

**The possibilities of gentle teaching in the care of dementia  
Based on a study at a group home for demented elderly**

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Group home for demented elderly 'Egao wo misete' \*\*\*\*

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**Background and objectives**

We sometimes use the words 'problem behavior' or 'maladjusted behavior' to describe the inapt behavior of demented people. In other words, care is aimed at removing or reducing what we consider 'improper actions or behavior'. We try to eliminate wandering, insomnia, and restlessness. Such approach is referred to as behaviorism or behavior modification.

We give rewards and punishment with the purpose of improving behavior. As such we only shown an interest in changing others.

Sometimes this leads to "control" or "domination", and puts on the path to "care without ideals".

Such care causes "fear" and "confusion" in demented people. "Support" turns into "domination", the strong "control" the weak, and "submission" replaces "empathy".

Are our criteria and standards indeed the only correct ones? The world which demented people are confronted with is our real society. They are struggling hard to live their daily lives. I believe that we should accept this, and chose to live and learn together with them.

We can help those that are alienated, isolated, and discriminated against by society, and in the process of doing so, we can transform ourselves as well.

We renounce the method of giving rewards or punishment to improve the behavior of people with behavioral disorders.

We have selected the way toward the "psychology of mutual dependence" in order to create a "feeling of companionship", practice "unconditional valuing", and achieve "mutual change".

## **Methods**

The method of gentle teaching was created in the 1980's by the American psychologist John McGee.

After obtaining degrees in psychology and pedagogy from Kansas University, he was engaged for 6 years in the education of homeless children in Brazil.

He was Associate Professor at Nebraska University and Creighton University, and presently continues clinical work as representative of Gentle Teaching International, and gives lectures and workshops.

We have participated in workshops by John McGee in Japan, and started our present program in April 2001, on the basis of the book *Beyond Gentle Teaching (A Nonaversive Approach To Helping Those in Need )* by John J. McGee and Frank J. Menolascino, published in 1997 in Japanese.

## **Location**

Group home for demented elderly "Egao wo misete", 9 tenants (2 men, 7 women), a private one-storied house, 8 staff members (6 full-time, 2 part-time), 24-hour care.

The subject of this study was 1 tenant with particularly severe behavioral maladjustment, who was observed for a 12-month period from April 2001 to March 2002.

Gentle teaching is a very effective method for people who have problems with human relations (due to intellectual impairment, mental disorders, dementia, being homeless, etc.) in every age group from children to the elderly, regardless of the presence or absence of disorders.

The emotion which plays the most important role in gentle teaching is "warmth". It is important to express warmth as human beings, and not to lose this "warmth" under any circumstances.

### **Companionship**

This refers to establishing the emotion of companionship between two people (the person receiving the support and the person giving the support).

Being with other people, in other words "companionship", is an innate desire of human beings.

The aim is to interact in a way that brings out the emotion that it is wonderful to be with others.

The subject feels safe with the helper, feels valued, which gives rise to a feeling of relationship. The helper should not be perceived as a source of fear, and nothing should be forced or ordered.

### **Safety and security**

Along with the perception that being with others and interacting with others is essentially wonderful, the subject obtains an increased sense of safety and security. The helper's hands, words, and facial expressions tend to become a source of fear. The helper must first take a good look inside oneself and ask "What am I giving? Am I valuing or controlling the other person?"

### **Human engagement**

The helper's fundamental role is to convey the message that human relations, in other words, being together and participating together, are wonderful. The aim of human relations is not to evoke interest within the limits of a given task, but to bring out a desire to be with us. In other words, it is about feeling that it is wonderful to have human relationships, to be with people, to interact, to share, and to give and receive human values. In particular for people with behavioral maladjustment, it is very important to build a companionship relation on the basis of the common ground of

being together.

### **Unconditional valuing**

Unconditional valuing reinforces the significance of being together and is like a driving force that lies hidden within human relations.

In other words, it involves raising the other person's motivation, praising, respecting, listening to what the other has to say, and expressing and sharing this either with words or with expressions. Through valuing in the helper's interaction with the patient, the helper can come closer to the patient both emotionally and physically by for example making eye contact, extending a helping hand, and talking to the patient. This way the helper shows an interest in the patient's human dignity, value, existence, and participation. When the helper asks for a handshake, and the patient reacts with a warm look, then that warm look signifies a response to the valuing by the helper. At this stage, a change occurs both in the helper and the patient.

### **Subject 79-year-old woman**

Course Around January 1997 (74 years)

Onset of dementia symptoms. Onset of wandering due to short-term memory disorder and disorientation.

June 1998 (76 years)

Dementia rating scales performed (Revised Hasegawa Simple Intelligence Assessment Scale: 11 points, N Mental State Scale for the Aged (NM Scale): 27 points)

NM Scale

\* Moderate dementia was diagnosed at this time.

June 1998

Started outpatient rehabilitation (day care) 3 times a week .

February 1999 (76 years)

Entered a health center for the elderly because of frequent wandering away from home without being able to return, often necessitating help from police.

April 2001 (78 years)

Entered "Egao wo misete", a group home for demented elderly.

\* Gentle teaching care was started at the group home for demented elderly in April 2001.

\* Because the patient has not been given a definite diagnosis of dementia, it is not clear which type of dementia (Alzheimer's disease, vascular dementia, complex dementia she has, but on the basis of her behavior and the pattern of onset, it can be assumed that she either has Alzheimer's disease or complex dementia.

## Results and Discussion

While in the health center for the elderly, the patient frequently showed disruptive behavior such as wandering, damage to property, unrest, refusal to wear clothes, refusal to bathe, allotriophagy, sleeplessness and shouting at night. It was therefore nearly impossible to carry on activities of daily living.

After moving into the group home for demented elderly, she was continuously assessed with three scales; the Domestic Life Functional Scale, the Community Life Functional Scale, and the Maladjusted Behavior Scale.

These three assessment scales were selected because it was deemed essential to improve the patient's activities of daily living, in order to give the patient's existence a sense of significance both to the patient as well as the other tenants.

### 1. Domestic Life Functional Scale

We assessed how often the patient did the following activities.

Not at all ... 0

One a month ... 1

Several times a month ... 2

Once a week ... 3

Several times a week ... 4

	A	B	C	D	E	F	G	H
a. cleaning	0	0	2	3	3	2	3	3
b. opening and closing the curtain	0	0	3	4	4	4	4	4
c. shopping	1	1	1	2	3	3	3	3

d. wiping the table	1	1	1	2	2	4	3	3
e. interacting with small children	0	0	2	3	3	3	2	3
f. folding the laundry	1	1	2	2	3	3	2	3
Total	3	3	11	16	18	19	17	19

The scale was administered

A: before moving in

B: when moving in

C: 1 week later

D: 1 month later

E: 2 months later

F: 3 months later

G: 6 months later

H: 10 months later

All items had only 0 or 1 in A-B, but showed remarkable improvement in C-D, and stabilized in E-G.

## 2. Community Life Functional Scale

Not at all ... 0

One a month ... 1

Several times a month ... 2

Once a week ... 3

Several times a week ... 4

	A	B	C	D	E	F	G	H
a. go out for a walk	0	0	3	2	3	3	4	4
b. go out shopping	1	1	1	3	3	3	3	3
c. stop by a coffee shop or cafeteria	0	0	0	1	1	1	1	1
d. go out to participate in social activities	0	0	0	1	0	1	1	1
e. go to a beauty parlor or hairdresser	0	0	0	0	0	1	1	1
f. go for a ride	0	0	0	1	1	1	1	1
g. meet with family or friends	1	1	3	3	3	3	3	3
Total	2	2	7	11	11	13	14	14

The scale was administered at the same times as above (A: before moving in - H: 10 months later).

Improvement was seen in all items, but in particular in items a, b, and g.

### 3. Maladjusted Behavior Scale

Not at all ... 0

One a month ... 1

Several times a month ... 2

Several times a week ... 3

More than once a day ... 4

	A	B	C	D	E	F	G	H
a. wandering, exiting without telling anyone	4	4	4	4	4	4	4	4
b. allotriophagy	1	1	1	1	1	1	1	1
c. illusions of things being stolen	0	0	0	0	0	0	0	0
d. inability to understand instructions	4	4	4	3	3	3	3	3
e. meaningless behavior	4	4	4	3	3	4	3	3
f. interrupting conversations or gatherings	4	4	3	3	3	3	2	2
g. trouble with others	4	4	4	4	4	4	3	3
h. insomnia at night	4	4	3	3	3	2	2	2
i. violence and vandalism	4	4	4	4	4	4	3	3
j. shouting	4	4	4	4	4	4	3	3
Total	33	33	31	29	29	29	25	24

The scale was administered at the same times as above (A: before moving in - H: 1 year later).

The degree of maladjusted behavior decreased for items of d, e, f, g, h, i, and j.

Items a-c remained unchanged.

## Results

1. With regard to daily life and community life, improvements in behavior were seen between 1 and 6 months after the start of gentle teaching.

2. By being together with the helper (staff member), the condition of maladjustment showed a tendency toward improvement.
3. When the patient was given a clear sense of "safety" and "togetherness" by the helper (staff member), the patient's stability increased and through the helper, the patient's interaction with others increased as well.
4. Other tenants started changing their perception and view of the patient as "someone they could live with".

### **Conclusion**

As a general conclusion, gentle teaching was clearly effective in the care of dementia. In particular, it was very useful in reducing conditions of maladjustment in the interaction with other people, while also reducing maladjustment in activities of living. Further research is required to determine whether there are differences in effectiveness depending on the type of dementia (Alzheimer's disease, vascular dementia, etc.), or depending on the progress of the disease (severity).

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