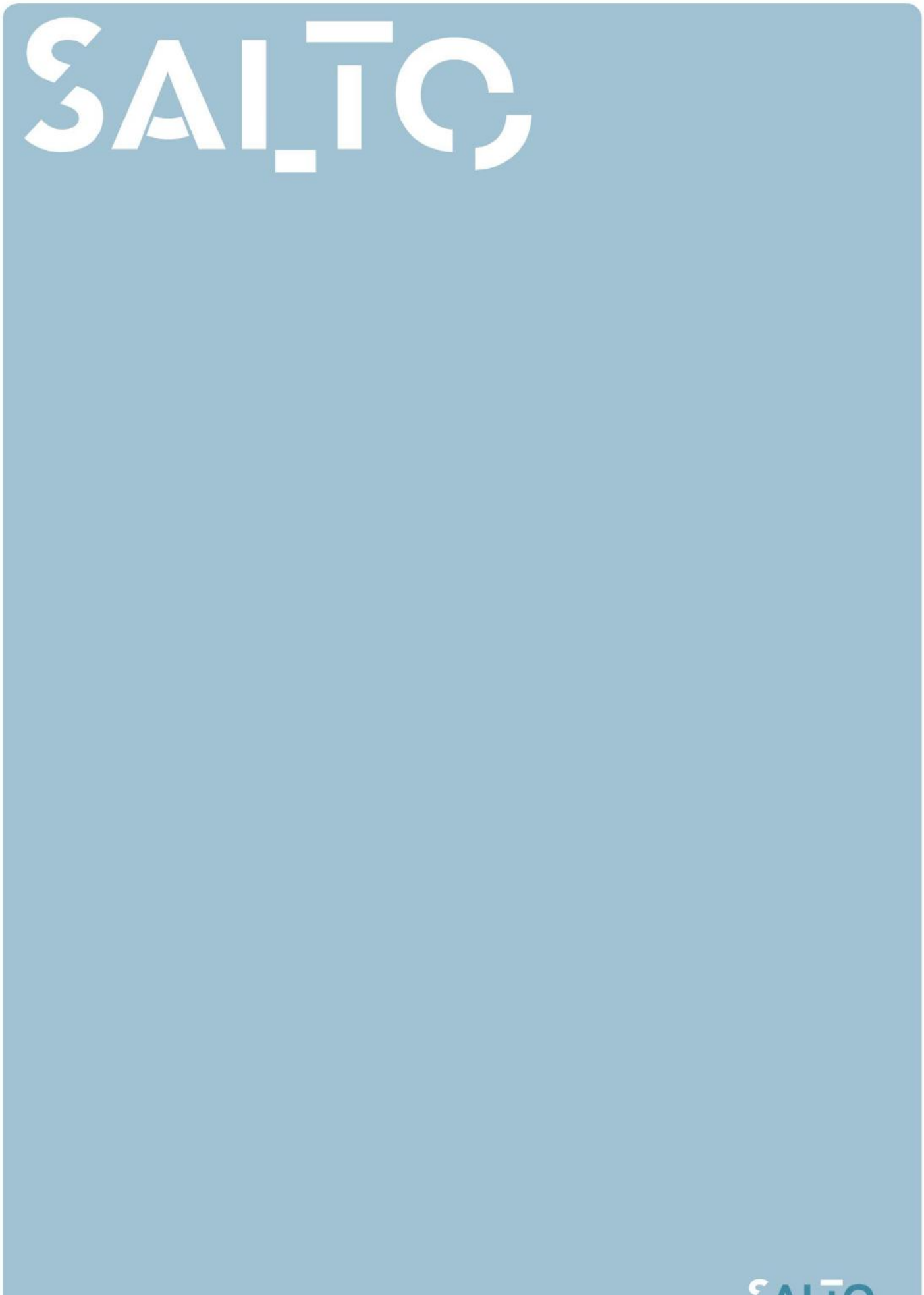
SALTO
Social Animation for Life quality training and Tools

Erasmus+



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INTELLECTUAL PRODUCTION 2

PI No. 2: Social animation training booklet

Training programme

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1. Introduction

Animation sociale“ (FR), “animación social“ (SP), “animazione sociale“ (IT) is a new term that has become part of everyday professional language as evidenced by articles in “animation“ and social work journals.

This document introduces the first proposal for implementing a training content on the topic of social animation with a minimum duration of 150 hours and a module-based format designed to meet the needs of each sector.

This training booklet offers a transversal approach to social animation as an element of institutional therapy and no longer as a mere occupational activity in the care and support practices for elderly and/or disabled people.

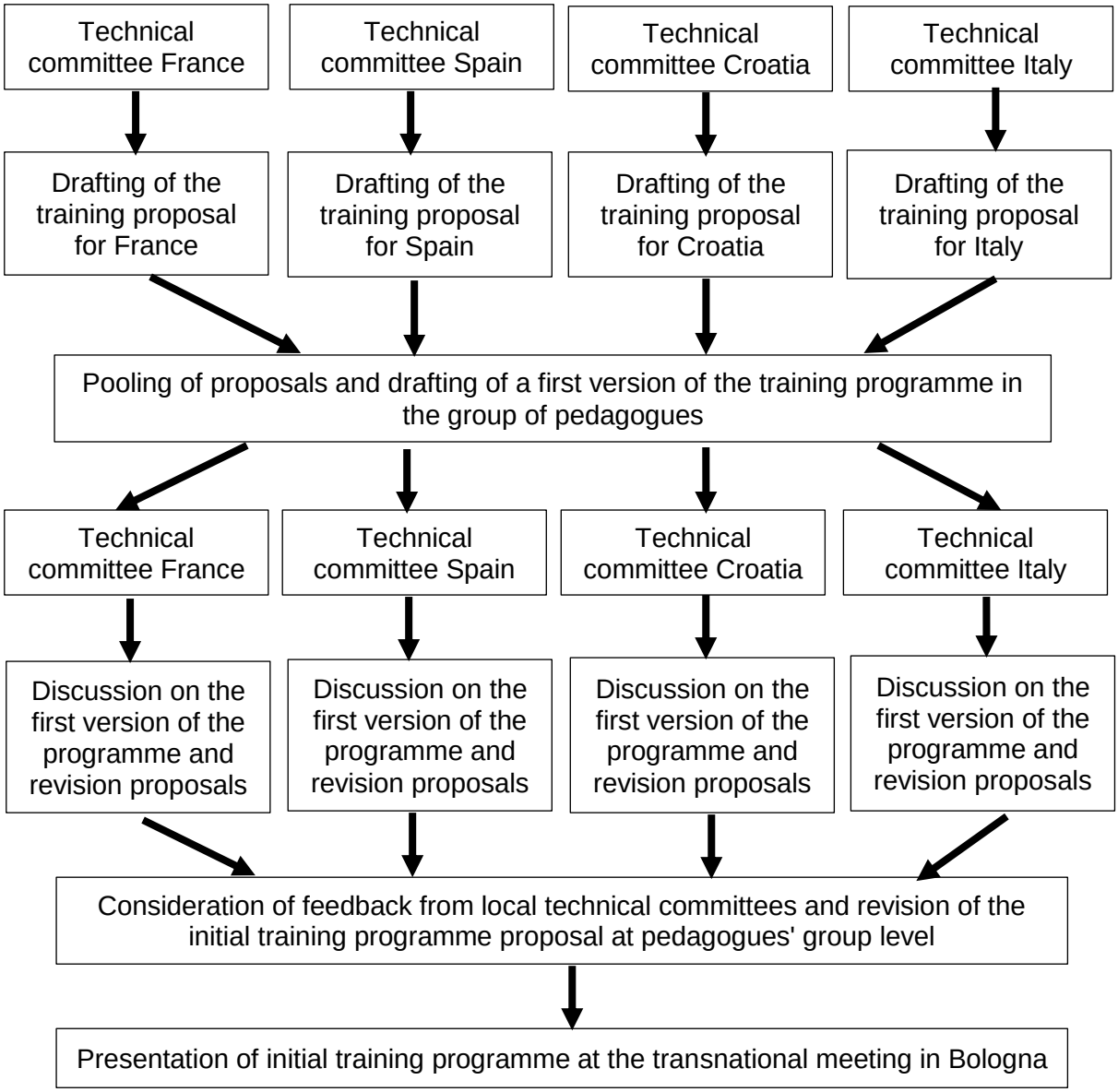
This modularised training content can be used in introductory training processes offered by universities and training institutions as well as by institutions providing ongoing training for practising professionals.

The initial training programme has been modified to take into account the feedback received by each member of the Pedagogues' group in their local technical committees. All feedback was pooled by the Pedagogues' group and by the representatives of the group working on intellectual production No.3 over a gathering and a Skype meeting. The following proposal was born from the pooling and co-construction both in the Technical Committees and in the Pedagogues' group.

The process that led to the creation of this initial model involved several participatory phases, with several meetings in person and via Skype.

The diagram on the next page describes the process.

The Pedagogues' group then developed a common framework of pedagogical and methodological references that forms the basis of the proposed training programme.


Technical committee France
Technical committee Spain
Technical committee Croatia
Technical committee Italy
Drafting of the training proposal for France
Drafting of the training proposal for Spain
Drafting of the training proposal for Croatia
Drafting of the training proposal for Italy
Pooling of proposals and drafting of a first version of the training programme in the group of pedagogues
Technical committee France
Technical committee Spain
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Discussion on the first version of the programme and revision proposals
Discussion on the first version of the programme and revision proposals
Discussion on the first version of the programme and revision proposals
Discussion on the first version of the programme and revision proposals
Consideration of feedback from local technical committees and revision of the initial training programme proposal at pedagogues' group level
Presentation of initial training programme at the transnational meeting in Bologna

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2. Conceptual Framework

2.1 Pedagogical references

2.1.1 Andragogy

Pedagogical reference
Andragogy
"Andragogy" refers to "the body of knowledge relating to adult learners in a parallel and distinct manner from the pedagogical model of children's learning" (Knowles, 1996). Knowles distinguishes between the concepts of andragogy and pedagogy because he believes that it is possible to identify a series of substantial differences between children and adult learning. Knowles outlines these differences between pedagogy and andragogy through six key principles: **1.** The need to know: adults feel the need to know why something has to be learned and what it can be used for. Therefore, the trainer's task is to help learners become aware of the "need to know". In addition, learning can be reinforced by real experiences. **2.** Self-image: children are seen and/or see themselves as dependent on others. Although adults consider themselves as responsible for their own lives, there are situations in life, work or school in which they are dependent. In such cases, their self-image needs to be reworked and the adult educator's task is to facilitate the transition from dependence to the ability for autonomy in learning and in life. **3.** The role of previous experience: the adult learning experience becomes more voluminous and qualitatively different from that of young people. New learning must somehow be integrated to previous experience. This indicates that the richest learning resources are found in the trainees themselves. For this reason, the use of experiential techniques (techniques that take into account learners' experiences, such as group discussions, simulation exercises, etc.) with regard to transmission techniques is fundamental in adult education. **4.** Willingness to learn: adults show a willingness to learn what they need to know or know how to do in response to life demands, especially in phases of evolution. Adults are willing to learn what they need and know how to manage their lives effectively. **5.** learning orientation: adult learning orientation is focused on real life. In fact, they acquire new knowledge, skills and values much more quickly and effectively when these are presented in the context of their application to real situations. The perspective is that of an immediate implementation of what has been learned **6.** Motivation: the most powerful motivators for adults are internal ones such as increased self-esteem, job satisfaction, improved quality of life.

Principles of andragogical model :

In 1984, Knowles suggested 4 principles that are applied to adult learning:

1. Adults need to be involved in the planning and evaluation of their instruction.
2. Experience (including mistakes) provides the basis for the learning activities.
3. Adults are most interested in learning subjects that have immediate relevance and impact to their personal life or their job.
4. Adult learning is problem-centred rather than content-oriented (Kearsley, 2010).

For more information on this subject

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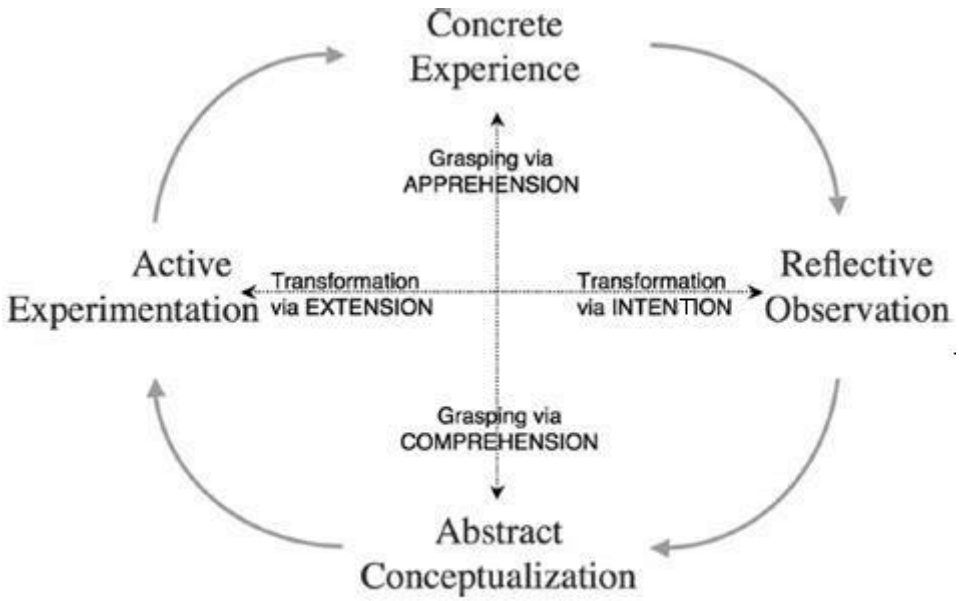
2.1.2 Experiential learning

Pedagogical reference
Experiential learning
Influenced by the work of Dewey (1938), Lewin (1961), Piaget (1971) and Kolb (1984), the current concept of experiential learning refers to a process in which participants shape their knowledge and visions through emotional and cognitive interactions with their biophysical and social environments. Also from this holistic perspective, Kolb resorts to four action verbs to describe this form of learning: to think, to feel, to perceive and to behave. Bell (1995) summarises this approach by describing experiential learning as a relationship between an individual and his or her environment in which the individual discovers a concrete and meaningful reality. In the first stage, the learner actively experiments rather than being placed in a situation of receiving the experience of others, as interpreted by his/her teacher (Herbert, 1995). In the next step, in a group, individually or with the facilitator, the learner has time to think about how to construct his or her own meanings and information based on the events he or she has experienced. For example, they may think about what they have learned, express their feelings or position about what has happened, separate the elements of the experience and relate these elements to their previous knowledge. The final step is to share the value of the experience with others or to test in the field what has been understood. The pedagogy of experiential learning is therefore similar to active and affective pedagogy: during the process, learners feel emotions such as challenge, compassion, pleasure, excitement, wonder, identification and desire to share their impressions. Delay (1996) makes a connection between this type of learning and the one described by constructivist theories according to which knowledge is built based on experience. In particular, Kolb's model synthesises the experiential learning models of Lewin, Dewey and Piaget based on the following assumptions common to the approaches of the three authors: - learning is a continuous process rooted in experience; - the learning process requires the resolution of conflicts between dialectically opposed modalities of adaptation to reality; - learning is a holistic process of adapting to reality; - learning involves continuous exchanges between the person and the context in which they find themselves; - learning is the process of creating knowledge. According to Kolb, the experiential learning process can be described as a four-phase cycle that involves four modalities of adaptive learning: concrete experience, reflective observation, abstract conceptualisation and active experimentation. In this model, concrete experience/abstract conceptualisation and active experimentation/reflective observation are two distinct dimensions, each of which represents two opposing adaptive orientations. The structural foundations for the learning process lie in the transitions between these four

adaptive models, through processes of apprehension / comprehension and intention / extension.



Kolb (1984)

Kolb therefore identifies four stages in learning:

- concrete experience stage (CE), where learning is mainly the result of perceptions and reactions to experiences;
- reflective observation (RO) stage, where learning is mainly derived from listening and observation;
- abstract conceptualisation (AC) stage, during which learning takes place through the systematic analysis and organisation of information and related flows;
- active experimentation (AE) stage, where action, experimentation and verification of results are the basis for learning.

During the **concrete experience** stage, the emphasis is on direct and personal involvement. This attitude engages the emotional sphere. The interpretation of experiences tends to highlight their uniqueness and complexity rather than possible general principles. The result is experienced as a personal outcome and is supported by an intuitive approach and situational adaptability. During training, activities that foster this phase are: workshop activities, field work, examples, simulations, role-playing, training on the job and in general all activities that remind participants of concreteness and application.

During the **reflective observation** stage, learning focuses on understanding the meaning through listening, confrontation and impartial observation. Comprehension, quality of analysis and reliability are of great importance. During training, tools best suited to this phase are: lessons, specialised readings, theoretical references, discussions, case histories.

During the **abstract conceptualisation** stage, learning focuses on the logical organisation of content and on the possibility of identifying rules and process dynamics that can be applied in a generalised manner. Abstract theories and demonstrations are developed through analysis, key concept identification, linkage between causes and effects. Training is carried out by means of tools such as lessons, articles, graphical representation and diagrams.

In the **active experimentation** stage, the focus is on finding options to deal with a concrete situation.

Effective and thorough learning involves all four stages of the process and the stage you start with is of no relevance. Indeed, it is possible to start learning at any stage of the cycle. Each one requires a variety of skills to ensure progress in the best possible way.

For more information on this subject

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2.2 Key concepts – bases

2.2.1 Quality of life

Key concept factsheet
Quality of life
In 1993, the World Health Organization (WHO) defined quality of life as “an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment.” According to Monique Formarier, who after graduating as a healthcare manager took on a training role and became editor of the journal *Recherche en soins infirmiers*, the areas that influence a person's quality of life are: - the state of health and severity of any disability, - psychological and spiritual aspects, - family and friends, - the socio-economic level. The concept centres on the notion of perception, "the person's overall satisfaction with the general meaning he or she gives to well-being". This emphasis on the individual's point of view adds to the complexity of the concept: quality of life is an appraisal criterion that is meant to be objective in nature even though it is the outcome of subjective interpretation. Quality of life varies according to each person's judgement based on their own norms and values. It evolves over time, at different stages of life. According to Zribi and Poupée-Fontaine, quality of life is partly related to the possibilities people have to take part in the decisions that affect them, both individually and collectively. Indeed, quality of life has a subjective dimension, i.e. each individual, according to his or her value system, culture, expectations and concerns, has a unique perception of what seems "good" to him or her. Thus, for people with disabilities, quality of life is correlated with the opportunity to express themselves about their personalised project. This idea asserts the right to: free choice, consent, access to all information and the person's participation in his or her personalised project. It is a case of recognising people as "subjects" to be accompanied and not "objects" to be cared for. Quality of life is also linked to the possibility of expressing oneself at collective, residential and urban levels. The aim is to enable people to exercise their role as citizens rather than being restricted to the role of passive beneficiaries.
For more information on this subject

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Formarier M., Les concepts en sciences infirmières Edition association de recherche en soins infirmiers Zribi et Poupée-Fontaine, Dictionnaire du handicap éditions aux presses de l'EHESP Article: des recommandations de l'ANESM sur la qualité de vie EHPAD : pourquoi ce thème Empan vol 92. http://www.who.int/healthinfo/survey/WHOQOL-BIBLIOGRAPHY.pdf

2.2.2 Empowerment

Key concept factsheet
Empowerment
The idea of the individual's role as an actor and citizen is the bedrock of the accompanying support. Empowerment recognises and strengthens people's decision-making and acting capacities, both on an individual and collective level. According to William Ninacs (2008 p.140), empowerment brings together 4 key components: participation, competence, self-esteem and critical awareness. As a whole and in their interaction, they enable a shift from a position where the individual is deprived of the power to act to one where he/she is capable of acting as a result of his/her own choices. The WHO defines empowerment in a mental health context as follows: "empowerment refers to the levels of choice, decision, influence and control that users of mental health services can exercise over events in their lives". Empowerment is a concept referring to a series of skills and resources that enable a person to exercise positive power or at least provide room to manoeuvre in his/her own life. According to definitions by Rappaport (1981) and Zimmerman (2000), empowerment is a process by which individuals increase their ability to actively control their own lives and encompasses three closely linked dimensions: an individual and psychological level, a social and organisational level and a political or collective level. Three dimensions of empowerment can be distinguished: - the individual dimension (relates to well-being and project building), - the socio-relational dimension (refers to the person in their relation to others), - the institutional dimension (relates to the person's life within organisations, their work or in respect of organising their free time). Empowerment or the lack of it has implications for all three of these different dimensions of a person's life. A project aiming to develop the individual's empowerment, to make him/her autonomous and capable of exercising his/her margin of intervention and initiative on his/her life context, must work on several dimensions and areas. Competences related to empowerment can be defined in relation to the three dimensions mentioned above. With regard to the individual dimension of empowerment, an educational process can help develop the following skills: self-esteem, self-confidence, sense of self-efficacy (self-assessment, feeling able to cope with problematic situations), ability to self-assess (identify strengths and weaknesses, take stock of skills), ability to read and understand the experience (recounting and analysing the most important episodes - positive or negative - in one's life), locus of control (my share of free will over events, the meaning I give to what happens to me), adaptation strategy (how to deal with a problem, to define achievement strategies). With regard to the socio-relational dimension, a project focusing on the notion of empowerment, through group work and cooperative learning methodologies, should make it

possible to progress in the following skills: communicating within the group (communicating opinions and points of view), cooperating, playing different roles in the group (proposal, opposition, mediation, guidance), managing conflicts in the group (acknowledging, understanding/analysing, resolving/resolving conflicts), pursuing group objectives (defining objectives, a work plan, developing methods, dividing work to achieve the goal), leading and monitoring group work (evaluating work success along the way, making changes if necessary). At an institutional level, empowerment means creating the organisational conditions for the person to feel part of the group, to be fully aware of their rights and duties, to make their voice heard (participate in the life of the institution, take responsibility, organise activities) and to take part in decisions that concern them.

Empowerment is therefore a term that involves all the knowledge, skills and relational modalities through which an individual or group can set goals and develop strategies to achieve them effectively, using existing resources.
From an action point of view, exercising empowerment means:

- being able to pursue goals,
- committing to achieve these goals,
- perceiving that there is room for manoeuvre on events,
- managing changes,
- building positive relationships,
- cooperating.

For more information on this subject

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Zimmerman M.A. (2000), Empowerment Theory. Psychological, Organizational and Community Levels of Analysis, in J. Rappaport, E. Seidman, “Handbook of Community Psychology”, New York, Kluwer Academic/ Plenum Publishers.

2.2.3 Gentlecare

Key concept factsheet
Gentlecare
The Gentlecare model, developed by Moyra Jones (1996), is an approach dedicated to seniors and caregivers to promote the well-being of the former and reduce the risk of burnout for the latter. This approach focuses on the elderly and the preservation of continuity of life. It requires, as a starting point, an analysis of the person: clinical and pathological condition, reconstruction of the biography, personal and contextual characteristics (Guaita, Jones, 2000). This broad-spectrum analysis is complemented by an assessment of the impact that the illness has on the individual, both physically and psychologically, in relation to their experience of the illness and coping strategies. This evaluation is carried out using quantitative tools, typical of multidimensional and qualitative evaluation, where caregivers (professionals and family carers) take on the role of observers of participants and their relationship with the elderly. The elderly are the object of evaluation and self-evaluation. This assessment includes the residual capacities of the elderly, daily actions and routines, caregivers' actions and responsibilities, and stress risks. This complex and extensive evaluation process leads to the implementation of a care project, based on realistic objectives, through the analysis of the strengths and weaknesses of the patient and of the given situation (Carbone, Tonali, 2007). In the design of care, the Gentlecare model looks at the physical environment, i.e. the place and space (or spaces) of care (Guaita, Jones 2000) that must be characterised by: safety, ease of access and mobility, functionality, flexibility and change. The carer also plays an important role in the care project, sharing and communicating with operators - who must be aware of the relational dynamics within the elderly person's family nucleus and of the family's resources - from techniques of organisation and daily management to strategies to deal with critical situations (Vitali, 2004). The activities consist of a daily routine tailored to each patient. It is based on the biographical elements and context, known and reassuring for the person, and the enhancement of his or her strengths. The aim is to create a complete correspondence between the needs and the proposed activities. Examples of activities that address the need for biological safety and integrity include pain control, being able to stay in comfortable positions, having sufficient rest time, conserving energy, and enjoying a family routine. Examples of how needs and activities relate to a sense of belonging are: relationship with pets, possession and access to important personal objects, plants, the possibility of receiving sensory stimulation, listening, touching, space organisation.

With regard to self-esteem, the needs related to activities are identified as follows: reminiscences and memories control of money, opportunities to help others, teaching, learning, remembering and engaging in creative activities. (Vitali, 2004)
For more information on this subject
Bibliographical references
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2.2.4 Well-treatment

Key concept factsheet
Well-treatment
According to the High Authority for Health in France (HAS), "well-treatment is a global approach to caring for patients and welcoming their families and friends with the aim of promoting respect of their rights and freedoms, as well as ensuring that they are listened to and their needs are met, while preventing maltreatment. This global approach highlights the roles and interactions among the various actors, i. e. the professional, the institution, the patient and their wider support network. It requires both individual and collective questioning from the actors involved". According to the recommendations for good professional practice of the National Agency for the Evaluation and Quality of Social and Medicosocial Institutions and Services (ANESM[1]), "Well-treatment is a culture that inspires individual actions and collective relationships within an institution or service. It aims to promote the well-being of the patient while keeping in mind the risk of maltreatment. It is not limited to the absence of maltreatment or the prevention of maltreatment. Well-treatment is characterised by a permanent search for individualisation and personalisation of the service provided. It can only be achieved within a given structure after continuous exchanges between all the people involved". The basics of well-treatment: - Well-treatment stems from a shared culture of respect for the person and their history, dignity and uniqueness. - For the health care professional, well-treatment equates to a way of being, saying and acting, mindful of others, responding to their needs and requests, respectful of their choices and refusals. Well-treatment includes the concern to maintain a stable institutional framework, with clear, known and secure rules for all and an uncompromising refusal of any form of violence. - The voice of the patient and family is valued. Well-treatment is a concrete approach that responds to their rights and choices. - The well-treatment process is a perpetual back and forth between thinking and acting. It requires both a collective reflection on the practices of professionals, and a rigorous implementation of measures recommended by this collective reflection to improve them. With this in mind, it leads to the adoption of a culture of permanent questioning. - The search for well-treatment is a continuous process of adaptation to a given situation. In essence, it is endless. It involves constant reflection and collaboration between all the actors engaged in personal support, in order to find the best possible response to an identified need at a given time.

[1] ANESM was integrated into the High Authority of Health (HAS) on 1st April 2018.

For more information on this subject
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2.3 Methodological references

2.3.1 Person-centred approach

Methodological reference factsheet
Person-centred approach
Currently, the attention given to the elderly in care services and retirement homes is closely linked to the deficits and pathologies from which they suffer, which makes it difficult to perceive the person as a unique, different and valuable individual. In this sense, care has been designed from a wellness perspective, where the professional and the institution decide for the good of others (improving their health, keeping them safe...) while ignoring what these persons feel and think. Importantly, leading a meaningful life is essential to being happy in old age too. Person-centred care is about supporting people who are being helped in a personalised way so as to develop their own life project, with their effective participation and taking into account, in addition to their needs, their preferences and desires. The Person Centred Approach (PCA) is based on recognising the dignity of each individual and their right to continue to own their own lives. When a person needs support, health and personal care are essential, but so are the things they love, their habits and personal relationships. What is crucial in this model is to know and uphold what is really important for each person at the present time in their life. Each person's life project corresponds to the choices and strategies that each individual implements to achieve their objectives and satisfy their desires with regard to work, family, leisure.... Everyone, consciously or unconsciously, has a life project. The elderly also have their own life project. In the PCA model, professionals and organisations serve as a support to seniors to pursue their life projects. In this regard, the individual is an active protagonist who decides what they want and how they want to live their lives. The environment and organisation become the support on which to develop life projects and ensure the well-being of people. PCA is a model that requires leadership from centre managers, involvement of professionals and participation of beneficiaries and their families. In some instances, all this implies changes in organisations. To deepen the model, we highlight five important aspects: **1.** Professionals: in this model, professionals do not act as expert prescribers who indicate at all times what to do or not to do with patients. In addition to providing technical guidelines for the proper care and protection of patients, they perform new tasks related to listening and observation, coaching, motivation and the search for opportunities and support. Professionals are able to empower patients.

2. A physical environment both pleasant and meaningful: physical environment is a very important dimension for the well-being of people. Person-centred care seeks to create a warm environment, far from the institutional character that is usually found in centres that care for people with disabilities or who are frail. The objective is to ensure that these structures resemble normal homes and, in short, that physical environment helps create a friendly, happy and stimulating (but calm) climate.
3. "Meaningful" therapeutic activities: great importance is given to the fact that therapeutic activities are meaningful for people. Routine, boring or childish activities, which are not very motivating, are left behind. Activities that really make sense are sought and developed. The intended aim is to put forward proposals people do not feel obliged to participate in just because professionals recommended them. This entails a major challenge within the model, because without abandoning therapeutic objectives, some interventions must be adapted and personalised and have to generate new alternatives.
4. Participation of the elderly and their families in the Care and Life Plan: in the PCA, the person's participation in the way they are cared for is something that cannot be relinquished even when the person suffers from severe cognitive impairment. Obviously, support from family members, close friends and professionals is then necessary. To achieve this support, these people may make decisions at any time of the day once opportunities to choose have been identified.
5. For all these considerations to be effective the organisation must be flexible and therefore some changes have to be made at organisational level. To this end, possible changes are promoted, planned and implemented gradually without losing sight of the fact that the quality of life and well-being of people is important. Efforts are made to move forward on the basis of consensus and to this end the involvement of seniors, their family members and especially care professionals is encouraged.

For more information on this subject

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2.3.2 ROT (Reality Orientation Therapy)

Methodological reference factsheet
ROT Reality Orientation Therapy
This is the most well-known multi-strategy approach (Taulbee, 1984, Zanetti et al., 2005). This methodology was devised by Folsom (1968) and later developed as a specific rehabilitation technique for patients suffering from cognitive impairment or cognitive decline (Baldelli 1990, Zanetti 1995, Baines et al 1987). This technique focuses on the cognitive stimulation of patients. They are presented with information about their personal history and time-space environment in order to reduce their behavioural and orientational disturbances and improve their autonomy and quality of life. It aims to help patients reorient themselves in relation to their own history and their environment. Two complementary therapeutic methods exist : 1. Informal ROT 2. Formal ROT ("in a structured context with professionals") ROT works well with patients with mild to moderate cognitive impairment, without sensory deficits and behavioural disorders that may affect participation in sessions. The following disorders, however, can be considered: apathy, depression, appetite disorders. Formal ROT, after training, can be provided by a well-trained facilitator, educator, psychologist or operator. Informal ROT can be delivered by a facilitator, educator, psychologist, operator, nurse, family member. ROT is currently one of the few examples of "cognitive training" that can produce positive results in patients with dementia. The enthusiasm with which ROT has been accepted by health professionals can be explained, at least in part, by its simple and economical technique, managed by relatively unskilled staff. In addition, ROT offers professionals and family members a sense of "doing something" for the person who has a medical condition. ROT's main criticism is that, when faced with improved cognitive performance, there is no impact on functional level and everyday skills. According to its critics, ROT's effectiveness is essentially dependent on the enthusiasm of operators.
For more information on this subject
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2.3.3 Enabling approach

Methodological reference factsheet
Enabling approach
The enabling approach (EA) is a speech-based interpersonal relationship modality that aims at a positive cohabitation among frail elderly people and/or those suffering from dementia, operators and relatives. The method used is the recognition of basic abilities and it can be used all around and it also applies to the training of operators. Born in 2000 in the Anchise group following Giampaolo Lai's conversationalism, the approach was enriched by the contributions of other authors: Naomi Feil and Validation, Tom Kitwood and the psychosocial approach, Moyra Jones and Gentlecare, Amartya Sen and the capability approach. EA exceeds the traditional approach to assistance that starts with an analysis of the needs of users and, in the case of people with dementia, tries to satisfy them without their involvement. Five *basic abilities* are considered to be included in the EA: **1.** *The Speech ability*, i. e. producing words regardless of their meaning. We value the word, especially that of the person suffering from dementia, whatever it is, even if it is truncated, repeated or meaningless, because the person who is speaking is not isolated, he/she immediately slips into a context. We seek, through appropriate verbal techniques, to keep the use of speech alive, convinced that the words of the person with dementia have meaning (from their point of view) even if we do not understand it. **2.** *The Communicating ability* (different from speaking) expressed through verbal, paraverbal and non-verbal language. **3.** *The Emotional ability*, i.e. feeling emotions, recognising and sharing the other person's emotions. **4.** *The Negotiating ability*, i.e. the competence to negotiate on everyday life things (an expression of this competence can be observed in the choice of the subject of the conversation during verbal exchanges). **5.** *The Deciding ability*, refers to daily choices even in the presence of cognitive deficits and in contexts of reduced freedom of decision. The extreme expressions of this competence are represented by behaviours of opposition, relational closure and isolation from the world. In an enabling environment the elderly can carry out the activities they are capable of, without feeling at fault, for the sole purpose of being happy (as much as possible) to do what they do, as they do it, in the context in which they find themselves. The second characteristic of the enabling approach is that it can be used both in specific contexts (e.g. retirement home intake interview, individual interviews, focus groups for people

with dementia, self-help groups for relatives, training courses) and in non-specific activities like occasional daily life meetings and professional activities of each operator.
For more information on this subject
Bibliographical references
Vigorelli P, (2019), The Enabling Approach projects for elderly with dementia, Youcanprint.

2.3.4 Alternative Augmentative Communication (AAC)

Methodological reference factsheet
Alternative Augmentative Communication
Alternative Augmentative Communication (normally abbreviated to AAC) is the term used to describe all modes of communication that can help communicate with people who have difficulty with the most commonly used communication channels, especially language and writing. It is defined as "Augmentative" because it does not simply replace or propose new communicative modes but, by analysing the subject's abilities, indicates strategies to amplify them (e.g. vocalisations, verbal language, gestures and signs). It is called "Alternative" because it uses strategies and techniques other than spoken language. This approach aims to create opportunities for real communication and effective involvement from the person; therefore, it must be flexible and tailor-made by the person themselves. This type of communication may include the use of new technologies for cognitive stimulation. Some studies have shown that the use of new technologies (tablets, PC-touch AAC programmes) leads to improved attention, manual eye coordination and improved coping with mood swings (acquisition of new skills and "self-esteem"). AAC is not regarded as a "method", but a set of techniques, strategies and technologies geared towards the person who does not speak, their interlocutors and their living environment. The priority is to facilitate the expression of people who do not speak or do not speak in an understandable way in order for them to better participate in life and relationship contexts. Within AAC, many different technical approaches exist that derive from comparing clinical, scientific and cultural experiences. The AAC expert has the technical responsibility to choose and apply the most appropriate and effective approach for the particular needs and characteristics of the non-speaker (age, basic pathology, residual communication skills, visual abilities, etc.) In accordance with these needs, solutions are adopted or suggested for the person's daily life. There is no single protocol as action depends on the person's basic pathology, age and communication needs. There is generally no gap between learning and functional use, as solutions must be learned in real communication situations directly through their use. Potentially, however, anyone who comes into contact with people with speech difficulties should be using AAC. It is customary for someone more experienced or competent to play a specific facilitator role.
For more information on this subject
Bibliographical references

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Websites

http://www.arasaac.org/aac.php
http://www.blissymbolics.org/index.php/about-blissymbolics
http://www.elmetodoarrietafilm.com/es/

2.3.5 Nonviolent communication (NVC)

Methodological reference factsheet
Nonviolent communication (NVC)
Nonviolent Communication (NVC) is a practice (and a communication process) designed and developed by Marshall Rosenberg, American psychologist, a student of Carl Rogers. Mr. Rosenberg grew up during the era of racial and class conflicts in Detroit, a city in which he was confronted with episodes of violence on an almost daily basis. He studied clinical psychology and comparative religions; he deepened his study of the lives of "bearers of peace" and became interested in all the disciplines that, in his opinion, helped him to understand the factors of violence and what contributes to reducing it. Trained in the field of humanistic psychology (A. Maslow, C. Rogers, E. Gendlin etc.) he has integrated his skills into the process he has called "Nonviolent Communication". In 1984, Mr. Rosenberg founded the Center for Nonviolent Communication, an international non-profit organisation with more than 100 trainers who disseminate NVC in 30 countries - in North and South America, Europe, Asia, the Middle East and Africa - and organise seminars for teachers, psychologists, parents, mediators, managers, prisoners and prison officers, police, military personnel, clergy and public administration staff. NVC proposes an easy to understand and effective method to get to the root of violence, suffering and conflict. Essentially, it is about knowing what frustrated needs are at the root of what we do or say, and what can help us reduce hostility, relieve pain and build more satisfying personal, emotional or professional relationships. The method is based on the development of awareness, empathy and communication skills. The novelty is in the integrative character, clarity and simplicity of the model that invites us to divert attention from thoughts (right/erroneous, you must/cannot, merit/guilt), in order to focus our attention towards four fundamental points or information that facilitate expression: - facts - feelings - needs - possible ways to meet these needs (strategies/requests) The method supports us and provides us with a safe path regarding the two components of communication: how we express ourselves and how we receive messages from others. On oral communication, NVC encourages us to differentiate between observations and evaluations, suggesting that we carefully observe what is happening, rejecting interpretations and favouring observation of facts rather than moralising judgements. It asks us to express our needs simply and honestly without criticising or insulting others, and to conclude by stating what we would like.

Practice therefore allows us to acquire great clarity about what we feel and the origin of our feelings; it helps us recognise and express our needs and values, and express precise and concrete requests at a given point in time.

By needs, NVC means a wide variety of requirements shared by all human beings: from survival needs such as food, air, rest, to more complex needs such as respect, autonomy, esteem etc.
In terms of listening, NVC allows us to understand the needs of others beyond the criticism, judgment or aggression we feel.
No matter how people address us, NVC enables us to realise that we have the power to choose between conflict or empathetic deciphering of the four pieces of information (facts, feelings, needs, strategies), even when they are hidden under a blanket of self-centred thoughts and expressed in tragic ways, through moralising judgements, claims or obligations.
This language is simple but requires training because the dominant culture in which we have been trained has probably taught us most often to communicate in a way that is disconnected from what is naturally alive in us and in others.
NVC assumes that any conflict is based on the inconsistency of proposed strategies, and that many alternative strategies can be devised to meet the same needs.
Needs are shared by all, while the means to meet them can be very different from one person to another and depending on the different cultures to which they belong.
In other words: needs are universal, therefore shared and understandable by all and, from them, we can all understand each other, while strategies are multiple and extremely subjective. If we stay focused only on the latter, it is easy to get to conflict and fuel violence.
In the presence of two contradictory points of view, the emergence of each other's needs allows a connection between the parties and the identification of relevant strategies to satisfy all needs.

In mediation, the facilitator's action therefore aims to:

- support the identification of each party's needs (regardless of how these are expressed),
- ensure that these needs have been properly perceived by the other party,
- stimulate the empathy that everyone needs to welcome and understand the other person's needs,
- ensure that everyone understands their own needs and those of others,
- help the parties to translate possible solutions into specific actions.

With NVC, Mr Rosenberg has initiated peacebuilding programmes in conflict-ridden countries such as Rwanda, Burundi, Nigeria, Malaysia, Indonesia, Sri Lanka, Sierra Leone, the Middle East, Colombia, Serbia, Croatia and Northern Ireland.

For more information on this subject

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Websites
https://www.cnvc.org https://www.nonviolentcommunication.com/index.htm

2.3.6 Reminiscence

Methodological reference factsheet
Reminiscence
Reminiscence is a psychosocial intervention that aims to increase well-being, self-confidence and personal integrity. It has been shown to be effective in reducing behavioural disorders in people with dementia. It is based on the natural predisposition of older people to re-evoke the past as well as on the preservation of long-term memory in the person with dementia. Through photographs, music and videos, technological tools such as computers can be used to facilitate the process of recovering memories. Reminiscence can also provide a support tool for the anamnesis of personal history by preserving memories during the subsequent stages of the illness. Reminiscence can be used for several purposes: to increase life satisfaction and well-being in the elderly, to intervene with elderly people suffering from mild and major depression and to stimulate cognitive functions in the context of dementia. Short-term memory is one of the cognitive abilities mainly affected by dementia, while long-term memory remains intact until severe stages of the illness. Cognitive deterioration involves a loss of identity, associated with autobiographical memory, and social relationships (Addis and Tippet, 2004). Indeed, our memories are fundamental to sharing our experiences, for our relationships and to maintaining our identity and sense of self (Addis, 2004, Cohen and et al., 2006). Reminiscence therapy is based precisely on the importance of memory in supporting the person's identity and well-being. It can be defined as "discussing past activities and experiences with another person or in a group, generally with the use of aids such as photographs and other elements of the past like music" (Woods et al., 2008). Reminiscence is not only an intervention but is useful for "the achievement of many objectives, including communication, socialization, pleasure and involvement" (Woods, 1999). The main objectives that reminiscence achieves are the stimulation of memory, the improvement of mood and well-being, the effectiveness of care through the personalisation of the intervention and the alleviation of the caregiver's burden. Research shows that factors predictive of the success of reminiscence therapy exist. Studies by Watt and Wong (1991) show a link between the use of integrative and instrumental reminiscence and significant improvements in positive adaptation and psychological well-being, with significant reduction in depressive symptoms (Karimi et al., 2010; Bohlmeijer et al., 2003). There is a better outcome for people with a positive attitude towards reminiscence than for those who lose interest (Bohlmeijer et al., 2003). To design a satisfactory intervention, it is necessary to define specific factors: the environment, the objectives of the intervention, the characteristics of the reference group and the competence of the intervention leader. Two types of therapy can be identified :

- Simple reminiscence: unstructured and spontaneous narrative of personal life. The central objective is to recall positive memories, facilitate communication and social contacts to improve immediate well-being (Webster et al., 2010). The lead person's role is to facilitate the process of spontaneous reminiscence and promote social interaction.
- Life review: it is more structured, focused on the integration of positive and negative events. It is aimed primarily at people who need support and coping strategies to overcome life's adversities. It helps the person to have an overview and remember how these events occurred and became what they are. This allows us to focus on the adaptation resources used in the past and on the values that have enabled the person to successfully adapt to change and overcome life's difficulties. It therefore has a function of problem solving and identity formation. The main objective is self-acceptance: people are encouraged to reformulate their experiences in a more appropriate way, integrating positive and negative experiences. The leader must have more specific abilities, and must try to restructure the meaning of past events.

For more information on this subject

Bibliographical references

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Wood P, Ashley J. (1995) Stimulated presence therapy: using selected memories to manage problem behaviors in Alzheimer's disease patients. Geriatric Nursing, volume 16, numero 1 pp 9&14.

Website

Alzheimer association http://www.alz.org/

2.3.7 Validation

Methodological reference factsheet
Validation
This method was developed between 1963 and 1980 by Naomi Feil, a graduate of Columbia University and a member of the Academy of Social Workers. In the 1960s, Feil worked in a retirement home in Cleveland, USA, where she came into contact with the world of disoriented seniors and began to use validation. This technique consists of promoting the mental development of older people with problems, classifying their behaviour and helping them to regain their personal dignity. The Validation theory is based on the principles of analytical and humanistic behavioural psychology. Each of the following sentences presents a facet of the theory: - Accept your patient without judging him (Carl Rogers). - The therapist cannot really understand or modify the behaviour if the patient is not willing to change or does not have the intellectual capacity necessary for introspection (Sigmund Freud). - Consider your patient as a unique individual (Abraham Maslow). - The feelings expressed, then recognised and legitimised by a listener who enjoys the patient's trust will become less intense. When ignored or refused, feelings take on strength "The ignored cat becomes a tiger" (Carl Jung). - Each phase of life has a central task that we must face within a time frame within the short space of human life. We must strive to complete this task and then move on to the next task (Erik Erikson). - A neglected task needs to be completed in the next stage (Erik Erikson). - Human beings strive to maintain balance (homeostasis) (S. Zuckerman). - When recent memory (short-term memory) weakens, very old people restore balance by recalling old memories. When visual ability decreases, they use the eyes of the mind to see. When the hearing fades, they listen to the sounds of the past (Wilder Penfield). - Distant memories, well preserved, persist in the very old person (FG Schettler and GS Boyd). - The brain is not the only regulator of behaviour in the very elderly. Behaviour is a combination of physical, social and intrapsychic changes that occur during the short period of life (Adrian Verwoerdt). - Autoptic examinations have shown that many very old people survive with severe brain damage, remaining relatively well oriented (Charles Wells). - There is a reason behind the behaviour of very old maloriented and disoriented people (Naomi Feil). - Every human being is precious regardless of his or her degree of behaviour (Naomi Feil).

As can be seen, these sentences, chosen by the author, present a theory that puts at the centre the profound respect for the elderly, considered important despite the damage caused by psycho-physical decline.

Validation is based on the Erik Erikson's theory of life stages, which emphasizes the strict dependence between the biological, mental and social aspects of the human being and his actions. In practice, it states that we will succeed in accomplishing a given task, which falls to us at a certain stage of our lives, only if we have successfully completed the previous tasks of the first years of life.
There is another stage of life, reached by those who live to an advanced age: during this period, the emotions unresolved in the past must be unlocked: everyone in this condition feels the need to be listened to; otherwise they will irreparably slip into a vegetative state.
Thus a fundamental task for the operator using Validation is emerging: to listen, even if we will probably not succeed, given the now advanced stage of life, in achieving a true resolution.

Below are some fundamental points of this technique:

1. Gather information about the elderly person.

In particular, it is essential to know: their stage of disorientation; the unfinished tasks and emotions; the human and emotional relationships of the past; the profession, hobbies; the relationship with religion; the way in which the person faces difficulties and losses; clinical history. This information can be collected through questions to the person, asked at different times of the day and for at least two weeks; the questions have been highlighted by Feil, as they must be precise enough to guide the operator.

2. Assess the stage of disorientation.

The stages can be:

- First stage: orientation disorders.
- Second stage: temporal confusion.
- Third stage: repetitive movements.
- Fourth stage: vegetative life.

3. Meet with the person regularly and use validation techniques.

The duration of each interview depends on the stage of disorientation in which the person is: from a minimum of one to a maximum of fifteen minutes (the shortest time is dedicated to those with major problems). In any case, it is not the quantity, but the quality of the allocated time that counts. The ideal frequency also depends on individual situations: from several times a day to a few weekly meetings, or even less frequently. It is important to be able to perceive when the elderly person is feeling less uncomfortable as this indicates the end of the interview (in this case too, Feil gives very precise indications).

For more information on this subject

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2.3.8 Montessori method

Methodological reference factsheet
Montessori method
Maria Montessori created the method that bears her name by observing children. It is based on the child's sensory, physical and intellectual capacities to enable the development of their potential. For her, the conditions for the success of this personal development are: - Respecting the rhythm of individual characteristics, - The awakening of the bond with others. The Montessori approach in the clinical field is being tested for the first time by Dr Cameron Camp, author of the Montessori-Based Dementia Programming (MBDP) at the Myers Research Institute in Beachwood, Ohio, of which he is the director. In this clinical and rehabilitation context, Dr Camp experimented with the principles and materials of Montessori pedagogy. This application, says Dr Camp, has proven to be a winner. By studying the role of the cerebral tonsils, groups of neurons preserved until very late in people with dementia of the Alzheimer type, we can see that: - If the rational brain is altered, the emotional brain works. - If the declarative memory is altered, the procedural memory works. People's environment is redesigned to support behaviour and autonomy. Thus, by circumventing deficiencies and relying on preserved skills, people with cognitive impairments can relearn everyday gestures. It is then our perception that changes. We borrow Maria Montessori's motto: "Help me to do it alone". To make the patient's journey effective, it is planned to personalise and build it with his or her active collaboration and that of his or her family. More generally, it is necessary to ensure that the Montessori method and associated materials are appropriate to the person's needs. The following are some important points to respect: **Starting from observation.** Montessori specialists build their own educational proposals based on careful observation of patients, providing them with equipment adapted to maintain and strengthen their residual capacities. This serves to look at the subject in a new way, focusing attention not on the disease, but on the person's abilities. **Need for order.** Storing and using equipment in a certain order helps to maintain internal order. The isolation of a quality is characteristic of Montessori equipment and allows attention to be focused on only one aspect of the equipment. For example, working on sound or colour, roughness or length, size or taste... This allows attention to be focused on a single aspect of the material. A characteristic of Montessori material is to focus on a feature. **Sensory skills.** Senses are the tool everyone possesses in order to know and recognise the living environment. When preparing the equipment, the specialized operator will adapt it (depending on the subject and the situation) to deal with any possible sensory disabilities.

Use of appropriate equipment. The equipment used must be adapted to the subject's level of competence: it must not be too easy (risk of boredom) nor too complex (can lead to frustration).

Need for regularity and routine. Disorientation is one of the first symptoms of the disease and is a great challenge to face with the patient. Each activity seeks order by having its own place, a precise and ritualised mode of execution, always clean and tidy.

Work on memory, in particular on procedural memory. The field of memory is explored through the exploration of the senses, from concrete to abstract, through simple, linear paths, characterized by a clear and defined procedure. The specialised operator introduces each activity through a precise presentation, based on a careful analysis and the selection of the necessary movements.

Attention to interpersonal relationships. During the presentation of the activity, the individual relationship between the patient and the specialised operator allows the creation of a rapport of trust and mutual knowledge useful for the construction of an optimal rehabilitation programme. Furthermore, group activities make it possible to maintain social relations, cooperation and mutual assistance.

Work on language. Maria Montessori studied an effective system to promote reading and writing, based on concrete actions, to move from hand to mind and abstraction.

Caring for oneself and the environment. The proposed activities stem from the needs expressed explicitly or implicitly by the patient and are relevant to daily activities, useful to maintain autonomy as long as possible; in addition to personal care, the activities aim to take care of the living environment: watering plants and flowers, cleaning leaves, dusting...

Freedom of action and choice. The patient is free to choose the activity to be performed and the duration of its execution. The (open) activity ends when the subject is satisfied with the work done. No programme is predefined by the operator. What matters is to stimulate the patient's interest by presenting materials that are "attractive" to him or her, i.e. useful to stimulate his or her well-being and skills. This approach will make it possible to work on the self-esteem that the patient often has to rebuild, as well as on his autonomy of thought. Self-correcting material allows the subject not to be corrected from the outside in case of error, but to independently find the solution to the problem.

Effects and consequences:

- Reactivation of the capacity for social connection
- Desire to belong to a community of people
- Participation in everyday life activities
- Enhancing and calming families
- Reclaiming and rehumanising the environment
- A change of perspective on the disease and people

For more information on this subject

Bibliographical references

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2.3.9 Occupational therapy

Methodological reference factsheet
Occupational therapy
Occupational therapy (OT) is a rehabilitative health profession that promotes health and well-being through occupation. It is a rehabilitation process that uses "doing" and the many activities of daily life as its preferred means. Through individual or group intervention, it engages the whole person with the aim of helping them adapt to a specific physical, psychological or social context or condition in order to improve their overall quality of life, even in a situation of disability. It is supported by "Occupational Science", born from scientific research and based on the importance of occupation in human nature. Occupations are all activities that are significant for their cultural context, adapted to age, choices, organised and carried out by each individual to support himself, experience the joy of living and contribute to the economic and social life of the community (Canadian Association of Occupational Therapy, 1997). Occupation is the purpose of OT but also the means by which we try to modify the person's bodily functions (sensory-motor, perceptive-cognitive, emotional-relational abilities); generally there are three areas in which we can find occupations: personal care, work (school) and leisure activities. Occupational therapy is practiced in a wide range of settings, including hospitals, health centres, the home, workplaces, schools and nursing homes. Patients are actively involved in the therapeutic process and the outcomes of occupational therapy are diversified, patient-led and measured in terms of participation or satisfaction derived from participation (World Federation of Occupational Therapy). Occupational therapists (OTs) play an important role in helping people of all ages. Occupational therapy is necessary to overcome the effects of dysfunctions caused by illness, ageing, accidents, temporary and permanent disabilities. Occupational therapists intervene professionally so that the person can perform daily or professional activities with the highest degree of autonomy possible. They are qualified professionals who find solutions to everyday problems. Occupational therapists take into account all physical, psychological, social and environmental needs by providing support that makes a difference in the patient's life, with a renewed sense of meaning and the opening of new horizons. Occupational therapists assist users by empowering them to make decisions: they bring their medical, psychological, cognitive, social and technical skills and help the person choose the goals and form of treatment he/she most favours, by giving him/her the opportunity to speak. Occupational therapists receive extensive training. It gives them the skills and knowledge to work together with individuals or groups of individuals who have a structural or functional deficit due to a health problem and who face barriers to participation.

Occupational therapists believe that participation can be supported or limited by the physical, social, attitudinal and legislative environment. The practice of OT may therefore aim to change aspects of the environment to increase participation.
For more information on this subject
Bibliographical references Jane Clifford O'Brien (2017), Introduction to Occupational Therapy, Elsevier.
Website
Canadian Association of Occupational Therapy https://www.caot.ca/

2.3.10 Cognitive stimulation

Methodological reference factsheet
Cognitive stimulation
Cognitive stimulation is an intervention that is strategically oriented towards the person's general well-being in order to increase their involvement in tasks aimed at reactivating residual skills and slowing down functional loss due to the pathology. The scientific world's initial mistrust of non-pharmacological treatments for dementia has given way in recent years to a growing interest due to two types of motivations. First, the limitations of pharmacological efficacy impose a multi-component clinical approach that is based not on the patient's (impossible) cure, but on the care (understood as taking care) of the overall quality of life. Second, the evolution of neuroscience has only enriched the data supporting the plastic and adaptive nature of the nervous system in the face of internal and external changes, including those due to traumatic or pathological events. Indeed, neuroplasticity refers to the brain's ability to modify its structural organisation and functioning to adapt to new demands. The complex functions that the brain manages are determined by the number of connections between nerve cells. To clarify this, we will use the famous automobile metaphor. The nervous system could be compared to a very rich road system on which huge amounts of information travel. Normally, to go from Lyon to Paris, I enter the motorway, the journey is generally quite fast and easy. If, however, the motorway is blocked due to an accident, I will always be able to reach Paris thanks to a rich network of national roads. It will take me longer, the traffic may be less easy, I may also get lost, but in the end I will reach my goal. Mental activity, environmental experiences, the quality of cultural training and work over the life course are powerful factors that determine the number and quality of active neural connections. The more connections a network is equipped with, the more alternative routes it provides which can replace and compensate for circuits damaged by disease or minor trauma. In the brains of adults and the elderly, remodelling phenomena mainly concern two neurological processes: the formation of new synapses (connections between neurons) in response to damage caused to consolidated nerve pathways, and the reactivation of rarely used latent pathways. Cognitive stimulation therefore acts by promoting the progressive functional reactivation of secondary nerve pathways which are widely distributed in adult nervous systems. In response to a lesion or physiological loss of neural material it would therefore be possible to recover some inhibited connections through systematic stimulation experiments (Cesa-Bianchi M., 1999). Our brain seems endowed with a kind of cognitive reserve constituted by the high number of nerve cells we have and the number of pathways that connect them. One could imagine a large

army engaged in war operations: soldiers from elite corps (such as our neurons) used in the most delicate operations can be subject to dramatic losses but also replaced by training new soldiers to substitute their missing comrades. This is how our brain, if sufficiently stimulated, autonomously repairs its own small damages.

It is not only the number of connections that is decisive, but also their strength, i.e. the frequency with which they are used. Every time a path is traversed by new information, it stabilises and consolidates, so that the more we "dust off" a memory or skill, the more we encourage its maintenance.

It is a well-known experience for those who decide to resume a sport they have not practiced for many years. The first movements are uncertain, a little clumsy and even rigid perhaps, but after a little training the pleasant feeling of easily rediscovering overlearned gestures (exercised many times in the past) and quickly recovering the fluidity of movement they had in the past.

Objectives of cognitive stimulation:

- Promoting the use and over time maintenance of residual functions. Cognitive deterioration does not occur in all subjects with similar characteristics with the same level of severity. The degree and quality of remaining abilities differs between patients.
- Understanding the overall and specific level of functioning and modulating the activity proposal in order to promote the use of skills that are still sufficiently retained. Cognitive stimulation is therefore a highly structured activity not to be confused with any other type of recreational and playful proposal. The difference between a naive intervention and a correct stimulation does not primarily consist in the individual activities offered, but in the targeted, individualised and specific nature of the exercises.
- Promoting rewarding experiences that support self-esteem and self-image. For any type of proposal to be accepted and implemented by the elderly person with dementia, it must be adapted to the person's interests and social skills. In particular, it is important that the activities allow for a healthy self-esteem and promote the maintenance of a good personal image. For this reason, activities carried out through childish material can sometimes be experienced as humiliating and therefore rejected.

For more information on this subject

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2.3.11 Sensory stimulation

Methodological reference factsheet
Sensory stimulation
Aging is normally associated with gradual deterioration of the five senses. However, there is limited knowledge about the evolution of senses due to dementia (Strøm, Ytrehus, Grov, 2016; Wittmann-Price 2012). What we do know is that the way a person with dementia interprets what they see, hear, taste and smell seems to change due to the disease (National Institutes of Health, 2002) and according to the stage of dementia (Alves et al. 2014). Sensory stimulation is based on the activation of one or more senses (taste, smell, sight, hearing, touch) through various tools and materials. This helps to stimulate the senses. Sensory activities provide a level of stimulation that works on awareness and attention through the simplicity of the tasks. Various psychosocial interventions based on sensory stimulation, sometimes called "activities, methods, therapy or stimulation", have been developed (Fossey et al. 2006, Kolanowski et al. 2010). Types of sensory stimulation and their benefits: **1.** Auditory stimulation: Very useful for improving mood, cognition and relaxation. This includes a wide range of sounds: natural sounds, symphonies, songs, etc. Listening to sounds is an essential part of connecting with our senses. Many patients with dementia have hearing problems and it is therefore essential to stimulate this sense, remembering that adjustments may be necessary. **2.** Tactile stimulation: This type of stimulation involves texture and touch awareness. The brain pathways are used and stimulated every time we use our hands to hold something. **3.** Visual stimulation: Sight is one of the most important senses and helps us manage a very large amount of information. Tragically, Alzheimer's disease and various dementias can affect the visual processing system. - Light therapy is a visual therapy that has been successfully tested in patients with Alzheimer's disease and dementia. It can improve sleep cycles, reduce wandering and improve cognition and behavioural functioning. - Films and videos offer both auditory and visual stimulation. When choosing a film to stimulate memory, it is better to choose either a film with a story that can easily be followed or the beneficiary's favourite film. Movies with beautiful images, for example those set in nature, or with soft music, are suitable. The way the living space is decorated is very important. Creating a visually stimulating environment, even with photos, can be extremely useful for a person with dementia.

- The way the living space is decorated is very important. Creating a visually stimulating environment, even with photos, can be extremely useful for a person with dementia.

4. Olfactory stimulation

Some of our oldest and strongest memories are activated by smell. Well-known basic aromas such as mint, lavender or rosemary are used for olfactory stimulation. These essences are also used in aromatherapy, which is much more than just sensory stimulation. Spices and flavours can also stimulate memory or the sense of taste.

5. Snoezelen

This is called controlled sensory stimulation. It is used on people with severe intellectual disabilities who are exposed to a "calming" and "stimulating" environment called the Snoezelen Room (or more precisely a multisensory stimulation room) that uses light effects, sounds, music, perfumes, surfaces, tactile forms and taste stimuli.

To date, several studies are available in literature on the use of the Snoezelen methodology as a therapeutic tool. Results show that following multisensory stimulation sessions there is a reduction in non-adaptive behaviours together with an incentive for positive behaviours (Baker 2001, van Diepen 2002, Hope 1998, Long 1992). In short, the Snoezelen approach makes it possible to manage behavioural disorders, promotes relaxation, contact, interpersonal relations, well-being and reactivation of the person. The operator therefore adapts to the person's forms and methods of communication; as a partner he/she is fully involved in the action because he/she is the one who interacts and helps the person interact with the surrounding objects, as a conscientious guide. The operator is also open to the signals sent and encourages the free choice of the person.

For more information on this subject

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SALTO

3. Unit Format

Each unit is presented according to the following methodological framework in order to highlight the main elements of the training project.

Unit factsheet
Audience (initial training or continued training)
Instructors
Backdrop (Vocational Training Centre, University, workplace)
Aims and objectives
Contents
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)

3.1. UNIT 1 – BENEFICIARIES/USERS: CHANGING MODELS

UNIT 1 – BENEFICIARIES/USERS : CHANGING MODELS
Audience
Initial and continuing training
Instructors
Experts in geriatrics, neuropsychiatry, psychology
Context
Vocational training, university, workplace
Aims and objectives
- Getting to know the profiles of beneficiaries; - Knowing their rights; - Changing representations, models and stereotypes to adopt a posture of watchfulness and empathy.
Contents
- Ageing and/or disability: pathologies, cognitive disorders, physiological, psychological and social aspects, etc. - Impact on quality of life; - Legislation on the rights of fragile and dependent persons; - Elderly or disabled people in other cultures (anthropology); - History of ageing and people with disabilities (by geographical area); - Evolution of generational profiles in our regions.
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Methods Brain storming on ageing/handicap (oral or written). Choice of inductive or deductive sequence: one can either start from case or problem analysis to arrive at the theoretical or the theoretical elements can be presented first, then the cases and problems. Contributions through multimedia supports. Case studies in small or large groups. Active pedagogy focused on a given problem, in small groups. **Tools**: computer, video projector, slideshow, internet, case study, flip chart. **Space**: room with movable chairs.

Recommended number of participants: 25 max **Recommended duration**: 15 hrs
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)
Diagnostic evaluation: Brain storming **Formative evaluation:** Observation of group activities Discussion **Final evaluation (of learnings) :** Questionnaire/test on theoretical aspects Case study to apply the theory

3.2. UNIT 2 – SOCIAL ANIMATION: A LEVER FOR QUALITY OF LIFE

UNIT 2 – SOCIAL ANIMATION: A LEVER FOR QUALITY OF LIFE
Audience
Initial and continuing training
Instructors
Experts in socio-cultural animation, pedagogy, innovative methodologies (music therapy, theatre, etc.)
Context
Vocational training, university, professional site
Aims and objectives
- To know/acquire the approaches and methods of social animation in order to apply them in a given context; - To organise enabling spaces and atmospheres/resources conducive to well-being; - To adopt an empathetic relational communication style; - To develop activities that promote well-being and the preservation of personal skills; - To design, develop and evaluate interventions based on social animation.
Contents
- Organisation of spaces and resource atmospheres ▪ Montessori method - Communication ▪ Nonviolent Communication ▪ Validation ▪ Gentlecare - Animation methods ▪ Sensory stimulation methods ▪ Cognitive stimulation methods ▪ Person-centred approach ▪ Occupational therapy ▪ Enabling approach ▪ Psychomotricity – Physical stimulation ▪ Reality orientation therapy (ROT)

▪ Reminiscence - Use of new communication technologies - Project implementation and person-centred evaluation
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Tools Contributions with multimedia support Videos External interventions Putting it into practice Participatory activities Case studies Simulating the implementation of an animation project External visits and/or activities **Spaces**: depending on the planned activity. **Recommended number of participants**: 25 max **Recommended duration**: 40 hrs
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)
Formative evaluation: Observation of activities Discussions **Final evaluation (of learnings):** Case study and project simulation

3.3. UNIT 3 – RELATING/COMMUNICATING WITH BENEFICIARIES/USERS

UNIT 3 – RELATING/COMMUNICATING WITH BENEFICIARIES/USERS
Audience
Initial and continuing training
Instructors
Experts in communication and/or psychology and/or pedagogy and/or social work
Context
Vocational training, university, workplace
Aims and objectives
- Improve the relationship and communication with users for a better quality of life; - Acquire skills to: ▪ listen and communicate with beneficiaries in an empathetic way (nonviolent communication), ▪ take into account verbal and non-verbal communication (Gentlecare), ▪ know how to manage the admission phase and critical moments, ▪ take into account and value diversity.
Contents
- Empathetic communication – nonviolent communication (Rogers), - Verbal and non-verbal communication (Gentlecare) - Admission/welcome, daily life and critical moments - Managing diversity – intersectionality (gender, ethnicity, age, etc.) - Verbal and non-verbal communication - Alternative communication (use of new communication technologies, etc.)
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Methods Videos Simulations: communication scenarios Simulations: step into the shoes of the elderly/disabled Workshops Role-playing games Video analysis Case studies

Group work **Tools**: computer, video projector, slideshow, internet, case study, flip chart, camcorder, etc. **Space**: room with movable chairs, video. **Recommended number of participants**: 6-15 max per instructor. **Recommended duration**: 20 hrs
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)
Diagnostic evaluation: Brain storming on communication with users (oral or written) **Formative evaluation:** Observation of activities Discussions **Final evaluation (of learnings) :** Questionnaire on theoretical aspects Role-play and scene specific simulations
Sources
KILT project http://www.kilt-project.eu **Brené Brown** Réflexion sur la notion d'empathie https://www.youtube.com/watch?v=1Evwgu369Jw

3.4. UNIT 4 – COMMUNICATION IN THE WORK TEAM FOR THE QUALITY OF LIFE OF PROFESSIONALS

UNIT 4 – COMMUNICATION IN THE WORK TEAM FOR THE QUALITY OF LIFE OF PROFESSIONALS
Audience
Initial and continuing training
Instructors
Experts in communication and/or psychology and/or pedagogy and/or social work
Context
Vocational training, university, workplace
Aims and objectives
- Facilitate communication dynamics in the work team to improve quality of life and prevent burnout; - Acquire skills to: ▪ listen and be able to communicate with colleagues (nonviolent communication) ; ▪ know and recognise group dynamics; ▪ recognise and manage communication contexts and flows (informal, formal, etc.); ▪ prevent and manage conflicts.
Contents
- Nonviolent communication (NVC)/Empathetic communication - Group dynamics: interactions, roles, etc. - Information flow management, critical analysis of information, collective decision-making: Six Thinking Hats (Edward De Bono). - Use of new communication technologies, etc.
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Methods Videos Simulations: communication scenarios within the team Workshops Role-playing games Video analysis

Case studies Group work **Tools**: computer, video projector, slideshow, internet, case study, flip chart, camcorder, etc. **Space**: room with movable chairs, video, camcorder. **Recommended number of participants**: 6-15 max per instructor. **Recommended duration**: 15 hrs
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)
Diagnostic evaluation: Brain storming on communication in the work team (oral or written) **Formative evaluation:** Observation of activities Discussions **Final evaluation (of learnings):** Questionnaire on theoretical aspects Role-play and scene specific simulations

3.5. UNIT 5 – INVOLVEMENT OF FAMILIES AND FRIENDS

UNIT 5 – INVOLVEMENT OF FAMILIES AND FRIENDS
Audience
Initial and continuing training
Instructors
Experts in communication and/or psychology and/or pedagogy and/or social work, experts in innovative methodologies.
Context
Vocational training, university, workplace
Aims and objectives
- Facilitate family empowerment and communication between team and family; - Acquire skills to: ▪ listen and communicate with families in an empathetic way (NVC); ▪ promote the training of families and volunteers; ▪ involve the family in the daily life of the centre (collaborative areas); ▪ include families in social animation activities; ▪ integrate the volunteering element into the daily life of the centre.
Contents
- Active listening. - Nonviolent communication. - Organisation of training activities for families and/or volunteers. - Active involvement of the family in key daily activities (good practices: focus groups, Alzheimer's café, counselling, participation of the family in programming sessions, etc.). - Social animation projects with families (good practices). - Use of new communication technologies (Skype, etc.).
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Methods Workshops Simulations: communication scenarios with families Role-playing games Video analysis Case studies

Testimonies Good practice analysis Group work Development of training projects for families and/or volunteers **Tools**: computer, video projector, slideshow, internet, case study, flip chart, camcorder, etc. **Space:** room with movable chairs, video, camcorder. **Recommended number of participants**: 6-15 max per instructor. **Recommended duration**: 20 hrs
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)
Diagnostic evaluation: Brain storming on communication with family and friends (oral and/or written) **Formative evaluation:** Observation of activities Situation analysis Discussions **Final evaluation (of learnings):** Simulations of communication scenarios (role play, scene setting, etc.) Project development

3.6. UNIT 6 – EMPOWERMENT OF BENEFICIARIES/USERS

UNIT 6 – EMPOWERMENT OF BENEFICIARIES/USERS
Audience
Initial and continuing training
Instructors
Experts in socio-cultural animation, pedagogy, psychology, social work, innovative methodologies.
Context
Vocational training, university, workplace
Aims and objectives
- Promote beneficiary/user empowerment; - Acquire skills to: ▪ recognise and highlight the needs, capacities and interests of individuals; ▪ heighten awareness of the relationships (social, emotional, etc.) between beneficiaries; ▪ involve beneficiaries in daily activities; ▪ involve beneficiaries in the organisational life of the organisation; ▪ ensure beneficiaries remain at the core of their own life project.
Contents
- Empowerment (theory and practical application) - Active citizenship (theory and practical application) - Analysis of needs and interests - Person-centred approach - Empowerment projects (analysis of good practices) - Methodologies and strategies for empowerment - Use of new communication technologies
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Methods Lesson with multimedia resources Case studies in small or large groups Active pedagogy based on a given problem (small group) Workshops Analysis of good practices

External visits Testimonies Group work Development of projects aimed at empowering users/beneficiaries **Tools**: computer, video projector, slideshow, internet, case study, flip chart, camcorder, etc. **Spaces**: room with movable chairs, video projector. **Recommended number of participants**: 25 max **Recommended duration**: 20 hrs
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)
Formative evaluation: Project analysis Discussions **Final evaluation (of learnings):** Questionnaires on key concepts Project development

3.7. UNIT 7 – RELATIONSHIP WITH THE LOCAL AREA

UNIT 7 – RELATIONSHIP WITH THE LOCAL AREA
Audience
Initial and continuing training
Instructors
Experts in socio-cultural animation, pedagogy, psychology, social work, innovative methodologies; socio-cultural mediators.
Context
Vocational training, university, workplace
Aims and objectives
- Embrace the local and regional dimension to promote active citizenship; - Acquire skills to: ▪ know and take into account the local area and its resources/opportunities; ▪ take into account the specificities of the home and living environment (promote connections between the home and institutions); ▪ develop partnerships with the local area; ▪ foster experiences of social inclusion (disability, intergenerationality, interculturality, etc.).
Contents
- Mapping of key players in the area - Diversity in the community (social inclusion) - Analysis of relations between users and local area - Creation of participatory projects by involving other organisations and/or the local area - Networking (COMPARES Project) - Thinking about the service user's home in relation to local resources - Use of new technologies for the local network
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Methods Contributions with multimedia resources Cartography workshop Case studies in small or large groups Active pedagogy based on a given problem (small group) Analysis of good practices

External visits Testimonies Group work Drama project **Tools**: computer, video projector, slideshow, internet, case study, flip chart, etc. **Space**: room with movable chairs, video projector. **Recommended number of participants**: 25 max **Recommended duration**: 20 hrs
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)
Formative evaluation: Cartography analysis Project analysis Discussions **Final evaluation (of learnings):** Cartography development Project development
Sources
COMPARES Project http://etcharry-formation-developpement.fr/fr/projet/compares-competences-partenariat-reseaux **KILT Project** http://www.kilt-project.eu

3.8. UNIT 8 – DEVELOPING A SOCIAL ANIMATION PROJECT

UNIT 8 – DEVELOPING A SOCIAL ANIMATION PROJECT
Audience
Initial and continuing training
Instructors
Experts in socio-cultural animation, experts in pedagogy, psychology, social work
Context
Vocational training, university, workplace
Aims and objectives
- Learn the principles of planning, carrying out and evaluating an animation project; - Acquire methodologies and tools to assess the animation needs in a care context; - Develop an animation project according to needs; - Contextualise and evaluate the implications of an animation project.
Contents
- Planning an animation project - Situation and needs assessment - Definition of objectives - Choice of animation methodology - Description of activities (equipment, spaces, duration) - Definition of evaluation tools - Implementation of an animation project - Evaluation of an animation project - Examples of animation projects
Methods and description of the activity **Tools, number of people, spaces, timings, etc.**
Methods Simulations on one's own professional environment or practical case studies Work placement Assessment of projects already completed Group work for project planning Simulations and risk analysis (SWOT) Practical implementation of the project and impact assessment **Tools**: computer, video projector, slideshow, internet, case study, flip chart, etc.

Space: room with movable chairs, video projector, meeting areas in institutions. **Recommended number of participants**: 25 max **Recommended duration**: 30 hrs
Methodological guidelines for evaluation (diagnostic, formative and final evaluation tools)
Formative evaluation: Project assessment according to selected methodological indicators Discussions **Final evaluation (of learning achievements) :** Project analysis Results analysis for completed projects Verifying project risk analysis