, the health care environment is a substantial one. Over 20,000 older people currently reside in long-stay care in Ireland: 5000 in health board hospitals; 1500 in welfare homes; 1500 in district hospitals; 6000 in private nursing homes; 3000 in voluntary nursing homes or hospitals; 3000 in psychiatric care. A large proportion of these residents suffer from dementia, varying from 10 per cent in health board welfare homes, to 20 per cent in health board hospitals, to between 25 per cent and 60 per cent in private and voluntary homes and hospitals. As attitudes to care have changed in recent years, so too has our understanding of caring for those with debilitating illnesses such as the dementias. Contemporary research and writing have focused very strongly on the ‘presences’ rather than the ‘absences’ of those with dementia and other communicative illnesses (Kitwood 1993). In support of this, rehabilitative approaches have been very successful in enabling people who had heretofore not been considered candidates for rehabilitative intervention. Others have shown that the care environment can indeed act to debilitate people, through care practices which prevent development and rehabilitation and which act to further cut off people from resources within themselves, within others and within the environment (Connors 1997). In particular, care staff play a key role in determining whether or not the environment is enabling or disabling. Recent research has shown that staff who are trained in person-centred dementia care choose more person-centred strategies, and fewer disease-focused strategies when dealing with

patients with dementia (Lintern and Woods 2000). Through training, staff in that study became more aware of patients' needs for independence, occupation, understanding and self-worth, improving the quality of care they were able to deliver to patients in the programme.

A second important implication of quality of life and psychosocial interventions is their consequences from a care management perspective. Many behavioural problems, such as emotional instability, resistance to care and physical and verbal attacks, arise from sensory deprivation, unskilful caregiver-patient interactions, and patient anxiety, fear and loneliness (Leverett 1991). Fogel (1994) has identified two important patient-related factors producing problem behaviours which are amenable to modification through intervention (a) the patient's perception of the current situation; (b) alternative outlets for self-expression. Given this evidence, it is apparent that quality of life and psychosocial interventions can help reduce behavioural problems by increasing enjoyable contact between patients and staff, increasing sensory stimulation, reducing patient anxiety and loneliness; providing opportunities for the patients to express and enjoy themselves; and by facilitating social interaction and group activities.

A third area in which quality of life and psychosocial interventions can have an important effect is communication. Communication is essential to healthy cognitive, emotional and social functioning, and this is particularly true in the case of dementia where changes in communicative abilities and challenging behaviours cut people off from others and from their own identity. It is probably best to consider communication and relationship as sides of the same coin. Improved communication helps to build relationship with others and maintain relationship with self, and a better image of self and others improves communication. Given the impact of communication and relationship on quality of life, it is not surprising that each of the interventions discussed focuses in some way on these factors.

Interventions to improve the quality of life of older people in residential care focus on social and psychological functioning and on identifying and reducing disability introduced by the care environment. Such strategies include:

- minimizing medication
- maintaining self-esteem
- developing meaningful activities
- enhancing activities of daily living
- introducing specific interventions (Lubinski 1995).

Unifocal interventions have been used to improve both verbal and non-verbal communication skills including: Problem-solving for Behavioural Management (Gallagher-Thompson 1994); Sensory Stimulation and Exercise

(Rader 1987); Ways of Coping (Morris *et al.* 1992). It is noteworthy that the target factor common to all of these management approaches is communication capacity, and that all of these interventions recognize its primacy. Unifocal interventions such as work therapy, communication training, music therapy, reminiscence work and reality orientation also appear to have significant positive effects on patient functioning and quality of life (Penhale *et al.* 1998). However, multisensory interventions, such as Sonas aPc, entail the best of these elements.

The basis of this approach is epitomized by Lubinski:

Communication becomes the crucial difference between isolation and social connectedness, between dependence and independence and between withdrawal and fulfilment.

(Lubinski 1981: 339)

Like many interventions, the activities involved in Sonas provide opportunities for the caregiver and the person with dementia to enjoy positive experiences together which are inherently relationship building. However, this programme goes further, aiming to activate the potential for communication. The intervention is particularly beneficial as it taps into the important psychological domains of self-esteem and agency (through task completion and acting on the environment), increasing interpersonal and social contact, providing practice through memory exercises, and achieving this in a non-threatening way. Sonas is designed to meet the needs of older people with dementia (including Alzheimer's, Parkinson's disease and stroke). This approach has been adapted to create a second programme called Anam, which is specific to older people with intellectual disabilities.

Sensory stimulation

The theory behind the use of sensory stimulation incorporates aspects of meeting needs (Ellis and Thorn 2000), avoiding sensory deprivation (Hilgarde *et al.* 1979), the possibility that stimulation can produce actual change in the brain (Ellis and Thorn 2000), and the contribution of unstimulating environments to the dementing process (Bower 1967). In the latter study the author suggests that both organic and psychogenic factors are involved in the advance of dementia – an idea that resonates with more recent work (Kitwood 1990). Benefits of sensory stimulation activities resulting in improvement in activities of daily living; memory function; cognitive ability; verbalization; socialization; decreased depression and medication have been noted (Witucki and Twibell 1997), although these authors recognize that it is not easy to separate responses to sensory stimulation from responses to human interaction.

Although there are differing views surrounding the amount and delivery of sensory stimulation (Ellis and Thorn 2000), and the need for sensory regulation to ensure maintenance of vigilance and to rule out habituation (Wood 1991), there is a growing body of literature that indicates its positive effects (Kovach 2000). Work over the past few years has taken an important step in looking at how stimulation can be taken out of the 'white room' situation into more accessible locations (McNamara and Kempenaar 1998; Wareing 2000; MacDonald 2002).

Memory impairment is a major feature of dementia, and it is suggested that increasing awareness through attention to the senses in the situation where memories are laid down may help later recall in the same situation (Killick and Allan 2001). These authors also suggest a link between emotion and memory in that emotional disturbance such as anxiety or depression may affect encoding and retrieval.

Background to Sonas aPc

The word Sonas is Irish and means well-being, joy or happiness and the initials aPc stand for 'activating potential for communication'. It is therefore not a system that sets out to cure the communication problems experienced in dementia, but rather to assist people to realize whatever potential they have. Sonas is a needs-led approach arising from the observed need for interaction between older people and their environment – the environment consisting of both physical surroundings and people. It was the paucity of interaction that made Sister Mary Threadgold, a speech and language therapist and Sister of Charity, aware of the need for some kind of intervention that would engage people in long-stay facilities, many of whom had dementia, in such a way that it would promote interaction.

It is not possible to interact with our fellow human beings unless we communicate with them, even if our communication is not of the verbal kind. Indeed, a large proportion of natural human communication takes place through non-verbal channels including facial expression, body language, gesture and tone of voice or vocalization. As well as lack of communication in many of the residential facilities Sr Mary visited, there was also lack of stimulation in the environment. She felt that the non-verbal communication she observed appeared to communicate sadness and dejection. Sr Mary had worked for a number of years with people who had profound intellectual disability, and had found that the use of music and touch provided a successful means of interacting with them and tapping their resources. Recognizing the link of cognitive impairment between dementia and intellectual disability, she considered that a similar approach might help people with dementia to realize their communicative potential, and she devised a method of multi-sensory stimulation aimed at activating whatever potential for communication is retained.

Ideology

The idea behind this method was that an environment would be created within a group session that would provide both sensory stimulation and communicative partners. The structured format of the group session comprises the following:

- a signature tune
- opening and closing songs
- relaxing and dance music
- exercises
- opportunity for use of percussion instruments
- stimulation of the senses of smell, taste and touch
- proverbs and poetry
- time for participants who chose to make a contribution of their own.

Each section of the session has a special significance. The role of the signature tune is to alert people through a musical trigger of memory. The opening and closing songs address each person by name, emphasizing individuality, and greeting is made through eye contact and handshake. The purpose of the singalongs is to trigger memory and to facilitate expression through singing. The exercise component of the session gives opportunity to take part in gentle exercise to instruction and demonstration. The association of words and actions in this section assists in promoting understanding. It is thought that interactive exercise promotes awareness of others (Dinan 1998), and this will accentuate the social and communicative environment that the group session provides.

Touch is introduced through gentle massage on the shoulders and back, accompanied by relaxing music, and there is opportunity for further expression through dancing or the use of percussion instruments. Group members are given a chance to complete proverbs, which are well learned early in life, often repeated and well laid down in memory. It is suggested that well-learned material can be drawn from what has been accumulated over the years without necessarily having to relearn (Woods 1992). Poetry is incorporated in the session and this can be listened to or joined in with, according to the preference and ability of the participants. During the session the senses of taste and smell are also stimulated.

Repetition of the same structure is a strong point of the Sonas approach and this is facilitated by the fact that the programme is packaged on audiotape/CD along with an instruction manual. This does not mean, however, that variety cannot be introduced. There are points in the programme where different stimuli can be introduced, and this allows practitioners to use their skills and judgement as facilitators, and to respond to the needs and abilities of the members of the group. The packaging of the approach has two further advantages:

- 1 It assists carers in their interactions – the programme guides them and they are then able to focus fully on their clients.
- 2 The taped format also means that the clients will receive the same input regardless of who is delivering the session. This adds to continuity for older people in a culture where staff changes may be frequent.

The Sonas group session has been described above and it is the main thrust of the approach. It is, however, acknowledged that a group is not necessarily appropriate for every individual. This may be because of the individual's preference. Some people do not function well in a group or the behaviour of someone may detract from the experience of others. With this in mind, Sonas aPc also offers an individual session based on music and touch. This is carried out on a one-to-one basis by a facilitator, again following a set format with certain pieces of music being associated with gentle massage on the shoulders, back, hands and head. The aim of this session is also to activate the potential for communication, but it does this in a different way. The session is designed to promote relaxation and calmness, to communicate through music and touch, and to provide a communicative partner who will respond to any spontaneous communication that comes from the older person.

Communication is at the centre of Sonas and the reason for using sensory stimulation in its aim to activate communicative potential is that there is a very definite link between the senses and communication: 'If the loop of communication has any beginning, it starts with our senses' (O'Connor and Seymour 1990). A brief consideration of how a sensory experience can lead to communication will help to clarify this.

Using the visual sense as an example, the experience of seeing trees covered with yellow, gold and red leaves will communicate the season of the year. This immediate level of communication can be taken a step further with memories being triggered by the association between sensory stimulation and what it represents. The strength of long-term memory may then be a source of support for communication. This sense also brings a wealth of information through the observation of facial expression, body language and gesture.

Looking at the other senses in turn it is possible to see how each can make its own contribution to the communication process. Hearing has its obvious function of receiving verbal communication – the words and sentences that we use. It also picks up the vocal tone that is a hugely important part of any verbal message, and a part that is often heavily relied on by people who may no longer be able to interpret the meaning of the words they hear. As well as the interpersonal aspects of communication that are received through the sense of hearing, there are environmental sounds that convey information, for example, passing traffic, domestic duties being carried out or weather conditions.

The olfactory sense may receive the smell of cut grass and this will communicate that somewhere in close proximity a lawn is being mowed. The familiarity of a perfume may indicate someone's presence, or the smell of food preparation may indicate an imminent meal. The sense of taste can tell the nature of what is being eaten, whether it is liked or disliked and if it is fresh or stale. Touch can be thought of in two ways, tactile and interpersonal. The tactile way brings information about texture, temperature, shape and humidity, and the interpersonal way can inform of the intent behind the touch. Through the way in which touch is used, infants know whether or not they are cared for (Montagu 1978). There is no reason to assume that this is only the case with infants and that it does not also apply to adults and older people.

It is known that the natural ageing process has an effect on the senses, and in the older population there can be specific sensory loss. Where this is the case, stimulation of all the senses can help to compensate. It is easy, for example, to imagine that people who have visual loss will rely more heavily on their sense of hearing for information regarding their surroundings. There is also the suggestion that the olfactory sense is diminished in Alzheimer's disease (Vance 1999). This fact is recognized by the multisensory approach of Sonas. Music is extensively used throughout the session, not just because it acts as an auditory stimulus, but also because it is seen to have wider benefits. Music is thought to have effects which calm people, diminish wandering, help to access memories and improve self-esteem and social cohesion (Pickles 1997).

Whilst the main aim of Sonas aPc is to activate potential for communication, it also aims to train and support carers in the use of this approach, to encourage a communicative environment and to have stimulation of communication seen as an essential part of care planning. Sonas is an approach devised in response to the need to address communication difficulty, an approach that uses creativity, imagination and experience. The philosophy on which it is based recognizes unmet communication need; the right to realize potential; the importance of preventing social isolation, promoting integration, quality of life and personal dignity.

Sonas aPc Training

The whole Sonas approach, whether group or individual, is delivered by trained practitioners. These practitioners do not need to have a professional qualification but rather are people who possess certain personal qualities. Desirable qualities are sensitivity to older people, energy, enthusiasm, openness to the broader aspects of communication and sincerity in their interactions with people. The training itself is given at a two-day workshop over a period of six weeks and focuses on communication and how it can change under certain circumstances (e.g. in dementia), the influence that the

environment can have on communication and how to implement the Sonas approach. Sonas and Anam training workshops are delivered by a panel of tutors who have themselves undergone an intensive four-day training course and carried out supervised workshops.

Sonas aPc is a not-for-profit organization which has charitable status and receives funding from the Irish government on an annual basis. Approximately 5000 people in Ireland, USA, UK, Channel Islands and Australia have been trained in the Sonas approach, with the result that many thousands of older people are currently receiving its benefits.

Some of the benefits reported by staff who use the system are:

- increased interaction
- improved concentration
- emotional interchange
- reminiscing
- increased awareness among staff of abilities rather than disabilities
- catharsis
- lightened atmosphere.

Since its inception in 1990, Sonas has received many reports from people who use it as to its effectiveness, but as with any intervention this needs to be supported by evidence.

Qualitative evidence for the efficacy of Sonas

The credibility of any intervention lies partly in a theoretical base and partly in empirical evidence of its efficacy. In 1996 a study was carried out by Linehan and Birkbeck and this unpublished work suggested that the Sonas method was indeed effective in increasing the levels of purposeful activity, social interaction and verbal communication. There was also an associated improvement in spatial orientation, independent functioning and use of initiative over the study period, together with a reduction in the occurrence of inappropriate behaviour. The improvements in behaviour noted during the session were observed to carry over into the post-session period.

In 1998, Sonas aPc entered into a pilot project with four residential units of care, training members of staff who then provided 20 Sonas group sessions bi-weekly for some of their residents (Harmill 1998). This was a fact-finding exercise to see how the approach was being used in the units and to gauge its benefits for residents, staff and relatives. The result of this was a considerable amount of positive feedback and a lot of anecdotal evidence suggesting that Sonas had indeed been of benefit. There were comments from staff such as: 'Sonas I have found to be of immense value in observing levels of communication' and 'During the time of Sonas there were noticeable positive improvements in the residents' communication skills and a

general increase in their self-confidence.' Relatives' comments such as 'Shows some signs of taking initiative in conversation and in asking the odd question' and 'He grips cardigan buttons to indicate that he doesn't want to go to bed. See a huge change in him - he is much more bubbly now' indicated that they had seen some positive change.

The following is a description which highlights the change that occurred in one person who took part in the study and the new information gained by members of staff. A brief profile of the lady supplied by staff stated: 'Likes company, seeks attention, likes radio/TV, no verbal communication.'

Reports from the Sonas session facilitators stated: 'Some words' after session one; 'Words used appropriately' after session four; 'Responds well to proverbs' after session eleven. The intervention of Sonas was able to bring to light that someone who had previously been thought to have no verbal communication was, in fact, able to use speech appropriately.

Quantitative evidence for the efficacy of Sonas

Following this pilot study a research protocol was developed to determine the benefits of Sonas using objective measures, operationalizing the aim of Sonas (to activate the potential for communication) in terms of standardized measures of cognitive functioning, mood, behaviour disturbance, communication and physical self-maintenance. Two studies, known as Model Unit Projects 1 and 2, were carried out using this protocol. In each study, staff from participating units (hospitals/nursing homes) were trained in the delivery of Sonas, and patients with dementia who had the functional capacity to complete cognitive and other assessments were selected to participate. In the first study, Model Unit Project 1, the initial cohort consisted of 32 residents, 24 who would receive Sonas and 8 others acting as a control group (at the time of the first analysis there were 18 remaining in the experimental group). In the second study, Model Unit Project 2, 64 residents took part. In the first phase, 48 received Sonas and 16 acted as a control group, while in the second phase all of the residents remaining in the study (the experimental group and the former control group) received Sonas. In both studies, experimental and control groups were matched by gender, age and cognitive functioning after initial assessment. Details were also recorded of main diagnosis; time since diagnosis; time since admission; coexisting conditions; time since last medical examination; and psychoactive medication. The outcome measures used were as follows: cognition (Mini Mental State Examination; Folstein *et al.* 1975); mood (Geriatric Depression Rating Scale; Sheik and Yesavage 1986); behaviour disturbance (Baumgarten Dementia Rating Scale; Baumgarten *et al.* 1990); disturbance in activities of daily living (Blessed-Roth Scale; Roth *et al.* 1988); communication disturbance (Holden 5-point Scale). After initial assessments were complete, residents assigned to the experimental condition participated in Sonas sessions on a bi-weekly basis. Control groups

Table 6.1 Model Unit Project 1 sample characteristics at Time 2

Gender	Experimental group			Control group		
	12 Women	6 Men	5 Women	8 Dementia	3 Men	
Diagnosis	13 Dementia	5 Parkinson's				
Age	Mean 78.86	SD 7.01	Range 60-94	Mean 81.25	SD 6.2	Range 64-90

were brought together for the same duration and with the same frequency for an informal chat but no other activities were introduced. The findings of the two studies are now described.

Model Unit Project 1

The sample for Model Unit Project 1 as analysed at Time 2 is described in Table 6.1, and indicates a proportionate balance between experimental and control groups on key variables such as gender, diagnosis and age.

The analysis indicated that those who had received Sonas had improved cognitive scores, reduced depression scores, reduced ADL disturbance scores and reduced communication disturbance scores compared to baseline. There was no significant change in the functioning of the control group on any of these variables except mood: the control group also had reduced depression scores (see Table 6.2). While the observed changes in functioning in the experimental group could be attributed to the intervention, the improved mood in the control group is likely to have been a function of the increased social contact experienced by the group, as this was the only change in their activities during the period.

As the sample size in Model Unit Project 1 was small, a further study with a larger sample was conducted that included people with other communication difficulties besides dementia, e.g. stroke, Parkinson's (Connors 2001a).

Model Unit Project 2

In Model Unit Project 2, the experimental group consisted of 48 residents initially. The control group (initially $n = 16$) received no intervention for the first three months, then received Sonas for a three-month period, allowing for the effects with the combined sample to be examined. Demographic variables of the sample are described in Table 6.3.

Due to illness and death, a number of residents were lost from the study, and attrition rates for the experimental and control groups are described in Table 6.4.

After residents in the experimental condition had received Sonas for three months (T1 to T2) there were significant increases in cognitive scores, and

Table 6.2 Means and significance levels: experimental and control groups at 2 assessment times ($N = 26$)

	Experimental ($n = 18$) Mean	SD	Control ($n = 8$) Mean	SD	Significance
Cognition T1	12.00	4.97	14.37	4.43	NS
Cognition T2	14.94	6.30	14.87	5.59	NS
Difference T1, T2	$P = 0.01$		NS		
Mood disturbance T1	4.11	3.32	3.87	4.01	NS
Mood disturbance T2	2.61	2.83	1.62	2.55	NS
Difference T1, T2	$P = 0.02$		$P = 0.01$		
ADL disturbance T1	11.02	3.26	7.12	3.48	0.011
ADL disturbance T2	9.00	3.37	6.50	4.26	NS
Difference T1, T2	$P = 0.001$		NS		
Communication disturbance T1	13.05	6.61	7.50	7.32	0.023
Communication disturbance T2	10.05	3.55	9.00	5.96	NS
Difference T1, T2	$P = 0.03$		NS		
Behaviour disturbance T1	25.16	9.14	15.12	8.45	0.010
Behaviour disturbance T2	24.38	10.57	23.75	17.51	NS
Difference T1, T2	NS		NS		

Table 6.3 Model Unit Project 2 sample characteristics

Gender	Experimental group ($n = 48$)			Control group ($n = 16$)		
	43 Women	5 Men	16 Women	10 Alzheimer	6 Other	6 Other
Diagnosis	27 Alzheimer	21 Parkinson's				
Age	Mean 81	SD 8.06	Range 66-98	Mean 81.25	SD 6.6	Range 64-92

Table 6.4 Sample sizes and attrition from the study at Time 1, Time 2 and Time 3

	Time 1	Time 2 (3 months)	Time 3 (6 months)
Experimental group	48	43	37
Control group	16	14	12
Total	64	57	49
Attrition		7	15

Table 6.5 Means, SDs and significance levels: experimental and control groups

	Experimental Mean	SD	Control Mean	SD	Significance
Cognition T1	10.13	4.81	11.58	4.42	NS
Cognition T2	12.83	5.56	11.66	4.69	NS
Cognition T3	13.00	7.45	14.83	6.13	NS
Difference T1, T2	p = 0.000		NS		
Difference T2, T3	NS		0.01		
Difference T1, T3	p = 0.002		NS		
ADL disturbance T1	11.02	10.59	13.66	8.27	0.011
ADL disturbance T2	9.00	8.97	14.83	8.27	NS
ADL disturbance T3	10.37	9.32	13.83	10.06	0.005
Difference T1, T2	NS		NS		
Difference T2, T3	p = 0.02		NS		
Difference T1, T3	NS		NS		
Behaviour disturbance T1	4.89	4.13	4.90	6.14	0.010
Behaviour disturbance T2	4.81	3.62	6.00	6.80	NS
Behaviour disturbance T3	3.89	4.01	2.60	3.30	NS
Difference T1, T2	NS		NS		
Difference T2, T3	0.01		0.053		
Difference T1, T3	0.07 (NS)		NS		
Communication disturbance T1	10.59	7.74	11.90	8.05	NS
Communication disturbance T2	8.97	5.60	11.91	6.86	NS
Communication disturbance T3	9.32	6.65	8.25	6.01	NS
Difference T1, T2	0.08 (NS)		NS		
Difference T2, T3	NS		0.03		
Difference T1, T3	NS		NS		

at six month follow-up (T2 to T3), there were significant reductions in mean ADL disturbance and behaviour disturbance scores also (Table 6.5).

There were no significant changes in the control group during Time 1 to Time 2. Having acted as controls to the experimental group during this time, the control group then began receiving Sonas. After three months (Time 2 to Time 3), mean cognitive scores had increased significantly and mean behaviour disturbance scores had fallen significantly for this group. The results support a positive effect of Sonas on resident functioning, improving cognition and reducing behaviour disturbance.

In the experimental group with diagnoses of dementia only (n = 20), there were significant increases in mean cognitive scores from Time 1 to Time 2

Table 6.6 Means and SDs of experimental group with dementia vs. other diagnoses

	Experimental group - dementia		Experimental group - other diagnoses	
	Mean	SD	Mean	SD
Cognition T1	8.15	3.78	12.47	4.93
Cognition T2	10.00	3.09	16.17	6.03
Cognition T3	9.10	4.41	17.58	7.77
Difference T1, T2	0.01		0.001	
Difference T2, T3	NS		0.063 (NS)	
Difference T1, T3	NS		0.003	
ADL disturbance T1	19.80	7.74	13.76	10.78
ADL disturbance T2	20.55	8.24	13.88	10.29
ADL disturbance T3	18.00	9.48	13.11	10.78
Difference T1, T2	NS		NS	
Difference T2, T3	0.048		NS	
Difference T1, T3	NS		NS	
Communication disturbance T1	14.95	7.35	5.47	4.37
Communication disturbance T2	11.60	5.28	5.88	4.32
Communication disturbance T3	12.15	6.83	6.00	4.73
Difference T1, T2	0.01		NS	
Difference T2, T3	NS		NS	
Difference T1, T3	0.07 (NS)		NS	

and reductions in mean ADL disturbance scores from Time 2 to Time 3 (Table 6.6). In the experimental group with diagnoses other than dementia (n = 17) there were significant increases only in mean cognitive scores from Time 1 to 2 and Time 1 to 3.

A further analysis looked at the entire group of residents (original experimental and control groups together) when all were receiving Sonas in the final three months of the study. For the entire group (n = 49), there were significant reductions in mean behaviour disturbance scores and activities of daily living (ADL) disturbance scores (Table 6.7). For those with dementia only in this group (n = 28), there were significant reductions in mean behaviour disturbance scores (t = 2.71, df = 27, p < 0.01) and ADL disturbance scores (t = 2.29, df = 27, p < 0.03). For those with diagnoses other than dementia in the combined group (n = 21) there were significant increases in mean cognitive scores only (t = 2.67, df = 20, p < .014).

Together, the MUP studies suggest that Sonas does help to improve a number of behaviours essential to communicating (and to quality of life) such as cognition, mood, self-maintenance and communicative capacity itself. In this sense, it achieves its aim of 'activating the potential for communication'.

Table 6.7 Means and SDs: combined group receiving Sonas from T2 to T3 (n = 49)

	Cognition		ADL disturbance		Behaviour disturbance	
	Mean	SD	Mean	SD	Mean	SD
Time 2	12.55	5.34	16.83	9.37	5.10	4.57
Time 3	13.44	7.13	15.28	10.26	3.59	3.87
Difference T2, T3	0.074 (NS)		0.030		0.003	

The approach appears therefore to be particularly useful in working with those who are withdrawn or whose ability to communicate has been diminished by illness and/or institutionalization. Older people with dementia in residential care are particularly vulnerable in this respect.

Sonas in the community

Sonas is not an approach limited to residential care and there is also scope for its application in the community. One such application which we have examined in our research is with carers of people with dementia who face the deterioration of the communicative abilities of the person with dementia and deterioration in the relationship between caregiver and patient. To evaluate the efficacy of Sonas as a community intervention, measures of carer well-being, quality of life, interaction with their relative, and functioning of the person with dementia were taken before carers were trained in using aspects of the Sonas approach with their relatives, and again after 6 weeks and 12 weeks (Connors 2001b).

The study found that communication ability of the person with dementia and the level of interaction between the person with dementia and the carer were the strongest predictors of carer well-being. Communication ability of the person with dementia was significantly associated with carer quality of life ($p = 0.003$), psychological health as measured by the GHQ12 ($p = 0.03$) and stress ($p = 0.03$). Interaction between the carer and the person with dementia was significantly associated with carer quality of life ($p = 0.002$), stress ($p = 0.004$), psychological health as measured by the GHQ12 ($p = 0.01$), and willingness to institutionalize the person with dementia ($p = 0.004$). The results emphasize the primacy of interaction and communication as variables affecting carer health and well-being.

With regard to the effect of Sonas, carers who completed the training had significantly higher *interaction* scores than those who did not ($p = 0.003$). While there was no difference between the training and non-training groups at baseline, the training group had significantly improved in interaction with the person with dementia ($p = 0.041$), carer psychological health ($p = 0.034$), and carer quality of life ($p = 0.041$).

While the results show some benefit to participants in the short term, the effects had dissipated by the week 12 follow-up. Unless integrated into an overall strategy of supported home care, the benefits of activities such as Sonas are unlikely alone to overcome the many other burdens carers shoulder: the grinding routine of around-the-clock care; the ongoing loss and impending institutionalization and death of a loved one; inadequate social support; and inappropriate or inadequate social and medical support. The findings stress the huge importance to carer health and well-being of communication and interaction between the carer and the person with dementia. Consequently, it is not surprising that carers were very positive about the Sonas programme, especially the opportunity it provided for contact with other carers, and the professional support it gave. To respond to the needs identified in the study, Sonas has developed a communication and stress management training course for carers, and is currently training three groups of carers in a pilot intervention.

The way forward

A lot of the past for Sonas aPc has been devoted to training people in its implementation, developing the approach in both residential and community settings and establishing its credibility as an evidence-based practice. The future holds many challenges in carrying this approach forward. These challenges lie in forming a foundation which will allow Sonas to be a sustainable and accessible method of intervention.

In order for any intervention to be sustained, certain factors are necessary. First, it must continue to have effective application. This means that continual review of the approach is needed, and that it keeps pace with changes in the nature of the older population and with the advancing knowledge about conditions like dementia. It also means that there is a need for continued research. Second, there must be a level of committed support from people who are in a position to empower and enable the care practitioners who actually carry out the programme. The required support can be divided into three categories:

- 1 Provision of training.
- 2 Provision of resources by way of staff, time and facilities.
- 3 Listening to the voices of those who are carrying out the sessions so that the intervention can influence the total care of people with communication difficulty.

There are aspects other than training that are needed to ensure that there is a positive change in the delivery of care: an increase in perceived confidence and competence among staff may well lead to innovation, but innovation must be encouraged by managers if enthusiasm is not to be dampened.

Training alone then is unlikely to be enough' (Nolan and Keady 1996). Trying to facilitate this need for a committed approach to the care of the whole person with dementia and other communication difficulties is one of the main challenges that Sonas aPc now faces. In pursuit of this it has recently developed more structured modular programmes which are designed to assist health care professionals, their teams and family carers in better implementing the Sonas approach beyond the session into the care environment of the older person. These programmes involve all the stakeholders, including staff, management and families. These initiatives, together with training for family carers, will occupy Sonas aPc for some time to come, and it is hoped lead to a better climate of care.

As well as providing a way of addressing communication in dementia that is both sustainable and credible, there is a need for accessibility of the programme. Its accessibility depends first on the support of those who manage the service and their recognition of the importance of addressing psychosocial, emotional and spiritual needs as well as physical needs. Second, it depends on the ability of the small Sonas organization to make this intervention available in a wider geographical way.

Whether or not we believe that dementia is an illness, a disability, or a different way of 'becoming', we need to accept the fact that people with dementia do not seem to be able to alter their path. So whilst the challenges are considerable, it is incumbent on those of us who do not have dementia to find ways of keeping company and maintaining interaction, communication and relationships with those of us who do. The dynamics of Sonas at the level of process are opaque, but the benefits at the level of behaviour are quite tangible. At a process level, the Sonas aPc method appears to work because it taps into latent general abilities such as thinking and acting that prefigure, give rise to and enable communication. This reawakening of the potential to communicate is an extremely profound occurrence because it brings people back into communion with themselves, with others and with their environment. Communication is central, and as one person with dementia has put it:

You see, you are words. Words can make or break you. (Killick 1997)

Sonas works because, unlike much of the rest of society, it embodies a real optimism about illness and about old age. In contrast, health care that proceeds from a pessimistic view of ageing is unlikely to appreciate the importance of, or provide opportunities for, communication. Apart from the direct benefit to patient quality of life, improvements in care-relevant behaviours are inevitably passed on to frontline staff. Improvements in behaviour and activities of daily living (ADL) make caring for people easier, reduce the workload, may lead to greater job satisfaction and ultimately improve overall quality of care.

The prevalence of dementia, and Alzheimer's disease in particular, continues to grow in the Western world and the effects on families worldwide are devastating. In the absence of medications that might slow, stop or reverse the progress of the disease, improving quality of life and quality of care through interventions such as Sonas is the essence of contemporary dementia care. To date, Sonas has been shown to significantly improve patient quality of life and quality of care in residential and day care settings. As an intervention in community dementia care, it has been very well received by carers. Apart from the immediate practical benefit, interventions such as Sonas demonstrate that health care is most effective in meeting deeply human needs only when the principles it applies are themselves deeply human.

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