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The Enabling Approach, an Italian Approach to Persons Living with Dementia

Pietro Vigorelli

Gruppo Anchise, Milan, Italy.

***Corresponding Author:** Pietro Vigorelli, Gruppo Anchise, Milan, Italy. (pietro.vigorelli@approcciocapacitante.it)

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Abstract:

The review summarizes 20 years of clinical practice and research into an innovative approach to the care of Persons Living with Dementia. It is an approach that places the words, those of the caregiver and those of the patient, at the center of attention and which has the aim of promoting a Happy-enough Coexistence between speakers. This review is organized into two sections: the first on the generalities of Enabling Approach, the second on some of its practical applications: Welcoming Conversations; Computational Analysis of Conversations, The Anchise Corpus; Groups for Family Members (ABC Groups); Anchise Group and Website.

KeyWords: enabling approach; non-pharmacological treatment of dementia; anchise corpus; computational analysis of conversations; welcoming conversations; ABC Groups; elementary competencies; conversazionalismo

Introduction

The widespread diffusion of dementia throughout the world, the significant public and private spending for the treatment of Persons Living With Dementia (PLWD) and the lack of satisfactory drugs are an incentive to develop research in two directions: biological research, aimed at early diagnosis and more effective drugs in the cure of the disease and psychosocial research aimed at the patient care.

In Italy, much attention is paid to the management of PLWD through non-pharmacological treatments, such as those imported from abroad (especially Gentlecare® and Validation®), and those born in Italy such as the ApproccioCapacitante® (Enabling Approach - EA) the only codified, recorded, with a diffusion from North to South Italy, which is presented in this review.

EA is a professional intervention based on the words that seeks to create an enabling environment in the location where elderly persons with dementia live, including all types of dementia, particularly Alzheimer's disease (AD).

The goal is to create the conditions for a Happy-enough Coexistence between the speakers: Persons Living With Dementia (PLWD), caregivers and family members.

When an enabling environment is created, subjects feel allowed to perform activities which they are capable of doing, in their own way, without feeling in error. The only purpose is to be as happy as possible, in doing what they are doing, in their own way, in the particular context in which they are. In this environment they can exercise their Elementary Competencies, especially the Speech Competence.

This review is organized into two sections: the first on the generalities of EA, the second on some of its practical applications. A satisfactory Italian bibliography is available on the website www.approcciocapacitante.it.

1. Generalities of EA 1.1.

Origin and intersections

The EA was introduced in the early 2000s in Italy by Pietro Vigorelli [1-7], and has spread through multi-disciplinary seminars and training courses organized by Anchise Group in Milan and across Italy. From the methodological point of view, the EA is derived from direct experience in assisting people and from the study of verbal exchanges between PLWD and caregivers, which were recorded and carefully transcribed. The EA has its roots in the concept of Therapeutic Alliance[8-10] and is derived from Giampaolo Lai's method called Conversazionalismo[11-15].

It is however appropriate to remark that this method intersects a number of works of different Authors.

Tom Kitwood's (TK) Malignant social psychology highlights the environment pathogen power on the clinical evolution of the PLWD[16]. In a similar way EA considers in particular the exchanged words as important elements of the environment that can affect the clinical presentation of the illness and the person happiness.

Many non-pharmaceuticals treatments proposed for dementia are linked in various manners to Carl R. Rogers's (CRR) Client-centered therapy[17-19]. In a similar way EA shifts the attention away from the illness towards the PLWD and the caregiver.

Naomi Feil's (NF) Validation Therapy highlights the relevance of emotive aspects in the relationship with the PLWD[20]. Similarly a EA goal is to recognize the Elementary Competencies of the patient affected by dementia and among these the Emotional Competence.

The European Reminiscence Network (ERN) propose Reminiscence Therapy as method to improve the quality of life, of both the PLWD and the caregiver[21]. Similarly the ABC Group (ABCG) based on EA (see below) has the objective of improving the happiness of the caregiver and of the PLWD in each very instant and place of their mutual relationship.

The Care Manual of Alzheimer Europe aims at the harmonization of the person needs with the caregiver coping strategies[22]. Similarly the ABCG assume that one of the tallest challenges of the caregiver is to cope with the feeling of hopelessness before the illness and proposes the objective of meeting this challenge by becoming a therapist expert in the use of words.

Kenneth Hepburn, Marsha Lewis, Jane Tornatore, Carey Wexler Sherman, Judy Dolloff (KH, ML, JT, CWS, JD) - University of Minnesota) in The Savvy Caregiver Program highlight how important is the self-care for the caregiver and the involvement and well-being of the PLWD[23]. In similar way the ABCG has as objective the well-being of the caregiver and the possible happiness of the patient.

Capability Approach of Amarthia Sen and Martha Nussbaum (AS, MN), developed in a different field, finds many intersections with the EA because of the relevance given to Multiple Identities and to the Contractual and Decision making Competence of the person[24-26].

SPECAL Approach (SPecialized Early Care for Alzheimer's) proposed initially by Penny Garner (PG) considers the well-being of the person as the top priority and concentrates on what a person can do, rather than what he cannot, in analogy with the EA[27].

Moyra Jones's (MJ) Gentlecare highlights the importance of creating a prosthetic environment, where the persons can live 24 hours a day, rather than insisting on the value of the single rehabilitation session[28]. In similar way the EA has the goal of creating a favorable environment throughout day life. EA is a way of being and relating that everybody may learn and may be used in all contexts.

Traditional Reality Orientation Therapy (ROT)[29-30] has been the base from which Aimee Spector (AS) started Cognitive Stimulation Therapy (CST), an original program neatly differentiating from ROT and making the most not only of the proposed activities, but also of the relational behavior of the operator[31]. This evolution of ROT towards CST is another evident sign that presently many researchers are experimenting new techniques and pay great attention to the relational behavior of the caregiver just as EA does.

The environmental influence on the presentation of the illness (TK) and on the care results (MJ), the relevance of the relational behavior during care and rehabilitation (CRR), the need of considering the emotive world (NF) and of recognizing the free choice of **functioning** (AS, MN) also for persons living with dementia, the possibility of choosing as objective the person well-being (KH, ML, JT, CWS, JD, PG) as well as the caregiver's (AE, ERN), are all ideas which modify the approach to the care of the person and that, considering the specific differences of expressions of each Author, still do intersect the EA proposed here. This list, that is certainly incomplete, is reported to thank the previous Authors and to share with them the effort of finding instruments useful to improve the quality of life of PLWD and their relatives.

1.2. The main components of Enabling Approach

The main components of EA are here described: 1.2.1. an approach based on the words, 1.2.2. the Recognition of Multiple Identities (people with dementia are not only people in need of assistance; in every person there are several stratified identities), 1.2.3. the Recognition of Elementary Competencies and the Recognition of the point of view and value system of people, 1.2.4. the clinical good practice.

1.2.1. An approach based on the words

Language disorders are a relevant component of the clinical picture of dementias, especially in AD, starting from the anomies of the initial phase to the lack of verbal communication of the advanced phase of the illness.

In these diseases the communication function of speech (which guaranties the ability of sending and recognizing messages linked to the meaning of words; in practice it allows the possibility of understanding and of being understood, and it is related to the semantic value of the verbal language) deteriorates earlier than the conversational function (which allows the exchange of words, in a more or less good manner, independently from the goal of communicating; eventually it makes possible a conversation without communication; this function is related to verbal fluency, independently of the semantic value of the words) As a result of that dissociation between the communication function and the conversational function, the PLWD and the caregiver tend to give up the use of speech when it would still be possible.

Starting from that observation, in Italy G. Lai has proposed a new approach to the care of PLWD which makes the most of the verbal speech and which constitutes an application of the Conversazionalismo introduced by him in the eighties of the last century[11-15]. It should be noticed that in Italy the Conversazionalismo is developed later but independently of the Conversation analysis developed in the 70's by Sacks H., Schegloff E. and Jefferson G.[32] and is a fundamental pillar of EA.

The EA is intended to be a method to be used with the others rehabilitation treatments, but it is a new method aiming at a new goal. The method originality consists in exploiting the verbal language instead that the non-verbal. It consists in keeping alive the use of speech when it is deteriorated but still possible, in the meantime giving up the recovery of the semantic value of words, when this is unattainable.

The two main techniques of EA, borrowed from Conversazionalismo, consist in two rules, don't ask questions and give back the narrative motif that is, re-expressing to the patient the minimum unit of meaning that the therapist detects from his words.

1.2.2. Multiple Identities and Disidentity

Normally, when dementia is diagnosed the person is considered by the caregiver only on the deteriorated aspects. The many features of the character, the long personal history, the capabilities still alive, are ignored.

Using Amarthia Sen's language[26], we can say that the person is deprived of his Multiple Identities (i.e. father, son, pensioner, former, teacher, music lover, dog owner…) and he is reduced to a mono-identity of 'affected by dementia'.

Using Lai's language[14], we can obtain an antidote to the reductive view of mono-identity with a different point of view, the Disidentity: "The Disidentity is a linguistic creation useful to solve a few practical problems: the concept of Disidentity gives us the possibility of accompanying the patient in all the possible worlds he inhabits".

The Disidentity, for example, allows the caregiver to relate to the PLWD as mother, when he acts as a daughter, as daughter when he acts as a mother.

In Lai's opinion, the Conversational method starts from the point of view of Disidentity and sees each interlocutor in the instantaneous 'I' appearing in the pronounced sentence, a discontinuous and changeable 'I'.

The EA sees the dementia as an illness of identification, since the patient affected by dementia is not recognized in his Multiple Identities. The purpose of the EA is to take care of the person recognizing his Multiple Identities (Disidentity).

The Recognition of Multiple Identities concern also the Recognition of Possible Worlds were the person inhabits (the World of Before and the World of After, the World of Here and the World of There).

1.2.3. The Elementary Competencies

Considering the person in his mono-identity of 'affected by dementia' triggers a series of phenomena aimed to eclipse the so called Elementary Competencies: Speech and Communication Competences, Emotive Competence, Contractual and Decision making Competences[1,4].

The Speech Competence is shown with the use of verbal language (producing and exchanging words), as it is possible in the different stages of the disease regardless of the semantic value of the words.

The Communication Competence uses not only the verbal language, but also the non-verbal and near-verbal language.

The Emotional Competence consists in being aware of one's own emotions, to be able of feel, express and see them recognized.

The Contractual Competence satisfies the patient's need of participating to the choices regarding the everyday life. It refer also to work towards agreements or compromises through speaking (an expression of this ability is observed in the negotiation of the narrative theme during verbal exchanges);

The Decision making Competence is related to the choice criteria based on the system of values of PLWD, as he is able to conceive it. This competence refer to daily choices even when cognitive deficits are present and in contexts where freedom of decision-making is much reduced (extreme expressions of this competence are represented by oppositional behaviors, relational closure and isolation from the world).

1.2.4. Recognition of Elementary Competencies

The Recognition of Elementary Competencies is a complex activity which consists of:

o Focusing attention on each Elementary Competence in the moment in which it appears, as it appears;

o Identifying, which means understanding and naming the Elementary Competence that appears;

o Accepting that person say what they say, express what they express, without interrupting or correcting him;

o Facilitating the appearance of Elementary Competencies without judging (Elementary Competencies should not be judged as right or wrong);

o Giving Effectiveness, which means seriously considering what the speaker is expressing and, if

appropriate, passing from words to action.

1.2.5. The Enabling Approach in the clinical practice

The EA consists in creating the conditions where the person can perform the activities he is still able to do, as he can, without feeling of being in error.

The objective is to make, in the limits of possible, the person happy of performing what he does, as it is done, in the context of his environment.

The EA is based on recognizing the Multiple Identities, Possible Worlds and the Elementary Competencies of the person, it is not connected with the rightness of the action to be performed and it aims to the happiness of the patient.

This approach makes the most of the patient autonomy on the bases of an innovative concept.

Traditionally the autonomy is considered the aim of the rehabilitation intervention; the therapist works in order to increase the autonomy level of the patient.

Following the EA, on the contrary, the autonomy is considered the mean to favor the possible happiness of the patient; the enabling therapist detects the autonomy whenever it appears, as it is shown or when it could have been shown but it is eclipsed. The task of the therapist becomes the favoring of the emerging of the Elementary Competencies to contract and to make decisions whenever he is interacting with the person.

1.2.6. The happiness as objective

The EA is a care method placed among the rehabilitation methods but which, due to his basic philosophy, is different from these methods. The EA is not properly a rehabilitation method because it does not aim to recover the lost functions. The EA final goal is the possible happiness of the person, the happiness possible in the actual moment and in the given context.

1.2.7. Tools and settings

The EA focuses attention on verbal exchanges between the speakers; the tools are listening and words.

An operator employing the EA would capture the Elementary Competencies of the interlocutor as they occur and how they occur, and with his own verbal intervention, the enabling techniques (such as Don't ask questions, Don't interrupt, Don't correct, Don't complete sentences, Listening, Respecting the silence and the slowness, Accompanying with the words, Giving back the narrative theme, Echoing response, Supplying fragments of autobiography, Recognizing the emotions, Looking for a Happy Meeting Point (HMP), etc.) would give Recognition of these Competencies.

To create an enabling environment, it is possible to use the EA in both specific and non-specific settings.

Specific settings include:

o Welcome Conversations, when people enter Nursing Home;

o Individual Recognition Therapy, based on the EA;

o Recognition Groups, which are conversation groups for PLWD;

o ABC Groups, which are groups for relatives of PLWD managed by a therapist;

o training courses for caregivers.

Non-specific settings include:

o all professional activities (such as nursing, medical, recreational and rehabilitation activities),

o informal meetings of everyday life.

Therefore, this kind of interpersonal relationship can be adopted by all caregivers (both professional caregivers and family members), with all people with dementia, in every context, 24 hours a day.

In this way the EA is ecological and can become like the air which people breathe.

2. Exemples of Enabling Approach in the clinical practice

Below we briefly discuss on 2.1. Welcoming conversations; 2.2. Computational analysis of conversations. The Anchise Corpus; 2.3. Groups for family members (ABC Groups); 2.4. Anchise Group and website.

2.1. Welcoming conversations, a feasibility and effectiveness study

In this chapter we summarize the results of a research on Welcoming Conversation (WCC) based on the EA for newly admitted residents with dementia in Nursing Homes (NHs) and Day Care Centres (DCCs).

Every new access to a NH is a critical moment both for the newly admitted resident and for nursing team. A WCC based on the EA has been formalized as a good practice for the promotion of successful admission.

The aim of the research is to evaluate the feasibility of WCC in ecological conditions, i.e. in the clinical practice of different NHs, by operators with different qualifications and different degrees of training, with elderly people with different degrees of dementia.

The WCC was conceived along lines that would not interfere with the ordinary admission procedures of the different NHs or DCCs. It usually takes place on the day after admission and is carried out according to the EA. It is meant to last five minutes, but can be terminated sooner if the person shows signs of strain or lack of interest; on the other hand, it can go on longer if the person wants to go on talking. This conversation is not intended to elicit information nor to assess the person's cognitive status – aims that can be pursued at other times and by different tools. The WCC is seen as a coming together of two persons who do not know each other and who wish – and at the same time are afraid of - getting to know, and being known by, the other. Its primary goal is that of creating an experience of *Happy-enough Coexistence* in the hic et nunc of the conversation, even in the presence of cognitive impairment.

2.1.1. A feasibility and effectiveness study

This study[33,34,35,6] (look at footnote 1) was designed to evaluate feasibility and effectiveness of the WCC based on the EA for newly admitted residents with dementia in NHs and DCCs and to evaluate its impact on professional caregivers.

The study was articulated in two phases: the first was aimed at the implementation of the WCC in the participating NHs and the second at collecting through an ad-hoc self-administered questionnaire the changes in the verbal behaviour of each trained professional towards newly admitted or other already institutionalized residents at 4 weeks after the WCC. The selection of newly admitted residents for WCC was sequential and dependent on the presence in the NH of a caregiver trained to carry out the conversation. The participation of caregivers to the second phase was on a voluntary basis.

During the first phase 249 WCCs were collected, all based upon the EA and carried out by 66 professionals in 33 NHs and 5 DCCs of 7 Italian Regions. In the second phase, 164 questionnaires were collected, yielding the following results: in the 4 weeks following the WCC, the professionals had made a greater effort a) to interact with the newly admitted resident (33%), b) to talk with them (33%) and c) to make use of some of the enabling techniques (29%).

This study demonstrates the feasibility of WCC carried out according to the EA whith persons living with dementia of mild to severe degree. A four weeks follow-up self-administered questionnaire shows the positive changes in the verbal behaviour of trained professionals towards newly admitted residents, especially with regard to the practice of enabling techniques.

Footnote 1

[1] In collaboration with Alessandro Nobili (Department of Neuroscience, IRCCS Istituto di Ricerche Farmacologiche Mario Negri, Milano), Marie Victoria Gianelli (Università di Genova) and Maria Paola Bareggi (Residenza Borromea, Mediglia, Milano), Arianna Cocco (Residenza Ballestrero, Torino), Elisabetta De Lorenzi (RSA Fiori di Loto, Quarto, Genova), Guia Martinenghi (Azienda USL di Cesena, Forlì-Cesena), Liliana Piccaluga (RSA L'Arca, ASP Pio e Ninetta Gavazzi, Desio, Monza Brianza).

2.2. Computational analysis of conversations, the Anchise Corpus

2.2.1. Anchise Corpus

The Anchise Corpus has been collected since 2007 by the Gruppo Anchise (see www.approcciocapacitante.it), an association of experts based on the adoption of the EA for the research, training and care of persons living with dementia. The Corpus contains conversations between PLWD and caregivers who have different qualifications (health care workers, educators, nurses, speech therapists, doctors, psychologists, family members) but have previously undergone a specific training on the EA.

Accordingly to the protocol, after the greetings and the collection of informed consent, the speacher starts the conversation in the ways he deems appropriate to encourage the patient to speak, with sentences such as "Could you tell me something about how you are going to spend your day?", or "What do you do during the day?", or "We have some time to get to know each other better", or "Can we talk together so that I can get to know you better?". Then the caregiver is mainly silent, waits for the PLWD 's verbal production and when there is an interruption he takes the floor and continues the conversation in the wake of what the other has said. In general, the operator does not lead the conversation but rather he follows the interlocutor in his speech, in his possible world. The operator is absolutely not engaged in making a diagnosis or even in gathering information, but rather participates in the conversation in a way that promotes the well-being of both speakers during the conversation itself, using enabling techniques. The conversation lasts 5-10 minutes (it has no fixed duration) and ends when signs of tiredness or intolerance appear. Crucially, since the instructions are given to the caregivers in a training context, they may follow the prompts more or less faithfully, not as in an experimental setting where a protocol is strictly followed.

Since 2007, health professionals of Anchise Group have recorded, transcribed and annotated the conversations mentioned above, involving elderly people with cognitive impairment mostly residing in NHs. More specifically, participants are Italian speakers with obvious cognitive deficits (inclusion criterion: MMSE score = 0-28), with no psychological or behavioral disturbances hindering conversation, such as drowsiness, wandering, a markedly oppositional or aggressive attitude, evident psychomotor agitation, severe dysarthria, severe hypoacusis.

All received transcripts are inserted in the Anchise Corpus[36], just as material to be used in training sessions for NH operators, without selecting them based on adherence to the expected style. The Corpus is continuously updated thanks to the Anchise Group. A previous version of the Corpus was released in 2020: it contained 320 conversations, and it was called "Anchise Corpus 320"[37], while in the "Anchise 2022 Corpus"[38] the number of conversations involving patients are 417; at the time of this review it overcome 600 (see www.approcciocapacitante.it).

The interest of a study based on the Anchise Corpus lies in the fact that it is a Corpus in Italian, it is collected in an ecological environment, and it represents a rich and precious source of information on speech by subjects affected by dementia. It reflects the situation actually existing throughout the Italian territory (North, Center and South), in NH of large and small dimensions, with patients of either sex, with mild, moderate and severe cognitive deficits. The classification of patients is based only on the MMSE score. However, unlike prospective, controlled studies performed under standardized conditions, this Corpus was not created for research purposes, but rather to be used in personnel training.

2.2.2. Ecological setting

The collected dialogues can be considered as characterized by high ecological validity if compared to speech material elicited by means of reading tasks, picture description tasks or even purely narrative tasks. Despite some intrinsic limitations, the Corpus represents a formidable resource, not only because of the speech style employed herein, which offers precious data on dialogical Italian speech in persons with dementia, but also for the high number of the dialogues distributed almost over the entire MMSE scale. The sample represent a remarkable size given that in other works, which refer to controlled trials, the sample size is considerably smaller[39]. For works on speech in Italian, see De Stefano et al., 2021, which studied 47 unhealthy individuals[40]; Calzà et al., 2021, with 48 unhealthy individuals[41]; Dovetto et al., 2022, with about 20 unhealthy individuals[42].

2.2.3. The Anchise Corpus 320

The study of Anchise Corpus 320[38] with computational linguistic analysis confirmed some characteristics of the language of people with dementia, such as the reduction in the rate of names and the increase in deictics. The large number of the sample (320 conversations) and the use of computational analysis will make it possible to identify indicators of pathological language to be used in the preclinical phase, to trace the change in the linguistic abilities of people with dementia as the disease progresses, to put in relation the characteristics of the pathological language with a series of metalinguistic data such as age, sex and degree of dementia. The Corpus increased in the following months with the addition and annotation of other transcripts of dialogues of people with dementia.

2.2.4. The Anchise Corpus 2022

More recently a computational analysis on the Anchise Corpus 2022, consisting of 417 conversations, is underway by two research groups at the University of Salento (Lecce, Italy) and University of Turin (Turin, Italy) (look at the researchers in the footnote 2). Preliminary results confirm that people with a greater degree of impairment tend to have a reduced vocabulary, anomia, uncertainty in speech production, decreasing the use of participles, gerund and subjunctive moods, and flattening use of the tenses towards the present to the detriment of the past. Sentiment and emotions analysis showed inverse trends for joy and MMSE scores: less impaired individuals seem to be less joyful than others. Considering the ecological conditions, this is consistent with a gradual reduction in awareness in individuals affected by dementia.

Footnote 2

Francesco Sigona[1], Daniele P. Radicioni[2], Barbara Gili Fivela[1], Davide Colla[3], Matteo Delsanto[2], Enrico Mensa[2], Andrea Bolioli[4], Pietro Vigorelli[5]

[1]Laboratory CRIL & DReaM, Department of Humanities, University of Salento, Lecce, Italy

[2]Department of Computer Science, University of Turin, Turin, Italy

[3]Department of Historical Studies, University of Turin, Turin, Italy

[4]Independent Researcher, Turin, Italy

[5]Gruppo Anchise, Milan, Italy

2.3. Groups for family members

The ABC Group (ABCG)[43,44] is different from other self-help groups, as well as from psycho-educational groups and the support groups usually organized by the parents associations of Alzheimer patients. The ABCG is an original self–help group, led by a professional leader, based on the Twelve Steps proposal. They constitute the synthesis of EA adapted to the familial caregiving practice.

Traditionally the autonomy is considered the aim of the rehabilitation intervention; the therapist works in order to increase the autonomy level of the patient. In the GABC, instead, the autonomy is considered the mean to favor the possible happiness of the patient; caregiver detects the autonomy whenever it appears during the day, as it is shown or when it could have been shown but it is eclipsed.

The ABCG is inspired by **A**l-Anon[45] and Alcoholic Anonymous Groups[46], by **B**alint Groups[47] and by Lai's **C**onversazionalismo[11-15].

Starting from the year 2008 until today, 262 ABCGs have been started throughout Italy. The faithful transcription, in Italian, of some ABCG sessions can be consulted at www.approcciocapacitante.it.

2.3.1. The expert caregiver

Both the EA taking care of persons living with dementia and the ABCG for caregivers, focus their attention on the exchanged words.

In EA the therapist focuses on the words whenever they emerge, in ABCG the leader focuses on the words exchanged daily between the caregiver and the patient.

In managing the group, the goal is the caregiver happiness. What we do to reach this goal?

It is known that the caregiver suffering is in part due to the feeling of being impotent in front to the relentless evolution of the illness, in spite of the continuous end heavy effort put into the care.

To overcome this sense of impotence and frustration, the ABCG proposes to the participants to become expert caregivers as a way out from the impotence tunnel.

In this way we modify the care-giving objective, shifting the attention from the PLWD to the caregiver. Specifically, the caregiver should become expert in the use of the verbal language instead of looking for a non-realistic improvement of the functionality and autonomy of the PLWD. The ABCG meetings and the Twelve Steps are the instruments which allow the caregiver to achieve the objective. The improvement of Speech Competence and other Elementary Competencies is considered a positive but secondary result. In our opinion, the primary objective of the work with the caregivers must be placed at the caregivers own level, not at a different one, like that of the PLWD.

2.3.2. The Twelve Steps

The Twelve Steps are a synthesis of EA made suitable for familial caregivers and are used as guidelines to become a caregiver expert in the use of the speech with PLWD (see Table 1). They aren't strict rules; everyone should follow them as far as it is possible, keeping in mind that their main objective is, in first instance, to favor the caregiver happiness, and in second instance the patient's.

Table 1

1.	Don't ask questions
2.	Don't correct
3.	Don't interrupt
4.	Listening, respecting the silence and the slowness
5.	Accompany with the words
6.	Answer the questions
7.	Communicate also through non verbal language
8.	Recognize the emotions
9.	Answer the requests
10.	Accept what the patient does, as he does it, when he does it
11.	Accept the illness
12.	Taking care of one's own well being

The Twelve Steps

The first seven Steps are recommended to keep alive the Speech and Communicating Competencies. The first step in particular makes this approach different from others approaches.

Questions like Which day is today? Who am I? What have you had for lunch? are considered obstacles to the flux of everyday's conversation and are avoided. The 5th Step consists in accompanying the patient in his possible world, adjusting to his space-time, using specific techniques as Give back the narrative motif, Echoing response and Supplying fragments of autobiography, which means allowing personal involvement, enriching the conversation with personal memories related to the patient's narrative motif.

The 8th Step is meant to keep alert the Emotional Competence and consists in recognizing the patient's emotion (so like is expressed), in identifying it and giving it back with a verbal acknowledgement. The 9th and 10th Steps are meant to keep alert the Contractual and Decision making Competencies and to help the active participation to everyday's life choices.

The 11th and 12th Steps help the caregiver to overcome his own feelings of guilt and inadequacy and are important to reach a sufficient happiness (the possible happiness).

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2.3.3. Leadership of the ABCG

The leadership of the group is directive and hetero-centric. The group leader with his comments wants to prompt the direct participation of all the members of the group.

At the opening of the meeting he addresses the group inviting whoever wishes to report about a difficult, unsatisfactory or unintelligible conversation held with the sick relative. While the speaker reports, everyone else is invited to listen while keeping quiet, without interrupting.

When the speaker is through with his contribution, the group leader invites the participants to identify a critical moment in the conversation, helping to focus attention on words exchanged.

Anybody can report analogous conversations occurred to him, or possible *ways out*, alternative to that used by the speaker, in terms of words used.

The group leader listens to all the answers then takes the floor to highlight what results have been obtained with the words proposed.

For instance, if a caregiver tells that when asked questions, the patient replies he does not remember or interrupts the conversation, getting irritated, the group leader focuses attention on this fact and asks the group whether other words could be used in a similar situation, to help carrying on with a fluent conversation.

During the meeting, discussions are avoided. Everyone is free to tell his own experience, to listen other's people experience and to take home those ideas and suggestions that might be more valuable for him.

2.3.4.A pilot study

This study developed in the years 2008-2009, as part of the "Words that help" Project, co-financed by the Province of Milan[1]. It's a pilot study, carried out trough two ABCGs and a control group.

The trial objectives are the evaluation of the effectiveness of the ABCG in modifying the Verbal Behavior of the familial caregivers, in the sense of greater adherence to the Twelve Steps, and the auto evaluation of theirs well being.

The results show the effectiveness of the ABCG in modifying the Verbal Behavior of the caregivers, in the sense of greater adherence to the Twelve Steps. The perception by the caregivers of the changing in their own Verbal Behavior is stronger when the patient Verbal Behavior is more compromised. Regarding well-being, all the participants in the ABCGs declared that they felt better, they considered the group useful and would recommend it to other caregivers.

2.4. Anchise Group and website

The updating and implementation of the EA is ensured by the Anchise Group and the website www.approcciocapacitante.it. The Anchise Group is an association of experts that deals with research, care and training with EA. It was founded in 2005, has directly organized training courses for over 1000 professional caregivers and numerous others throughout Italy with the collaboration of 27 certified trainers. The website is an official organ of the Group; it is structured in various columns addressed to professional and familial caregivers and publishes the continuously updated Corpus Anchises. In the year 2023 it had 80000 visits, 560000 hits. In more recent years, some trainers from the Anchise Group are working on the implementation of EA in Switzerland, Chile, Argentina, Poland and Russia.

Conclusion

The Enabling Approach is an original approach to Persons Living with Dementia which is part of the wake of psychosocial approaches and is diffused widespread in Italy. Its originality consists in putting the word at the center of attention, even when the patient has serious language disorders and in shifting the focus from cure to care. The goal is not functional recovery nor the patient's autonomy. The Enabling Approach aims to encourage a Happy-enough Coexistence between speakers. The strong ideas underlying the approach are the dissociation between competence to speak and competence to communicate; the recognition of the patient's Multiple Identities and the Possible Worlds in which he lives; the recognition of his Elementary Competences (Speech Competence, Communication Competence, Emotional Competence, Contractual Competence, Decision making Competence) as he is able to express them, at the moment in which he expresses them.

The Enabling Caregiver does not guide the conversation but follows the interlocutor in her speech; he makes use of Enabling Techniques such as active listening, not asking questions, not correcting, returning the narrative motif, recognizing emotions.

The Enabling Approach does not require particular settings or equipment, is economically sustainable and is ecological: it can be adopted during normal care, recreational and rehabilitation activities, during informal meetings of everyday life, 24 hours a day, in all contexts, with all patients, with mild to severe dementia, by all caregivers.

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