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Thalen, M.; van Oorsouw, W. M. W. J.; Volkers, K.; Embregts, P. J. C. M.

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Integrated Emotion-Oriented Care for Older People With ID: Defining and Understanding Intervention Components of a Person-Centered Approach

Marloes Thalen^{*†} , Wietske M. W. J. van Oorsouw^{*} , Karin M. Volkers[†] , Elsbeth F. Taminiau^{*} , and
Petri J. C. M. Embregts^{*} 

^{*}Tranzo, Tilburg School of Social and Behavioural Sciences, Tilburg University, Tilburg, The Netherlands; and [†]Philadelphia Care Foundation, Amersfoort, The Netherlands

Abstract

An increase in descriptive evidence regarding person-centered approaches for older people with intellectual disability (ID) is important, due to increased life expectancy and the present lack of sufficiently underpinned interventions. This is especially true of interventions designed to increase well-being and quality of life. A specific Dutch example is the Integrated Emotion-Oriented Care approach. Despite its status as a good practice, its effectiveness has not yet been proved, nor has descriptive evidence been made available. The primary aims of this qualitative study are to identify the intervention components, to provide demonstrative illustrations and to gain an in-depth understanding of the use of these components in the day-to-day support of older people with ID. A content analysis of five key documents was carried out. Five semi-structured interviews were then conducted with early adopters, followed by a concept mapping study with daily users. The final stage in the data collection process was a series of five focus-group interviews with experts and experienced support staff. The five intervention components of Integrated Emotion-Oriented Care for older people with ID have been systematically identified and described in detail in five narrative summaries drawn up in collaboration with early adopters, experts and experienced support staff. This study provides valuable insights that offer descriptive evidence for Integrated Emotion-Oriented Care in the care for older people with ID. Both implications and possible opportunities for future research are discussed.

Keywords: aging, Intellectual Disability, Person-centered approach, quality of life, support staff

Introduction

A growing tendency to underpin the choice of interventions for particular target groups with current best evidence is noticeable in many healthcare disciplines, including the care of people with intellectual disability (ID) (Embregts, 2014; Perry & Weiss, 2007; Schalock, Verdugo, & Gomez, 2011). In their paper on evidence-based practice in developmental disabilities, Perry and Weiss (2007) clearly conclude that

evidence-based practice means that we question what we do so that we can help clients be the best they can be. We collect evidence to evaluate our work and we strive to be open to the answers we get. We make decisions based on the best data available and we share our knowledge with others and learn from each other (p. 171).

In other words, clinical initiatives (e.g., practice-based interventions) with a lack of scientific underpinning should therefore be

systematically evaluated and improved by creating a clear framework of its content, based on knowledge and experiences of current users (Newman, Kellett, & Beail, 2003). The current study provides a first step toward evaluating and improving the evidence base of a clinical initiative in the care of older people with ID.

In line with the developmental model for practice-driven evaluation developed by Van Yperen, Veerman, and Bijl (2017) and the impact theory put forward by Rossi, Lipsey, and Freeman (2004), a first bottom-up step that eventually results in the underpinning of interventions consists of the identification and understanding of intervention components (i.e., essential elements of the intervention, such as methods and activities which form part of the intervention). This requires researchers to work with service providers to gather information with the aim of clarifying and specifying the intervention components for a particular target group. Identifying and understanding intervention components is relevant: it adds to descriptive evidence, contributes to the development of evaluative measures at an individual level (Schalock et al., 2011), and helps in conducting procedural-reliability measurements that indicate whether intervention components are implemented as intended (Gresham, MacMillan, Beebe-Frankenberger, & Bocian, 2000).

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Correspondence: Marloes Thalen, MSc, Tilburg University, P.O. Box 90153, 5000 LE Tilburg, The Netherlands. E-mail: m.thalen@tilburguniversity.edu

A lack of an evidence base is present in the field of care and support for older people with ID (Innes & McCabe, 2012; Schaap, Fokkens, Dijkstra, Reijneveld, & Finnema, 2018). A specific Dutch example in this context concerns the Integrated Emotion-Oriented Care (IEOC) approach for older people with ID. This person-centered approach was adopted from the field of dementia care (Van der Kooij, 2014). According to the definition given by Droës, “emotion-oriented care” concerns

care aimed at improving emotional and social functioning, and ultimately the quality of life, of persons suffering from dementia by assisting them in coping with the cognitive, emotional and social consequences of the disease, and by linking up with the individual functional abilities and the subjective perceptions of the individual

(as cited in Finnema et al., 2005, p. 330). The “integrative aspect” of IEOC refers to the integration of emotion-oriented elements (e.g., validation and reminiscence) in daily nursing home care. IEOC has proved effective in the care for people with mild/moderate dementia and implementation of IEOC resulted in an increase in caregiver knowledge and skills in the field of dementia care (Finnema et al., 2005; Van der Kooij et al., 2013). Considering the increasing life expectancy of people with ID and additional physical and cognitive decline, it is not surprising that this has led to a need for adequate support and for a more integrated and person-centered approach (Campens et al., 2017), which in this case was derived from standard geriatric and dementia care.

Although IEOC has proved effective in dementia care, it has yet to be made clear what the intervention components of IEOC are and how these components should be used and applied to older people with ID. The aim of this qualitative study is therefore (1) to identify the intervention components of IEOC for older people with ID, and consequently (2) to obtain an in-depth understanding and illustration of the use of these components in the day-to-day support of older people with ID. The researchers used data triangulation by combining sources and methods to reduce bias and increase the trustworthiness of our findings (Wilson, 2014).

Method

Aim 1. Identifying IEOC Intervention Components for Older People With ID

Data triangulation of three sources in healthcare for older people with and without ID was used to identify IEOC intervention components: (Source 1) information in key documents, (Source 2) knowledge and experiences of early adopters, and (Source 3) knowledge and experiences of daily users.

Content analysis of key documents (Source 1). *Procedure.* First, a search in Dutch ID and geriatric literature was conducted by the first author to identify available documents with relevant theoretical models and peer-reviewed, empirically based descriptions of IEOC. Since this resulted in only two Ph.D. theses that address the use of IEOC in nursing home care for older people without ID (De Lange, 2004; Van der Kooij, 2003), an additional search in the

Dutch collection of gray literature was conducted. Documents were included as a key document if the document contained (1) relevant information regarding the intervention components of IEOC for older people with or without ID (i.e., the choice of the content must be justified by what you want to know), and (2) was suitable for qualitative analysis (i.e., unitized, written text) (Zhang & Wildemuth, 2009). This resulted in three extra key documents, that is, two Dutch books on IEOC for older people with ID (Groen & Weidner, 2015; Van der Kooij, 2014), and one Dutch policy document about IEOC produced by a nursing home care provider (De Waalboog, 2015). For example, the researchers excluded short descriptions on websites as key documents. Finally, the researchers asked the early adopters (Source 2) to validate the selection of key documents to ensure that no scientific or gray literature has been overlooked. All early adopters confirmed that Source 1 contained all available relevant key documents with regard to IEOC.

Then, a systematic qualitative content analysis was conducted that combined inductive and deductive reasoning (Zhang & Wildemuth, 2009). Three researchers (MT, WvO, and KV) independently and repeatedly immersed themselves in the data. They marked relevant quotes, coded them, and clustered the codes into subthemes and themes (i.e., intervention components). To ensure intercoder consistency, colleague debriefings were used to confirm overlaps and divergences with regard to the interpretations and coding decisions, including the development of categories, of the three researchers (Ritchie, Lewis, McNaughton Nichols, & Ormston, 2014; Thomas & Harden, 2008). A fourth researcher (PE) was consulted in cases where any doubts arose during the process. Both WvO and PE had no prior experience of the IEOC approach for older people with ID. Since no new or additional information was found in the fifth key document, the authors concluded that data saturation had been achieved, resulting in an initial list of IEOC intervention components (Marshall & Rossman, 2016).

Semi-structured interviews with early adopters (Source 2).

Procedure. Following the content analysis of key documents (Source 1), the researchers conducted individual semi-structured interviews with early adopters of IEOC (inside and outside the field of ID) with the aid of a brief interview guide. The interview guide was not based on the outcomes of the analysis of key documents, but merely intended to retrieve additional information regarding the intervention components of IEOC from another source (i.e., next to the information retrieved from the key documents). Each interview lasted on average 45 min and was facilitated by the first author. By asking the early adopters what they thought were the most important intervention components of IEOC, the researchers tried to validate and complete the list of intervention components with professional-expert knowledge. Audio recordings of the interviews were made, and these were transcribed verbatim. Three researchers (MT, KV and ET) then systematically analyzed the interview transcripts to find confirmatory and new information which could be added to the list of IEOC intervention components that was derived from Source 1.

Participants. A convenience sample of five early adopters with expertise in IEOC participated: two clinical experts, two policymakers, and one researcher. Participants were employed at three different Dutch healthcare organizations for older people with ($n = 2$) and without ($n = 3$) ID.

Concept mapping with daily users (Source 3). *Procedure.* Subsequently, a concept mapping method (Trochim, 1989) was applied to identify the factors that support staff and psychologists consider most important when carrying out the IEOC approach for older people with ID on a daily basis for further validation and identification of the IEOC intervention components. The concept-mapping procedure required the participants to answer one central question: What is IEOC for older people with ID? This resulted in 24 unique items with information regarding IEOC intervention components, which were consequently generated, prioritized, and sorted by the participants using the software program Ariadne 3.0 (Severens, 1995). Multi-dimensional scaling and cluster analysis were then applied to construct a concept map, which was interpreted by three researchers (MT, KV, and ET). If any doubts arose, a fourth researcher (PE) was consulted. All relevant information, both confirmatory and new, was added to the list of IEOC intervention components derived from Sources 1 and 2 (Table 1).

Participants. A convenience sample of five support staff members and three psychologists were recruited from three different residential locations within one Dutch healthcare organization for people with ID. All participants provided IEOC on a daily basis for an average of 11 months. Seven participants were female ($M_{\text{age}} = 47$ years, $SD_{\text{age}} = 11.4$ years, range_{age} 32–63 years). Participants had an average of 16 years' working experience ($SD = 9.9$ years; range 6–38 years) of caring for people with ID.

Aim 2. In-Depth Understanding of IEOC Intervention Components for Older People With ID

Following the three methodological steps used to achieve Aim 1, focus groups were held to better understand and make explicit how intervention components of IEOC (as identified under Aim 1) could be applied in the day-to-day support for older people with ID (Aim 2).

Focus groups with experts and experienced support staff to create narrative summaries.

Procedure. Two sessions with a group of eight experienced support staff and three sessions with a group of 13 experts (see participants) were organized. Each session lasted about 2 hours and was facilitated by a researcher with an overall understanding of the study to keep the sessions on track (Nassar-McMillan & Borders, 2002). Based on the final list of intervention components and subthemes (Table 1), a semi-structured interview guide was developed. Each group successively discussed each intervention component, by responding to the question: How do you perform this in daily practice? Audio recordings were made of the sessions and these were transcribed verbatim.

Subsequently, systematic analysis of transcripts was carried out to determine the meaning of and possible actions and activities associated with each IEOC component in day-to-day support for older people with ID. First, the transcripts were independently and deductively analyzed by three researchers (MT, WvO, and KV) to mitigate any bias that might arise from a single researcher (Zhang & Wildemuth, 2009). Second, the analyses of transcripts were discussed in colleague debriefings until full consensus was reached on how to apply the IEOC intervention components in daily practice (Krueger &

Casey, 2000; Ritchie et al., 2014). Third, this consensus led to a draft version of five narrative summaries in which the researchers tried to explain each intervention component as specifically as possible. A fourth researcher (PE) acted as peer reviewer to check the credibility and validity of the summaries. In addition, the summaries were then submitted to four members of the focus groups to verify that the summaries were accurate representations of their experiences (Ritchie et al., 2014; Zhang & Wildemuth, 2009). All of the researchers involved agreed on the final version of the narrative summaries.¹

Participants. A convenience sample of 21 participants was recruited from one Dutch healthcare organization serving older people with ID. Eight experienced support staff and 13 experts in the field of IEOC participated. Among these participants, two early adopters (Source 2), and seven of eight support staff members and psychologists who participated in the concept mapping procedure (Source 3) were again recruited for the focus groups. Support staff had an average working experience of 16 years ($SD = 14.8$ years; range 6–38 years) in caring for people with ID. Six support staff members were female ($M_{\text{age}} = 47$ years; $SD = 13.2$ years; range 33–58 years), and two were male ($M_{\text{age}} = 56$ years; $SD = 2.6$ years; range 49–63 years). Of the IEOC experts, 11 were female ($M_{\text{age}} = 50$ years; $SD = 7.4$ years; range 34–60 years), and two were male ($M_{\text{age}} = 56$ years, $SD = 2.7$ years; range 53–58 years). IEOC experts had an average working experience of 24 years ($SD = 9.5$ years, range 8–37 years).

Ethical Procedure

Ethical approval to conduct this study was granted by the Ethical Review Board of Tilburg University (EC-2016.29 and EC-29-2016.29a2). Participants were provided with written and verbal information about the nature and purpose of the study. They were informed that their responses would be processed anonymously and that they could withdraw from the study at any time.

Findings

Aim 1. Identifying IEOC Intervention Components for Older People With ID

Data triangulation (Sources 1–3) ultimately led to the identification of five IEOC intervention components and 32 subthemes in total as shown in Table 1. The findings will be further explained step by step.

First, content analysis of key documents (Source 1) resulted in 119 unique codes with information regarding the IEOC intervention components. To structure the findings, these codes were grouped into 30 subthemes. Subsequently, the subthemes were merged into four themes, called: intervention components (see Table 1; #1–4). Following, the analysis of the semi-structured interviews with experts (Source 2) resulted in 85 codes. The

¹The authors would like to point out that this manuscript includes a shortened version of the narrative summaries due to considerations of length. An extended version of the summaries is available from the first author on request.

TABLE 1
List of identified IEOC intervention components

#	Intervention components (themes)	Subthemes
1.	Support staff focus on the client's perspective to better understand the wishes, needs and behavior of the client	1.1 Find your way into the client's perceptions 1.2 Pay attention to/connect with the client's feelings 1.3 Have knowledge of/connect with their life story 1.4 Support the client's experience of this new phase of life 1.5 Be aware of one's own perception
2.	Support staff try to adequately adjust to the client's current needs when practising IEOC	2.1 Consider the individual client's wishes 2.2 Meet the client's changing support needs 2.3 Take the time to organize work based on what the client wants 2.4 Get a clear picture of the client's needs 2.5 Be flexible and continually adjust to the client's current needs 2.6 Continue to search for the client's needs and possibilities 2.7 Offer support while maintaining the client's autonomy 2.8 Involve the client in an active way 2.9 Pay attention to the client's own initiatives
3.	Support staff connect with the client in order to build a relationship with them	3.1 Connect with the client 3.2 Reciprocate 3.3 Give the client recommendations and explanations
4.	Support staff work in a team culture that is based on safety and trust	4.1 Speak the same language 4.2 Be on the same page/know each other's reasons on a team 4.3 Share personal experiences in a systematic way 4.4 Empower your own team 4.5 Create a climate of safety on the team 4.6 Collaborate
5.	Support staff create room for participation and perceptions from the client's informal network	5.1 Inform the informal network 5.2 Understand and acknowledge the involvement of the informal network 5.3 Make full use of the possibilities within the informal network 5.4 Support each other (support staff-informal network) 5.5 Solve problems together 5.6 Reflect in a continuous dialogue 5.7 Search together and meet the client's changing needs 5.8 Learn from each other (support staff-informal network) 5.9 Create space for the needs and perceptions of the client's informal network

See Findings for detailed narrative summaries #1–5.

majority of these codes ($n = 82$) confirmed the information that was already available from the content analysis of the key documents (Source 1). The remaining three codes contained new information about IEOC and led to the creation of two new sub-themes, called *Be aware of one's own perception* and *Create space for the needs and perceptions of the client's informal network* (see Table 1; #1.5 and #5.9). Finally (Source 3), concept mapping with daily users resulted in 24 codes, all of which confirmed the IEOC intervention components and the list of related subthemes drafted after Source 2. However, the prioritization of items that had emerged from the concept mapping procedure (Source 3) indicated that the collaboration with and involvement of informal network members were seen to be the most important items of all. This finding led to the decision to place all the subthemes relating to the informal network into a separate, fifth component, called *Support staff create room for participation and perceptions from the client's informal network* (see Table 1; #5).

Aim 2. In-Depth Understanding of IEOC Intervention Components for Older People With ID

For each IEOC intervention component, a narrative summary was created to give a detailed description of its meaning in the day-to-day support of older people with ID. The summaries also include examples of associated actions, activities, and aspects that should preferably be taken into account, and which provide information about the integrative nature of components.

Narrative summaries. #1: Support staff focus on the client's perspective to better understand the wishes, needs and behavior of the client.

General meaning. The first IEOC component refers to the client's perspective. In order to be able to focus on the client's perspective, it is important that support staff continuously and actively explore the question of who the client is. This search

will enable support staff to better understand the wishes, needs and behavior of the client (e.g., why someone has a certain taste in music), and to consciously adjust their support to the client (e.g., play the client's favorite music).

Actions and activities. To focus on the perspective of the client, support staff consult the client, their informal network, historical archives, photo albums, colleagues, and/or support-care files. Personal life history, habits, interests, religion, and traditions are all relevant to developing a better understanding of the client. Support staff get to know the client by imagining themselves in their situation ("place yourself in their shoes") and by taking time to make real contact with the client. All positive and negative moments of contact with the client are important in terms of achieving a better understanding of the client. It is necessary for support staff to continuously share these meaningful moments and situations (e.g., through integrated emotion-oriented consultation) with network members (Note: #1 thus links with #5) and team members (links with #4), to work together to interpret them with a view to achieving unanimity in how the client is perceived, and to report them (e.g., in an electronic care file and/or life book).

#2: Support staff try to adequately adjust to the client's current needs when practising IEOC.

General meaning. In addition to taking the perspective of the client (see Component 1), support staff try to adequately adjust to the client's current needs when practising IEOC (e.g., when the client wakes up anxious, the client might have had a restless night and is probably still tired). In addition, support staff approach each client both consciously and with an open mind, in order to comply as much as possible with their wishes and needs at that moment (e.g., let the client sleep late today, because it will help them recover). Support staff should have the confidence to allow time for this (e.g., by putting aside their own concerns and frustrations).

Actions and activities. Providing support based on the client's current wishes and abilities requires creativity, flexibility, courage, self-reflection, openness, vulnerability, and a willingness to depart from the standard routine or from set agreements (e.g., taking a walk because the client wants to enjoy the fresh autumn air, even though the laundry still has to be done). Support staff try to fulfill the client's wishes and needs insofar as this is possible by thinking in terms of possibilities. When a wish is really unfeasible for this client at this moment or when the client's health or safety is at stake, it is important to give an explanation to the client, search for alternatives (e.g., let the client sleep late, but do not let them stay in bed all day) or in some cases go against their wishes (e.g., they are not allowed to go out alone because their safety cannot be guaranteed). It is important to carefully discuss these (sometimes ethical) dilemmas in a multidisciplinary team, with the client and/or the client's informal network (links with #5) in order to make well-considered choices together (e.g., what to do about a client's wish to eat their favorite burgers, despite the impact on their health due to diabetes).

#3: Support staff connect with the client in order to build a relationship with them.

General meaning. When practising IEOC, support staff need to connect with the client in order to build a relationship with them. In doing this, it is important to be both honest and

sincere in all dealings with the client, as well as seeing and appreciating the client as an individual (regardless of their behavior and history), showing respect, taking the client seriously and approaching them in a way that they understand. Sharing certain personal information with a client can also be helpful (e.g., I have become a grandmother) without overstepping boundaries and losing sight of one's professionalism. What support staff want to share may differ from client to client (e.g., with one client, support staff might talk about their favorite holiday destination, with another about football).

Actions and activities. Making contact with a client can be done verbally or nonverbally (e.g., getting down to eye level to make eye contact). In doing this, it is important to know about the client's life story (links with #1), adjust to the client's pace and reaction time (e.g., talk slowly, wait for an answer, repeat the question if the client does not understand) and to check continuously whether there is actual contact with the client (e.g., the client could be distracted and no longer listening to what you are saying). The relationship between support staff and client can differ per person. Some have a better "click" with one client than with another; this also applies to the client's perspective. It is important to share this information in a team (links with #4), because forming a good connection with clients makes the work more enjoyable.

#4: Support staff work in a team culture that is based on safety and trust.

General meaning. Working according to IEOC requires a team culture in which support staff dare to be open and honest with each other based on safety and trust. Team members develop a bond in which they experience this safety and trust, as well as genuine interest in and attention to the well-being of all colleagues (e.g., each team consultation starts with the question "How is everyone doing?"). The individual qualities of each support staff member are brought into play; team members learn from each other and enjoy their work.

Actions and activities. Support staff are able to share their personal norms, values, and situations with the team (e.g., I have not fully recovered from my knee injury, so I would prefer not to go for a walk with the client today) or others can identify a situation (I see that your knee injury is still giving you problems, shall I go out with the client instead?). At team level, it is important to know which support staff and clients share similar interests and preferences, and with which client they feel an individual connection (links with #3). By being transparent about this, support staff can take over tasks and activities from one another, complement each other and provide feedback. The support staff do not have to do this on their own. The team manager and behavioral expert are also on hand to support the team. Team members can ask colleagues for feedback, but might also give colleagues unsolicited positive feedback (e.g., a compliment) and constructive feedback (e.g., asking how a situation might have been handled differently). By exchanging feedback, support staff can learn from each other, keep each other alert to changes in the wishes and needs of the client, and prevent actions from becoming routine (links with #1).

In addition, the team jointly bears responsibility for their actions. For example, if a support staff member forgets that a client prefers to shower in the morning instead of in the evening, other team members will kindly remind him/her next time

instead of getting agitated. When providing IEOC it is important that there are no negative consequences for the staff members in similar situations. Furthermore, other situations may arise in which support staff need to depart from the agreed approach (e.g., because the client's need has changed; links with #2). This might lead to tension between team members, but they can work toward a solution by explaining to each other why they made certain choices (e.g., I didn't do the laundry because the weather was nice so I decided to take a walk with the client instead). By consciously sharing experiences with the client and the client's informal network (links with #2 and #5), the team continuously develops a more accurate and complete picture of the client (links with #1) to create alignment between all individual support staff members (e.g., are we looking at this client in the same way; are we trying to reach the same goals?).

#5: Support staff create room for participation and perceptions from the client's informal network.

General meaning. When practising IEOC, it is important to create room for participation and perceptions from the client's informal network. Support staff work together with informal network members (e.g., family members, friends, and volunteers) in order to understand and support the client as effectively as possible. It is therefore advisable to explain the nature of IEOC to the network members, to discuss everyone's expectations beforehand and record them if appropriate (e.g., the family finds hygiene very important and expects to receive a telephone call when the client's hygiene is at stake). As a result, the team and care organization(s) are actively involved in providing IEOC as an approach to aging individuals with ID.

Actions and activities. When exploring the question of *who* the client actually is (links with #1 and #2), the informal network serves as a source of information and knowledge (e.g., by augmenting the client's life history, or by sharing pleasant and less pleasant experiences). Network members can also be involved in the way IEOC is provided (e.g., having the network members prepare dinner with the client because they enjoy that activity). To ensure effective collaboration between support staff and network members, it is important that support staff take the initiative in discussing aspects such as possible changes in the client's behavior or state of mind. During a conversation, support staff and network members work together in an effort to understand what might explain the client's behavior or mood at a given moment and how they can adapt their approach accordingly. It is also important to explain one's own considerations; why do support staff act as they do? In addition to connecting with the client, it is also important to acknowledge the specific role (e.g., a lifelong brother-sister relationship is different from a professional relationship), experience, and the wishes and needs of the individual network members (some of which may have a cultural dimension).

Furthermore, working according to IEOC might lead to dilemmas, resistance or tensions between support staff and network members, for example in cases where the wishes of the informal network appear to be out of step with the client's own wishes. At times, it may be necessary for network members and support staff to "take a look in the mirror" (e.g., how would they feel if they could no longer dress themselves because they are unable to button up a shirt?) or try to reach a compromise (e.g., by having the client wear a smart sweater instead of a shirt

with buttons). By inviting everyone involved in the client's life to focus on the client's own perceptions, needs and wishes, the network members might feel more at ease and experience greater trust in the support offered to the client. In addition, sharing experiences and staying connected with each other improves mutual understanding and leads to greater involvement of the network members.

Discussion

In recent years, there has been a growing interest to provide care and support based on evidence-based practices within many healthcare disciplines, also in the care for people with ID (Embregts, 2014; Perry & Weiss, 2007; Schalock et al., 2011). When it comes to the support of older people with ID, there is still a lack of evidence-base (Innes & McCabe, 2012; Schaap et al., 2018) which is a particular cause for concern when enabling support staff in maintaining high-quality care (Cleary & Doodey, 2016; Iacono, Bigby, Carling-Jenkins, & Torr, 2014; Janicki & Keller, 2012). Against this background, evidence-based practices from standard geriatric or dementia care, such as Integrated Emotion-Oriented Care (IEOC), could also be useful in the care for older people with ID (Campens et al., 2017). However, its intervention components and its application for older people with ID (i.e., descriptive evidence) had yet to be systematically analyzed.

The present study identified five intervention components of IEOC for older people with ID and used data triangulation to produce five related narratives. To better understand the significance of the components and summaries identified, two generic topics will be discussed here. First, the rich content of the narrative summaries indicates the emphasis within IEOC on *general well-being* of older people with ID. This broad focus on general well-being is of added value: in the face of increasing life expectancy (Bigby, 2004; Emerson et al., 2012) and the frequent occurrence of physical decline (Evenhuis, Hermans, Hilgenkamp, Bastiaanse, & Echteld, 2012; Haveman et al., 2010) there is a risk of the focus on the physical well-being of older people with ID becoming dominant (i.e., what the person "has" instead of "who" that person is: Shooshtari, Martens, Burchill, Dik, & Naghipur, 2011; Wark, Hussain, & Edwards, 2014; Schepens, Van Puyenbroeck, & Maes, 2018) and overshadowing well-being in its broadest sense. However, the Social Production Function (SPF) theory (Lindenbergh, 2013) emphasizes that aging is related to changing wishes and needs in other domains as well (e.g., social well-being). In line with SPF, IEOC might enable support staff to cope with the changing support needs of older people with ID in all domains of well-being (Schalock, 2004), and therefore contribute to their general quality of life.

The narrative summaries not only provide examples of how support staff can apply IEOC in caring for older people with ID on a daily basis, they also show that IEOC consists of several components that are closely connected and strongly interrelated (see links in the summaries). This is in line with the *integrative character* of IEOC, which refers to the integration of emotion-oriented care elements. In other words, IEOC is a multicomponent, integrated and holistic approach in which one

component is linked to another. As a consequence, a single initiative might be related to multiple components and can cause a chain of events in relation to more than one IEOC component at the same time (Rossi et al., 2004; Van Yperen et al., 2017).

Implications for Practice and Future Research

This study collected and integrated relevant information about IEOC from multiple sources. Although the involvement of a larger number of organizations and the inclusion of a broader range of perspectives (e.g., clients and their informal network) would have further strengthened the design, this study still has a number of relevant implications for practice and future research. First, the findings contribute to the awareness of the complex character and the possible challenges of implementing a person-centered approach. Not only is it noticeable that the IEOC components address various levels of support, from daily care to the involvement of the informal network, but all intervention components are also likely to be interrelated (i.e., one component can be conditional on another and every action affects multiple components). Working according to the IEOC approach requires specific competencies from support staff and entails several dilemmas related to the provision of person-centered support. It may therefore be challenging for support staff to implement this intervention in daily practice. The descriptive evidence in this study can contribute to the development of staff-training programs and consequently enhance the support staff's knowledge, skills, and attitudes in providing sufficient IEOC for older people with ID. For example, the extended version of the narrative summaries can be used as educational input for program developers (Van Yperen et al., 2017).

A second implication of our study concerns the future identification of professional and organizational preconditions that IEOC addresses. Applying the approach requires not only an understanding of the intervention components, their purpose and the target group, but also understanding the context in which the intervention is implemented (Rossi et al., 2004; Van Yperen et al., 2017). Both professional preconditions (e.g., specific characteristics of support staff, such as flexibility, courage, and vulnerability) and organizational preconditions (e.g., providing all necessary opportunities for staff to apply the approach, such as time and adequate staff training) define the necessary requirements toward achieving the successful implementation of IEOC. Future research could further identify these conditions and thereby further complement the descriptive evidence of IEOC for older people with ID.

Finally, the promising experiences with IEOC for older people with dementia (Finnema et al., 2005; Van der Kooij et al., 2013) emphasize the need for further research into the effects of IEOC on the quality of life of older people with ID in the broadest possible sense, for instance by examining the extent to which these clients, their informal networks and all relevant professionals benefit from such an integrative, person-centered approach. This can be done by constructing observational studies and questionnaires that include their experiences. The present study serves as a methodological case description to illustrate how researchers, together with care professionals, can take their first steps toward underpinning a practice-based intervention. Furthermore, the content of this study makes it

possible for those engaged in future research to formulate assumptions, select the right instruments, evaluate IEOC and expand the evidence base in caring for older people with ID (Rossi et al., 2004; Van Yperen et al., 2017).

Conclusion

Given the increased life expectancy of older people with and without ID, and the lack of sufficiently underpinned interventions aimed at increasing well-being and quality of life, there is a clear need to increase the descriptive-evidence base of the person-centered IEOC approach for this population. This study provides valuable insights that offer a first step toward improving the evidence base of IEOC in the care for older people with ID. The intervention components of IEOC for older people with ID have been systematically identified and described in detail in five narrative summaries drawn up in collaboration with early adopters, experts and experienced support staff. This study can therefore be seen as a preamble to the evaluation of IEOC, a contribution to the evidence base for an integrative approach for older people with ID and an important step toward making IEOC transmissible to other care providers. In addition, this study serves as a case description that illustrates how researchers can work with experienced support staff and experts to underpin their intuition-based knowledge.

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