Module 3 Training Materials

HOW TO REACT TO SITUATIONS OF VIOLENCE, ABUSE AND MICRO MALTREATMENT: SENSITIZATION AND INTERVENTION

Against violence in elderly care (AVEC)

2020-1-CZ01-KA2020-0783321

Co-funded by the Erasmus+ Programme of the European Union

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1. INTRODUCTION TO BEHAVIOURAL PROBLEMS

1.1. Basis for behavioural intervention

Thomas Kitwood (2003) in his work *Dementia reconsidered* talked about the importance of various factors in managing behavioural problems, especially in those people who may have cognitive impairment (dementia, brain damage, psychiatric disorder) and whose functional analysis could establish improvements in interventions significantly reducing the perception of aggression and violence.

Kitwood refers to two variables in this type of intervention. Knowledge of the pathology or syndrome that originates the cognitive impairment and the environment in which the behaviour to be eliminated or reduced develops.

- **Cognitive pathology or syndrome**. Within this model, it is established that there are a series of symptomatology in the processes related to brain damage that are inevitably associated with the neurological disorder, since they are part of the disease or syndrome that the patient has. For example, a person suffering from frontotemporal dementia will have a cognitive rigidity that will lead to obsessive thoughts, a person with Broca's aphasia will not be able to speak fluently, or a person with brain damage in the hippocampus will lose his memory. From this perspective, professionals who interact with these people should be trained in basic clinical symptomatology to be able to manage behavioural situations derived from them, avoiding forcing, trying to understand the behaviours, or giving time for the emission of the response. These concepts cannot be changed, only by working on the psychological acceptance of the symptomatology of an organically based disorder and mobilizing efforts and resources to enrich, stimulate and improve the context where the person develops would be the only way to improve this symptomatology.

- **Environment**. The environment is understood as all the care that interacts with and surrounds the patient. From the people in charge of the patient's attention and care, to the environmental spaces, activity schedules, family and contextual relationships or life goals.

  Among the aspects to be taken care of in the environment would be the following

  - Elder/speak "Environmental noise. Excessive background noise together with hearing problems can increase agitation and orientation problems.

  - "Cold" environments. The corridors of residential facilities should be "alive", resembling a house, making it easier for people to orient themselves, especially when they have dementia.

  - Caregivers. Each person who interacts with an older person must be aware and be sensitized to the "humane" treatment of these people, must work the principles of empathy, unconditional acceptance, and active listening.

  - Knowing life, "life history". The knowledge of life history is a great step to minimize behavioural problems. It helps to decrease agitated states.

Let's take for example the following situation. "Mr. X suffers from Alzheimer's disease and needs help with grooming and personal hygiene, according to the latest records noted by the direct care professionals he is very aggressive in the showers, having assaulted one of the aides. When we start to study the case of Mr. X, it can be observed that not every day he presents the same alterations. According to the data, it can be observed that behavioural problems have a higher probability of occurrence when the gerontology assistant "Y" performs the hygiene. When the assistant "Z" participates in helping Mr. "X", these behaviours appear to a lesser extent. The behavioural intervention process will be based on re-educating helper "Y" by setting behavioural guidelines that can improve his attention.

Therefore, behavioural problems are manageable and, to a large extent and as noted by Kitwood (2005), "the quality of life of people with dementia is inversely proportional to the relationships they have with those around them".

1.2 Guidelines to facilitate communication with people with cognitive impairment/dementia

When communicating with people living in institutions, it should be considered that many of them are cognitively impaired or suffer from dementias such as Alzheimer's disease. Therefore, it is advisable to take into account a number of important premises in order to understand the degenerative process in which they find themselves and that leads to a significant poverty of vocabulary, which generates numerous problems when expressing themselves due to aphasic problems that greatly hinder communication with them and generate significant behavioural problems. By improving communication, it will be possible to reduce behavioural problems; for this purpose, a series of techniques are proposed that will improve communication with these people:

- **Address the person face to face and slowly**. Calmly -without haste, but without pause-, let him/her see us, let him/her know who we are, let him/her recognize us from a soft and calm tone of voice.

- **Always put yourself at their eye level**. When we want to talk to this person and convey a message of calm or tranquillity or ask him/her to do something, it is important to put ourselves at his/her level, so that we can look him/her in the eyes.

- **Simple language**. Familiar words that the affected person can easily recognize.

- **Use short sentences**. It is important to simplify our speech, using short, clear, and simple sentences, because if we use a long sentence or complicated language, the patient will have forgotten the beginning before we have finished the sentence and will not understand us. In addition, this way we will avoid exhausting the patient with the effort of trying to understand long and complicated sentences that he/she will not be able to understand.

- **Speak slowly and clearly**. People with dementia need more time to perceive and integrate stimuli, so we must adapt to their pace and not provide more information than they can assimilate. Do not give an order until we have not understood what they are trying to tell us, giving them time to respond is the key to minimize behavioural problems.

- **Lower your voice**. Low tones of voice to provide the person with calm, serenity, and tranquillity.

- **Eliminate background noise**. The person with dementia has difficulty identifying and discriminating sounds and noises. It is therefore important to reduce background noises, so that the patient can focus on the task and enhance their learning.

- **Use simple questions**. Avoid beating around the bush when asking questions. Asking a simple, short, and direct question facilitates communication.

- **Let him/her express himself/herself**. Encourage the person with dementia to express their doubts and concerns. For this, it is vital to enhance their verbal and non-verbal communication.

- **Do not speak for the person with dementia**. Letting the person finish sentences and including him/her in conversations will prevent him/her from feeling displaced and may incur behavioural problems.

- **Treat the person with dignity and respect**. It is important to keep in mind that, despite the cognitive impairment that the patient may present, the patient is an adult and, as such, has his or her rights and deserves deep respect. It must be remembered that, although the person may need a lot of care to carry out daily activities, his or her dignity must always be guaranteed.

- **Promote non-verbal communication**. Once the verbal language has deteriorated and been lost, the form of expression of the sick person will be 90% non-verbal. Therefore, physical contact, caresses, holding their hands or putting an arm around their shoulders will be the most appropriate way to communicate with them.

Table 1. Example of communication summary table. *Source*: own elaboration.

Advice	Example
Approach from the front.	Avoid the back or sides due to loss of panoramic vision.
Simple language.	Avoid a word like "shower", change it to "cleaning" or "get pretty".
Short phrases.	Better “Would you like an apple or a pear?”, than “We have apples or pears for dessert, what do you prefer?”.
Speak slowly and clearly.	Without rushing and looking into the eyes to enhance the message.
Low tone of voice.	Gently speaking loudly conveys anger and upsets much more.
Eliminate background noise.	Car noises, TV in the background...
Facilitate expression.	Let him speak and express himself in his own way, through gestures, physical contact... We must bear in mind that when language fails us, gestures are enhanced.

Do not speak for the person.	Let her finish the conversation, place her in it, and let her express herself.
Include her in the conversation.	Avoid leaving her out. For example: talking about his illness or forgetfulness as if he were not there.
Dignity and respect.	Closed doors, avoid childishness, respect their privacy...
Improve non-verbal communication.	Gestures, caresses... Physical contact is key to improving behavioural problems.

2. KNOWING HOW TO ADOPT THE CORRECT POSITION AS A PROFESSIONAL

When it comes to dealing with problems related to violence, the different participants in the professional care teams for the elderly need to know how to adopt a neutral and balanced position in conflict situations. To properly carry out this process, the guidelines of the conflict must be adequately defined and analysed, as well as the appropriate methods to stay out of it and be objective in order to analyse situations calmly and rationally.

2.1. Appropriate methods to stay out of the way and be objective in order to analyse situations calmly and rationally

Before the appearance of a conflict situation that could end in a situation of violence or aggressiveness, different positions can be taken, the most important thing is not to lose your temper and focus on solutions, avoiding at all times taking the conflictive situation to a point where return in which both parties lose

Conflict is understood as the differences of interests between two or more parties. Some people understand it as battles to be avoided or won. Both positions are wrong because the bad thing is hardly the existence of the conflict, but its mismanagement. It is normal that in an intense and prolonged relationship the tension generated by work, difficulties, etc., occasionally frictions arise due to the difference in character of the members.

2.2. Attitudes that help improve conflicts from an equidistant position

Better than solving a conflict, it will always be better to try to prevent it. In this sense, there are attitudes that help and others that promote it.

Attitudes that prevent conflicts:

- Showing proximity
- Taking an interest in the opinions of team members
- Knowing the opinions of the participants involved in the conflictive situation
- Providing a personalized and friendly treatment
- Trying to ensure that they can express themselves freely, facilitating optimal resolution climates

Attitudes to avoid in order not to generate conflicts:

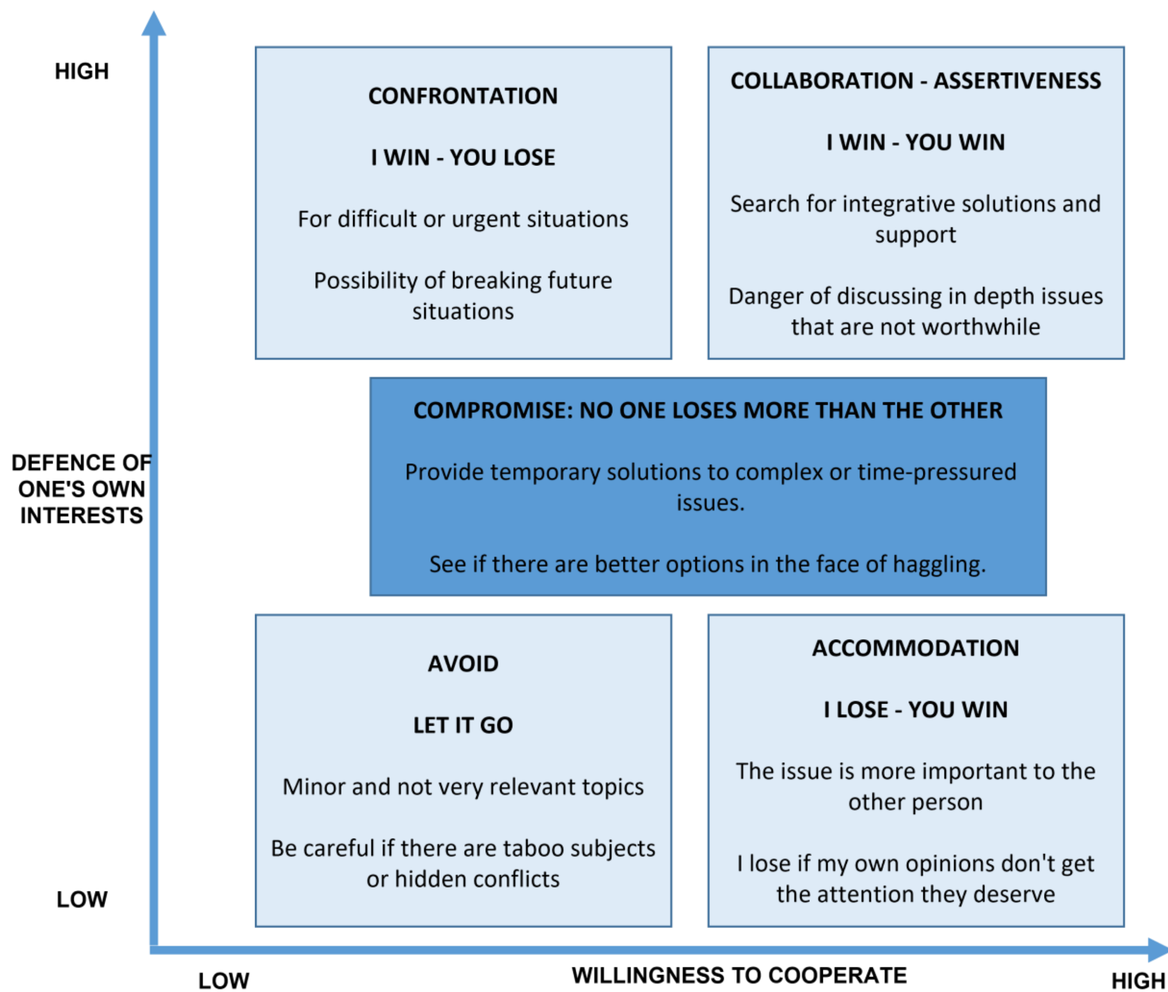
- Adopting dichotomous positions in which both parties want or believe they are right
- Giving contradictory statements
- Identifying comparative torts
- Being always condescending to the same party, leaving aside the other
- Promoting clearly unfair situations
- Providing preferential treatment towards any of the parties

2.3. Steps to be followed when intervening in a conflict

The intervention in a conflict can follow a guideline in **5 steps that favour a resolution.**

1. **EVALUATION:** five aspects of the environment surrounding communication in the work team are evaluated:
    a) **Mutual relationships.** It is from the relationship and not from the people that conflicts arise.
    b) **Nature and causes of the conflict.** The conflict will depend a lot on the causes that originate it. These can be differences in beliefs about how to achieve goals or differences in people's value systems (the latter compromise personal identity and are much more difficult to resolve).
    c) **Clarification of objectives. Clearly identifying goals** is necessary to resolve conflict productively.
    d) **Examination of the existing climate**: review of the communication environment, the tension factor, the precedents regarding similar situations, etc.
    e) **Behaviour to follow.** Initial determination of the behaviour to follow to deal with the conflict. There are five strategic lines to resolve conflicts, depending on the degrees of cooperation and activity.

These strategies are summarized in the following table



2. **ACCEPTANCE**: two people can perceive the same fact from radically opposite positions. In a conflict, we must try to understand and accept the differences and similarities between those involved. During this phase, both parties must recognize that the concepts and norms by which the other person is governed may differ from their own. Otherwise, the problem could remain unsolvable. Therefore, it will be essential, although difficult, to empathize with the other person.

3. **ATTITUDE:** the proper attitude to lead team members into productive interaction includes:
   - Try to maintain objectivity. Emotional self-control
   - Control biases such as stereotypes and prejudices
   - Stay flexible and open to finding solutions
   - Relaxation
   - Explore how one's own behaviour is perceived when compared to the other's

4. **ACTION**: the goal of conflict management is to initiate productive action to achieve one's goals. In this phase, the following elements will be considered:
    - Give credibility to the other party
    - Establish a level of trust
    - Raise the problem from both points of view so that both parties understand each other
    - Accurately use verbal and non-verbal communications
    - Control vocabulary
    - Observe how the other party communicates
    - Stick to goals. Don't stray from the topic
    - Do not promise anything that cannot be fulfilled
    - Do not present matters under the "win-lose" formula
    - Elaborate as many options as possible, including both points of view
    - Keep communication channels open with our environment and encourage interaction
    - Review and summarize the expectations and decisions of both parties

5. **ANALYSIS OF NEEDS**: although this variable must be present throughout the entire conflict management process, its meaning as a culmination phase is also important. You must check:
    - Whether the concerns of all parties have been heeded
    - Whether decisions can be implemented quickly and efficiently
    - If the effects of the solution are viable in the long term
    - Whether the relationship between the parties to the conflict has changed productively
    - Whether the decisions have been summarized and clarified. Whether the procedures have been revised to implement any changes

3. HOW TO REACT TO VIOLENT SITUATIONS

When reacting to aggressive situations, it is convenient to have knowledge about a series of elements that interact together to be able to intervene and develop intervention guidelines from the general to the specific.

3.1. Communication skills

Many behavioural problems can be solved by following a series of *communication steps*, in order to ensure a correct communication process.

1. Choose the **right time and place** agreed with the other person and be in an emotional state favourable to communication.

2. Be consistent and have reflected on **what is wanted**, what is **meant** and how to **say it better**.

3. Be aware of your **own filters** to send and receive messages.

4. **Listen actively and empathetically** and ask open or specific questions as appropriate to the topic being discussed.

5. Use an **assertive communication** style.

6. Express feelings and emotions in the form of "**I-messages**".

7. Use **clear, precise, consistent, and useful** messages.

8. **Accept** arguments, objections, or criticism, incorporating the other person's messages into our speech.

9. **Active listening**. Listening well is a cognitive, affective, and motivational skill that requires an attitude that shows our interlocutor that we are really understanding what they want to tell us. On the other hand, listening is an essential element to get to know the other person, to establish quality interpersonal relationships.

   The positive effects of active listening are, for those who feel listened to, helpful; By being more aware of your reality, you contribute to your personal growth. And for those who listen, it is a source of information, it contributes to modifying attitudes positively, acquiring greater sensitivity, tolerance, and flexibility. The skill of assertive communication.

10. **Communication styles**. There are three communication styles:
    a. **Assertive communication**: it implies expressing one's own feelings, needs and rights without threatening the rights of other people.

    b. **Passive communication**: implies the violation of one's own rights, by not being able to honestly express feelings, emotions, thoughts, and opinions. Accompanying verbal language appear non-verbal behaviours such as hiding one's gaze, tense postures...

    c. **Aggressive communication**: it involves defending our rights in a way that can sometimes be inappropriate and can violate the rights of the other person. The person expresses himself/herself in an imposing way, using coercion.

    For instance: you enter the room of your residence user and see that it is very messy with all the clothes on the floor. What do you say?
    - ✓ <u>Passive communication</u>: you say nothing and pick it up while internally protesting that it is messy and internally complaining repeatedly.
    - ✓ <u>Aggressive communication</u>: you go towards the user and reproach him/her for being messy, for not being considerate, that you are tired of telling him/her to clean up the room and things, that she doesn't know how to get along with others.
    - ✓ <u>Assertive communication</u>: you go to the user and tell him/her:

- "You *have a room full of clothes on the floor*" (facts).
- "I *feel like I'm your maid when you leave everything in the middle*" (feelings).
- "*Try to collect everything when you change tomorrow*" (behaviour).
- "*This way you will make me feel better*" (consequences).

3.2. The importance of messages from the "I" perspective to control violent situations

The ability to communicate from the self ("**I-messages**") are sent in the first person. When we use these messages, we are telling the other person that what I express is mine, my feelings ("I feel bad"), my opinions ("I think") and my wishes and preferences ("I would like that..."). In this way, we make it clear to the other person that we are not blaming him/her for what we feel/think/need. We let him/her know in an honest and respectful way that sometimes we may have differences or disagreements. It is a facilitating and persuasive message.

"**You-messages**" usually blame the interlocutor for our behaviour or opinions; with these messages, people can feel evaluated.

How do I create an "I-message"?

- Describe what the other does ("when you…).
- Express what you feel ("I feel…").
- Propose what you would like ("instead, I would like…").

Example: Lucas listens to the record player at such a high volume that it interferes with the conversation that his parents are having in the next room.

- You-message: "how can you scream so loud? Can't you be more considerate of others?"
- I-message: "when you yell so loud, we can't talk quietly. I'd like you to lower your tone of voice".

3.3. Communication in specific situations

Giving and receiving complaints:

On many occasions, other people do things that we dislike or annoy us. Many times, we do not dare or do not know how to say it. Other times, we are the ones who bother.

How do we receive complaints?

1. Say why you are upset.
2. Express negative feelings.
3. Ask the other person not to do what they have just done again.
4. Reinforce the other because he/she has listened to me. Advantages: making a positive complaint reduces the sources of irritation and antipathy in relationships. By listening to other people's complaints, they see that we care about what they say.

Give a negative or say no:

Sometimes, we find ourselves in front of people who ask us for things that we do not want to do and, because of fear of saying no, and getting angry, we give in (passive style) or adopt an aggressive style.

What should we do?

1. Listen without interrupting and trying to understand what is being asked to us.
2. Say no appropriately, explaining the reasons so that the other person understands our position and trying not to hurt their feelings. Be nice.
3. Suggest some other idea (offer alternatives). Advantages: if you know how to say no, you make your position known to others and prevent people from taking advantage.

We feel good because we do not have to do something we do not like or do not feel like doing.

Responding to persuasion or pressure:

What to do?

1. Listen to what the other person, publicity, media, etc., think about the subject.
2. Decide what you personally think about that topic.
3. Compare what the other person has said with what is thought.
4. Decide which idea is preferred and communicate it.

Ask for help effectively:

1. Express yourself with kindness.
2. Explain clearly what you want.
3. Explain the reasons why you need that help or favour.
4. Do not insist too much.
5. If they say yes, thank them.
6. If they tell you no, look for alternatives. When communication fails, conflict appears.

3.4. Phases of the anger curve

A. **Rational phase**: it is the initial period in which an adequate emotional level is maintained to discuss the solution of problems favourably.
B. **Trigger phase**: rise of emotion. When faced with an angry patient or family member, the most appropriate thing is for us to listen, we must avoid judging or interpreting their query.
C. **Slow phase**: it is important to empathize to avoid going back to the shooting phase. Ask open questions, to find out what's wrong, how you feel.
D. **Coping phase**: the fall of the hostility reaction occurs. You must wait for the reaction to "cool down" completely.
E. **Cooling phase**: back to calm.
F. **Problem-solving phase**: return to the rational level. It is the optimal time to solve the problem. Since we are immersed in a conflictive situation, we can choose the attitude that we are going to take in the face of it.

The four **most frequent attitudes** are:

- Withdrawal or avoidance approach: when you physically or emotionally withdraw from a conflict, you lose the opportunity to give your opinion. They are forms of withdrawal: stop talking, ignore the other person or act in business terms.
- Suppression or rapid mediation approach: suppressing a conflict is not talking about what is important. A mother of a resident asks us for an antibiotic because "in a previous time he/she had the same symptoms, but nobody give it to her, and finally it was pneumonia." Our attitude to finish soon is to give the resident the antibiotic.
- I win/ you lose or conquest approach: this attitude expresses the struggle for power in which one of the parties emerges as the winner. In the previous case, we would act like this in case of imposing our idea: “I am the physician”.
- Agreement or haggling approach: on many occasions, this attitude makes neither party feel too convinced. The mother asks us for the antibiotic, and you respond: “we are going to do the following: I am not going to give you the antibiotic, and we are going to wait 24 hours; tomorrow I will explore him/her again, and we will see what happens”.

There is a fifth attitude that views conflict as an opportunity (I win/you win). In this approach, broader solutions are discovered. Some guidelines to obtain solutions according to this approach are:

- Define everyone's needs.
- Try to pay attention to all of them.
- Recognize the values of others as your own.
- Try to be objective and separate the problem from the person (“tough on the problem, soft on the people”).

3.5. The difficult patient or family

A possible definition would be: “the one who manages to make you feel that unpleasant knot in your stomach every time you read his/her name on the agenda”.

Speaking about “difficult patients” is to give them a label that attributes all the responsibility to the patient or family member for being who they are, without considering that relationships are built between two or more parties, and we actually take an active part.

What can we do? We will work with the variables that depend on us, as professionals:

- Adopt an evaluative attitude rather than a defensive attitude.
- Accept the feelings and emotions that we have in front of the patient.
- Implement of our best communication skills.
- Think that it is not possible to have a perfect relationship.
- Do not get infected by the emotion of the other.
- Practice active listening.
- Empathize and show a desire to resolve the situation.

3.6. How to deal with difficult situations

1. **Stay calm. Respond instead of reacting**. To react is to become infected with the emotions of the other. Responding instead means behaving thoughtfully.

2. **Actively listen and offer no resistance**. If you present yourself to the other person as a wall, what you will probably achieve is that they attack with more force.

3. **Use I-messages**

4. **Use assertive communication techniques**:
   - **Broken record**. Repeat your own point of view repeatedly, calmly, without entering into the provocations that the other may make. “I understand that you are concerned about the fever, but an antibiotic is not indicated at this time… I understand that you are concerned that you have a fever, but I do not see the need to give you an antibiotic at this time.”
   - **Fog bank**. Giving the other reason in what we consider may be true in their criticism but refusing to enter into further discussions. In this way, we appear to give up the ground, without actually giving it up, because we make it clear that we are not going to change our position. “Every time I come in the afternoon, I have to wait a lot; You're right, I may have to vary my schedule."
   - **Negative assertion**. Avoid saying "I'm sorry" or "excuse me" that by dint of repetition mean nothing. Instead, use phrases such as "it was silly on my part", "I shouldn't have said/done", "you have all the reason”.
   - **Assertive postponement**. It consists of postponing the issue that is being discussed until a time when it is more appropriate: “I think this is not the time to talk about this issue, because we are very upset. We'd better talk about it tomorrow".
   - **Partial denial**. Useful technique with demands in which we are willing to play a part, but with certain conditions. It is expressed in such a way that, first, we say what we are willing to do something, and then continue with the part that we do not accept: “I have no problem staying two more hours for your query, as long as we do it the other way around on another occasion”.
   - **Complete negative**. Formulate the refusal clearly, without giving rise to insisting, but without hurting the interlocutor: "For such and such a reason, I can't give you a certificate for the nursery."
   - **Disarm the anger**. With this technique, we intend to focus on the interlocutor's negative feelings, ignoring the content of the request: “I realize that you are very angry about waiting. Let's see what we can do."

5. Separate the problem from the person

6. **Know how to ask questions:**
   a. Ask questions that guide the negotiation. If we see that the negotiation is not going in the direction it should, ask, for example: "Is this plan taking us where we wanted to go?".
   b. When the other person says general statements (“everyone, always, never”), ask: “Everyone? Forever? Never?".
   c. When the other person says rigid statements (“I won't be able to do that”), ask, for example: “What do you need to make that possible?”

3.7. Behaviour management in people with dementia. Behaviour alterations: how they occur and how to act

One of the most frequent problems in dementias are the so-called behavioural and psychological symptoms associated with dementia, known as (SCPD).

This symptomatology generates a high degree of suffering for both, the sick person and their environment, giving rise to difficult-to-manage situations in which knowing how to act is decisive.

Next, we proceed to point out how to respond to the most frequent alterations.

Agitation and aggressiveness

It can be defined as the presence of excessive, exaggerated or inappropriate movements or behaviours to the situation, and that are not caused by an external stimulus. It would include behaviours such as: restlessness, repetitive movements, manipulation of objects, repeated dressing and undressing, biting, scratching or throwing objects.

How to deal with aggressiveness and agitation:

Do not yell, hold, provoke or raise your voice
Do not confront or ask for explanations
Do not make sudden gestures or touch him/her unexpectedly or from behind
Empathetic, receptive posture, we must always remember that the smile is the damper of aggressiveness
Remove or remove dangerous objects from your reach
Look for eye contact, facilitating the progressive approach
Retreat out of range of his/her blows
Divert attention (verbally or environmentally)
Anticipate aggressiveness
Don't take it personally
Forget what happened, and always remember that the person is not cognitively well

Hallucinations

Hallucinations are perceptual disturbances in the absence of a stimulus. They are usually present in Lewy body dementia, also in Alzheimer's disease or in frontotemporal dementias. The most common hallucinations in people with Lewy body dementia usually include the presence of people or animals (in the form of bugs or insects) inside their home. There are mainly visual hallucinations.

Evaluate sensory deficits, mainly in sight and hearing (rule out cataracts and glaucoma)
Review pharmacology (mainly neuroleptics
Find the trigger: how, when, where and why it occurs
Never deny him/her the hallucination. Remember that for the person, it is real
Reassure him/her and approach slowly, always within his/her visual field, identifying yourself and telling him/her who we are at all times
You can try to distract him/her by showing him/her something he/she likes
If the hallucination is not dangerous, leave the person alone

Delusions

Patients with dementia often have fixed ideas of a delusional nature, which cannot therefore be changed by logical reasoning. The most frequent are ideas of theft (which appear as an attempt to explain the loss of objects in the initial and moderate phase of dementia) and persecutory or paranoid ideas, which can lead to running away without meaning or refusing food for fear of being poisoned.

Facilitate the location in the known and familiar space
Look for the trigger: analyse why, the moment before and after the delusion
Never humour the person or argue with them about the truth of this fact
Maintain a conversation with the person and reinforce coherent ideas, rewarding them for it
Diverting attention to pleasant activities or things that are known to be to the person's liking in order to divert attention
Do not leave the person alone
You should try to guide him/her calmly
Explain what you see or hear. If you don't understand, repeat information
Avoid speaking softly in his/her presence.

Insomnia

Sleep problems are present in dementias, they are very common in Alzheimer's disease (as a result of temporal-spatial disorientation), in vascular dementias (changes in sleep-wake rhythm) and in Lewy body dementias (due to alterations in the REM phase). They generate significant behavioural problems and alter the rest of caregivers.

Create a bedtime routine. Schedule sleep
Avoid daytime napping
Perform physical activity during the day, so that the person arrive tired at bedtime
Avoid excessive dinners or leave him/her hungry. Getting used to the routine of having a glass of warm milk helps you sleep
Avoid excessive fluids before bed
Go to the bathroom before bed
Proper room temperature
Quiet bedroom, if possible, away from other areas of the residence where there is more ambient noise
If he/she gets up, accompaniment to sleep, reassure and guide him/her

Disinhibition

Mainly present in frontotemporal dementias. Many patients present inappropriate behaviours in the sexual or behavioural aspect (impulsive behaviours) that can lead to strong aggressive behaviours.

Do not react in an alarming way or punish the person in the face of a problem of this type
Attention diversion
Help him/her get dressed by taking him/her to a quiet and suitable place
Adapt and modify clothes with special buttons so that they are not easily removed
Remember that when there are masturbation problems, the patient only does what makes him/her feel good and should not be blamed for it

Wandering:

The person with dementia can walk for hours without meaning to different places, with the danger that this can entail, mainly in the form of falls. Sometimes the wandering reaches the point of exhaustion.

Eliminate architectural barriers that prevent wandering, such as chairs or furniture in the corridors, which can cause falls
Surround new environments with familiar objects
Find the root of the behaviour, the time of the greatest incidence, the cause and treat it

Take a walk with the person and try to serenely divert attention to another rewarding or profitable task
Talk to him/her, try to calm him/her down, avoiding a catastrophic reaction such as a scream
Don't force him/her to sit down, it will rise again
Let him/her go by being more physically active, you will sleep better
Sign of boredom, try to increase his/her level of physical and mental activity

4. EMOTION REGULATION TECHNIQUES AND SOCIAL SKILLS

Ability to freely issue information

It consists of providing additional information to that directly stated in the question, normally referring to aspects of a personal nature (our opinions, ideas, activities, etc.). Sometimes it is a kind of invitation to talk about what the person thinks is appropriate. This ability fulfils two main functions: on one hand, it facilitates a topic of conversation, and, on the other hand, it stimulates others to talk about themselves, which will allow us to show interest in things that are important to them.

Therefore, it is about offering enough personal information during the conversation. You can also ask open questions or comments on the information provided, without forgetting that we also provide a lot of data to the interlocutor with our way of dressing, facial expression, the posture we adopt during the conversation, the language we use, etc.

For instance, when asked "Hello, how are you?", we can answer "Well" or "Well, I just finished some work, and now I'm finally calm". This second answer will give rise to the interlocutor to ask about the subject of the work, the reason for it, etc. thus facilitating the conversation.

Ability to make self-disclosures

As its name suggests, these are verbalizations in which the person reveals personal information about himself/herself. Its function is to provide the other information about ourselves that could not be known in any other way, or about our thoughts, feelings and reactions to the information that comes to us from others.

It makes it easier for communication to be carried out in a bidirectional way, which is essential, so that we are not interpreted as curious about other people's topics without sharing our own. For this, sentences in the first person are useful, for example: *"On that subject, I think..."; "What I want is power..."; "I would like..."*.

Self-disclosures are essential to achieving greater intimacy or friendship with a person, but do not do it in a rush. It is just as uncomfortable to establish a relationship with a person who doesn't reveal personal information, so that conversations are always kept on a superficial level, without advancing intimacy, like doing it with someone who reveals very personal information too soon. For this reason, self-disclosure should be symmetrical, that is, the two people disclose information at the same rate.

Ability to formulate a criticism

Before formulating a criticism, a series of previous components must be considered, such as choosing the right time and place. It is about selecting a situation in which our interlocutor is not upset and is available. We must also avoid formulating criticism in states of tension or anger with the other person, because in this way our behaviour would be aggressive and not assertive. Also, keep in mind not to wait too long after the behaviour being criticized occurred and only make one criticism at a time. One of the most important aspects of formulating a criticism is to operationally describe the behaviour being criticized, but without judging it and without generalizing it to other situations.

The **steps to assertively formulate a criticism** are as follows:

1. Describe the situation that is annoying or uncomfortable and that is intended to change with the realization of that criticism. In this sense, it is important to refer to observable behaviours ("When you...") and not to wishes or intentions assumed by us ("I know you would like to..."; "You did it on purpose... »).
2. Express the personal feelings that the performance of that behaviour provokes in us ("I feel...").
3. Subsequently, the changes that are considered necessary are suggested, so that we do not makes the partner's behaviour uncomfortable, proposing alternatives or options to it ("I would like that...").

   Let's look at an example:

   "Peter, I want to tell you something about your work. Every time you go into the warehouse to pick up a patient's medication, you leave all the containers on the table and don't put the boxes back where they were. When I go in later, I feel angry because I see everything disorganized, and I have a hard time finding what I'm looking for. That is why I would like you to leave everything in order when you finish collecting what you are looking for. I thank you for listening to me because this issue is important to me, and I think we can solve it easily".

From this general formulation, we can find variations depending on the objective of the interaction, depending on whether the priority is to inform or care for the relationship. Criticism can also be formulated to ask for a change in behaviour, but we will see this in the next section.

a. If the objective is to inform the other of the behaviour that is the object of criticism, we will use expressions such as "When you...", and we will express our feeling in the first person (I feel...).
   For example: *"...when you joke about my slip-ups in front of your friends [target behaviour] your jokes make me feel stupid [expression of feelings]."*

b. If the priority objective of the criticism is not to deteriorate the relationship, we will begin the criticism by expressing something positive about the other person's behaviour (I really like that...), then we express understanding (I understand that you...) and finally we accept a part of the responsibility (Maybe I...).

   For example: *"I really like that you are so motivated by work. I understand that sometimes you can get personally involved with a family, but I think that's a mistake, and you can't call the patient's house to see how they are doing. I understand that at first it reinforced you that you treated patients in a personal way, but you are going to resent it a lot if you continue with this trend".*

After the criticism, we must not forget to reinforce any positive behaviour of the other that is observed, even if no change was achieved (I'm glad we stayed; I appreciate you not being angry).

Ability to request changes in behaviour or performance of tasks

To carry out this type of communication, it is very useful to use a “sandwich” structure, that is, we formulate the negative comment between two positive comments, so that our interlocutor does not have a bad taste in his mouth.

To do this, we begin by referring to a positive behaviour, flattering the subject for the realization of this and then we introduce the proposal for change, criticism, or suggestion.

To finish, we refer to another appropriate behaviour or to the same one that we referred to at the beginning.

For example:

“It shows that you have worked on the subject, however, I think you should reinforce the practice, although of course your progress is remarkable”

"I find it pleasant to work with you, but if you were more organized, I think we would be more effective."

“You've been running late for two days, and I have to stay to explain how we're doing work. That bothers me a lot, and then I have to run away to be able to pick up my daughter on time. I hate being so stressed. I ask you to be punctual from now on”.

Ability to express opinions or criteria different from those of another member of the group

This ability is based on the personal right that we all have to maintain our own opinions, to change our minds if we deem it convenient, and for other people to respect our opinions.

When we want to express opinions contrary to those expressed by other members of the group, doing so in an assertive manner, an appropriate formula may be to initially give the person part of the reason for the opinion expressed, and then give our opinion. Phrases such as: “I have no doubt that you will have sufficient reasons to, …but…”; "I know that…. However, and despite everything...”; «It is true that…, despite everything, I still think that…»; «It is true what you say... but still I wish...».

For example:

"I know that in the hospital where you worked before, this procedure was done differently, but you still have to follow the protocols that we have established in this centre."

«I understand that you may think this of Maria, with the experiences you have had with her. However, I think we should invite her to dinner, so she doesn't feel relegated."

If by insisting on our opinion, we receive criticism from our colleagues, we can accept if we consider that they are right, or to insist on our opinion again if we think that we are right (“What you say is possible, but I find it hard to believe that I intentionally make mistakes”).

Ability to ask the other to confirm or express disagreement

It is used to favour the expression of agreement or disagreement with any argument or situation, or with the intention of knowing the position of an individual in a certain situation. To do this, we must pose a question in such a way that in his answer, our interlocutor had to opt for one of the alternatives.

Some ways to ask these questions would be:

– Is it correct to suppose that...?

– Am I right and what you say is that...?

– Am I wrong to think that...?

Ability to ask questions

This ability is used for various purposes: gathering information, holding conversations, generating doubts or inviting our interlocutor to reflect.

Two types of questions can be asked:

1) Open questions are exploratory and encourage the person to think about their feelings and thoughts. They allow the interlocutor to answer with amplitude and sincerity and continue reflecting on the content of the message that she/he transmits to us. But its fundamental characteristic is that in its formulation it does not guide towards the answer, and that it is usually answered with more than one or two words. For all these reasons, they allow conversations during a longer time.

   Examples of open questions would be: “How did you do it?”; “How is patient X doing?” "What do you mean by that?"; "How do you feel now?"; "What do you think of his attitude?"

2) Closed questions are asked to obtain specific information and have a direct or short answer, selected from a limited number of answers. Therefore, their main characteristic is that they require very restricted and specific answers (for example, yes, no).

   Examples of specific questions are: "Has patient X eaten yet?" "Do you work on Sunday?"

To improve communication, it is necessary to increase the number of open ones. So instead of "Did you have a good night?" we can ask "How was your night?" and instead of "Were you taking medication at home?" we can ask "what medication were you taking at home?". However, sometimes the need to specify something makes closed questions necessary. For example, “Is he diabetic?”, “Does he suffer from hypertension?”, Have you already changed his serum?

Ability to give compliments

Compliments highlight those characteristics that we consider positive in a person. If we communicate to the other the aspects that we like the most about him/her or what we consider positive, it will help us to make him/her more pleasant and improve our relationship with this person. In addition, praising unites people, they tend to be reciprocal, and it allows people to know what we like about them, thus increasing the probability that they will repeat it.

When issuing a compliment, we must consider a series of aspects:

- It must be justified and sincere, otherwise the other person will notice.
- It must be personalized, that is, highlighting the particularities of the person to whom it is addressed and adapted to the specific situation in which we find ourselves. In this sense, repeating the same complement to our interlocutor or reinforcing the same aspect in all the subjects reduces the credibility of the message.
- Finally, it must be as specific as possible, describing the behaviour of the person instead of using a general qualifier. For example, it is better to say "you have explained the problem very clearly to me", than to say "you are very intelligent".

In general, the **steps to follow when giving a compliment** are as follows:

1. Expression of affection and praise (always in the first person): «I think you are a good colleague»; "I think you're great".
2. Expression of positive feelings: "I like how you take care of patients"; "I feel very comfortable when I share guard duty with you".
3. Specify the positive or rewarding aspects of the other's behaviour in a clear and specific way: "your way of listening to me…"; "when you explain to the patient how to follow the treatment…".
4. Specify the situations in a clear and concise way, for example "how do you help me when I try to learn new things".
5. Offer reciprocal positive behaviour: "If you ever need anything, let me know"; "Come, I'll buy you a coffee".

Another more subtle form of praise, but which is very appreciated, is to repeat the name of the person with whom we speak throughout the conversation: "Very well, Luis"; "We agree, Peter".

4.1. Self-regulation in crisis intervention

The first psychological aid must be provided by the professionals who provide the first assistance, including the health professionals who treat you or who communicate the bad news.

The **objectives of crisis intervention follow four stages**:

1. **Somatic stage**: it is aimed at contributing to physical survival.
2. **Affective stage**: its objective is to identify and express the feelings involved in the crisis.
3. **Cognitive stage**: its purpose is that the person obtains the cognitive domain to understand the situation.
4. **Behavioural/interpersonal stage**: in this last phase, the aim is for the person to generate new patterns of behaviour and interpersonal relationships to adapt to the situation.

Thus, in crisis intervention, the physical survival of the person is first ensured, in order to progress through the different stages until adaptation to the new situation after the crisis is achieved.

The first psychological help that nursing professionals should provide, among others, is raised with a central objective: that **the person in crisis is capable of making decisions**. All crisis situations are characterized by impaired problem-solving skills. For the person in crisis, the essence of the problem is that he or she feels unable to cope with the overwhelming circumstances of the moment. In this sense, a well-dispensed help can assist the person to take the concrete measures that allow him/her to manage his own feelings and make decisions.

The basic concepts of crisis intervention are as follows:

- ✓ The coping capacity of those affected does not work well the person is overloaded.
- ✓ Prompt and targeted help can help bring functioning back into balance.
- ✓ Only those matters that cannot be handled by oneself can be handled by others.
- ✓ The help offered must be consistent with the individuality of the person.
- ✓ Aid must be withdrawn as soon as possible.

This help must be provided as soon as possible, so that we reduce the time that the person in crisis is alone. It is about reacting as soon as possible to the help provided. Another important aspect is that when the nurse intervenes, she/he does so convinced that her/his work will help the person reduce the impact of the situation. In this way, it will transmit security and confidence to the victim. This assistance must be carried out in a discreet, close place and, whenever possible, out of sight of the place where the events occurred to prevent it from causing rejection or fear in the affected person.

Effective communication in crisis

Crisis intervention is a helping process aimed at helping a person or family cope with a traumatic event so that the likelihood of being physically and emotionally harmed is reduced and the opportunity for growth is increased. This process is divided into two parts: psychological first aid and crisis therapy.

The objective of this first aid is to attend to the emotional disorder that the person suffers, as well as to their behaviour that is not adjusted to the place and time.

Crisis intervention consists of five steps:

1. Psychological contact.
2. Examine the dimensions of the problem.
3. Examine possible solutions.
4. Help adopt concrete solutions.
5. Monitoring.

Phase I. Psychological contact

In this phase we must try to make the person in crisis feel heard, understood, and supported. Other objectives of this first moment are to reduce emotional problems and favour decision-making.

To achieve these objectives, the following tasks are proposed:

- Invite the person to speak.
- Pay attention to facts and feelings.
- Summarize facts and feelings.
- Offer empathy and active listening.
- Promote self-disclosures.
- Share direct and indirect expressions of interest in his/her condition and problems.
- Provide physical contact.
- Offer acceptance and unconditional support.
- Communicate acceptance.

Likewise, in this first phase of the aid, there are a series of errors that must be avoided by the health worker who provides this care. It is about telling a personal event or of which we have news and that is considered similar to the one that the person in crisis is experiencing. It is also necessary to avoid judging the behaviour of the person, taking sides with one of the parties (if this is the case) or ignoring facts or feelings expressed by the person affected.

For example:

"It's just that who would think of going alone at that time of night?"

"Don't you think you provoked them? What did you expect!

"Look, what you say that you feel ashamed of what has happened is nonsense"

If it is necessary, instrumental help will be offered in this first stage, such as physical security, health care, shelter, etc.

Phase II. Examine the dimensions of the problem

This second moment focuses on knowing the immediate and subsequent needs of the person in crisis. Sometimes it can be complex, but other times it can be very simple, such as notifying a relative. Thus, the fundamental objective of the second phase is to discover the problems of the affected person that

must be treated immediately and those that can be postponed, due to the impossibility of treating them all at the same time.

How can these goals be achieved?

- Asking open questions about the precipitating event.
- Asking open-ended questions about what the immediate problems are, what members or friends are available to help, what thoughts they have at the moment in relation to the critical event and the problems arising from it.
- Asking open-ended questions about immediate and short-term needs, concerns, and problems. At this time of help, the health worker must avoid continuous abstractions and will try to describe the problem in a concrete and operational way. You also must be very attentive to possible signs of danger on the part of the patient, such as threats against himself/herself or others.

Phase III. Examine possible solutions

Once we have identified what problems the person in crisis has, it is about collaborating in finding possible solutions to immediate or subsequent needs.

To do this, our communication must focus on:

- Ask what has been tried so far.
- Try to analyse the advantages and disadvantages of the solutions that the person has proposed. It is important not to leave any obstacle to each solution unanalysed.
- If considered appropriate, provide new solutions, for example, a new behaviour of the affected, the redefinition of the problem, asking for external help or making a change of environment.

In this phase, it is very common for the affected person to show tunnel vision, that is, a very negative perception of the situation in which they feel unable to find any solution or a glimmer of hope. The professional must transmit to the person, at all times, a feeling of control and ability to deal with the critical situation. For this reason, we must avoid being so directive that the person has the feeling that all the solutions have been provided by the health worker.

Phase IV. Help adopt concrete solutions

Once the problems and possible solutions have been identified, it is a question of deciding which option is selected, among the proposals. In general, it must be considered that it is not about deciding on the ideal solution, but on the one that is most feasible, that is, the best among the available solutions.

Therefore, the objectives of this phase are, firstly, to implement immediate and concrete solutions and, secondly, to negotiate specific postponements, for example, of time, place, or people, if necessary.

The tasks that help achieve these goals are as follows:

- If the person is capable of acting, they should be encouraged to do so through active listening and a facilitating attitude.
- If the person is not capable of acting, one must be managerial in relation to the decision to be made. To do this, it is very useful to use verbalizations such as "I can act on your behalf".
- If deemed necessary, decisions can be postponed. In this case, it should be noted the time and place, as well as providing facilities for the meeting to take place.

Common mistakes are about trying to figure everything out right away and making long-term action decisions. The professional must prevent the person from being shy or avoiding accepting decisions when necessary.

At this point, the nursing staff can adopt two different attitudes:

a. You can show a facilitating attitude, if the affected person has the capacity to decide and act. In this case, it is about collaborating with him/her to favour decision-making.
b. A directive attitude can also be adopted, but only if the person is not capable of doing so, due to the emotional state in which they find themselves, or because there is an imminent risk that does not allow waiting.

Phase V. Monitoring

Finally, a final follow-up phase is proposed, which allows the professional to see how the situation has evolved. Although it would be desirable, it is very complex to carry it out in urgent care situations, which means that it is not carried out on most occasions.

If family members have attended, it is very useful to detect the family leader so that he/she can channel information or decisions, in case that he/she has the necessary serenity to do so. Information about the affected person must be provided, for example, how they are doing, if further steps are necessary, etc.

4.2. Emotion regulation techniques

Technique #1: Deep Breathing

It is one of the emotional control techniques that is very easy to apply and, furthermore, is very useful for controlling physiological reactions before, during and after facing emotionally intense situations. It is done as follows:

1. Take a deep breath while mentally counting to 4.
2. Hold your breath while you mentally count to 4.
3. Breathe out as you mentally count to 8.
4. Repeat the above process.

In short, it is about **doing the different phases of breathing slowly** and a little more intensely than normal, but without having to force it at any time. To check that you are breathing correctly, you can put one hand on your chest and the other on your abdomen. You will be doing the breathing correctly when only the hand of the abdomen moves when you breathe. Some also call it abdominal breathing.

Technique #2: Thought Stopping

If we talk about techniques to control emotions, this can also be used before, during or after the situation that causes us problems. Specifically, it focuses on **thought control.** To put it into practice, you must follow the following steps:

1. When you start to feel uncomfortable, nervous or upset, pay attention to the type of thoughts you are having, and identify all those with negative connotations (focused on failure, hatred towards other people, blame, etc.).

2. Say to yourself, “enough!”.

3. Replace those thoughts with more positive ones.

The problem with this technique is that it takes some practice to identify negative thoughts, as well as to turn them around and turn them into positive ones.

Technique #3: Muscle relaxation

This emotional self-regulation technique can also be applied before, during and after the situation, but its effective use **requires prior training.** If you want to put it into practice, follow these steps:

1. Sit quietly in a comfortable position and close your eyes.
2. Slowly relax all the muscles in your body, starting with your toes and then relaxing the rest of your body until you reach the muscles in your neck and head.
3. Once you have relaxed all the muscles in your body, imagine yourself in a peaceful and relaxing place, for example lying on a beach. Whichever place you choose, imagine yourself totally relaxed and carefree.
4. Picture yourself in that place as clearly as possible.

Practice this exercise as often as possible, at least once a day for about 10 minutes each time. If you have been convinced of the usefulness of the exercise, remember that you must practice it to automate the process and relax in a few seconds.

Technique #4: Mental Rehearsal

This is another of the emotional control techniques designed to be used **before facing situations** in which we do not feel safe. It consists simply of imagining that you are in that situation, for example, asking someone to go out with you, and that you are doing it well, while feeling totally relaxed and safe.

You must **practice mentally what you are going to say and do.** Repeat this several times, until you start to feel more relaxed and surer of yourself.

Technique #5: Thought Regulation

When we are facing a moment of mental discomfort, and we do not know how to manage our emotions, we usually experience something known as a "torrent of thoughts". Many times, these uncontrolled thoughts are negative and do not allow us to find a solution to the stressful situation.

For the same reason, regulating thought can be an effective emotional control technique. How can we do it? The first step will be **to detect the torrent of thoughts** and identify what kind of ideas come to mind. Next, we can try to write them down in a notebook if we are alone and then work on those affirmations.

Technique #6: Logical Reasoning

Closely linked to the previous technique of emotional control, logical reasoning consists of **analysing one by one the thoughts that cause us emotional discomfort** and reasoning them out logically.

Here is an example of how to do it:

1. Thought: " *I'm useless and I'm useless* "

2. Emotion: sadness and crying
3. Logical reasoning: " *To what extent is that statement true? What good is it for me to think that about myself? What can I do to change that thought?* "

Technique #7: Distraction

Techniques for managing emotions also include methods for **times of emergency**, that is, when we cannot control our feelings in any other way. When we feel overwhelmed by our emotions, we can try to distract ourselves with some comforting stimulus such as a song, a book, a film, etc.

Technique #8: Self-regulation

Emotional self-regulation is a technique to control emotions that **requires some practice**. However, it is very effective. To achieve self-regulation, we must follow the following steps:

1. Detect and point out the moments in which we lose control.
2. When we are calm, think about the triggers of the situation (what we were thinking when we lost control of our emotions).
3. Identify trigger thoughts before they lead to uncontrollable emotions.
4. Learn to regulate our emotions during times of crisis with the help of other relaxation techniques

Technique #9: Emotional Education

This is one of the exercises to control emotions and prevent emotional crises. Emotional education consists of **learning to detect feelings and value them without judging them** negatively. All our emotions are necessary on some level and help us adapt to the world around us.

Technique #10: Assertive Training

Assertive training is one of the emotional control techniques that requires a specialist to be successfully completed. This group of psychological exercises aims **to learn to respond assertively in the face of conflict.**

Some assertiveness training techniques are:

- Identify the situations in which we want to be more assertive.
- Describe problematic situations.
- Write a script to change our behaviour.
- Put this script into practice.

General recommendations:

1. **Be clear about the objectives of the communicative act/clinical interview:** establish and maintain the relationship with the patient, respond to their emotions, obtain and share information, explain and plan, make decisions and implement them.
2. **Design a teamwork strategy when informing the patient and the family,** so that all the professionals involved actively participate, contributing what is pertinent to achieve excellence in the therapeutic relationship.

3. **Acquire knowledge related to the elements involved in the communication process:**
    - Behavioural elements referring to the behaviours we carry out and that can be observed by others: verbal behaviours (content of what we say, and type of language used), non-verbal behaviours (those in which the word does not intervene, such as smiling or gaze) and para verbal behaviours (way of saying things, including volume of voice, speed of speech, intonation, etc.).
    - Cognitive elements related to the thoughts we have while the communication process is taking place.
    - Physiological elements that have to do with the reactions of our body when we communicate.
4. **Acquire and use social skills:**
    - Use assertiveness, especially to highlight the most important part of the message.
    - Use self-monitoring techniques (for example, the Jacobson technique) to improve relaxation in difficult communicative contexts.
    - *Active listening:* paying attention not only to what is said but also to how it is said, noting non-verbal and para verbal elements; show interest in what we are told, making affirmative head movements, using affirmative words ("yes", "I see"…); paraphrase the interlocutor's words, summarize and confirm the statements he makes.
5. **Incorporate additional communication skills and elements in situations of special complexity,** such as giving bad news, dealing with agony and death, talking about sex and/or stigmatizing issues (gender violence, child abuse, mental illness); manage emotions (stress, fear, anger, aggressiveness); communicate with people with special characteristics (cross-cultural differences, adolescents, people with hearing and/or visual problems, etc.).

5. RAISING AWARENESS OF ABUSE

Elder abuse is not a new issue, but it is of very recent interest in our society. It is in 1975 when we find the **first references** to this topic in various British scientific publications (Baker, 1975. Burston, 1977) and it is from that moment on that progressively the worldwide interest in older abuse begins to increase, equating this interest to other main issues such as respect for human rights or gender equality. Thus, the United Nations addresses for the first-time violence against older persons in the **II World Assembly on Aging** (Madrid 2002), in which a report on the matter is presented. At the same time, the International Network for the Prevention of Elder Abuse (INPEA), with the support of the WHO, publishes the "Absent Voices" Report, which has become a benchmark for the implementation of research processes- action in many countries of the world. This document contains a series of recommendations to set up a global strategy that contributes to responding to the problem of mistreatment of the elderly.

- Create and disseminate a research method to study violence against the elderly.
- Design and validate a detection and evaluation instrument for social and health professionals who work in the community.
- Develop educational materials aimed at professionals for a correct approach to the problem.
- Mobilize civil society through awareness campaigns that generate changes in attitude towards the elderly and especially towards mistreatment.

However, there are still few worldwide studies on the prevalence and collection and analysis of statistics on elder abuse.

The rising values of today's society, based on beauty and eternal youth, do not benefit older people. **Ageism** has become a form of discrimination and rejection for the mere fact of being of a certain age. Therefore, the group of older people is part of the population groups considered vulnerable, with a high risk of suffering abuse and negligent behaviour. The Spanish Office for National Statistics forecasts that in 2060 29.9% of the total population in Spain will be over 65 years of age and 13.1% will be over 80 years of age and over.

The increase in life expectancy has meant that the percentage of older people who require professional care and services aimed at promoting their health and well-being is increasing. The increase in the number of older people suffering from some type of neurodegenerative disease, which greatly limits the ability to carry out activities of daily life independently, together with the profound changes that have been taking place in recent decades in modern societies, both at a social level and in the structure and roles of families, it has contributed to generating situations of significant tension and anguish among the main caregivers who have been overloaded by having to reconcile on numerous occasions the care of the elderly with the development of their family life and work, when not, having to make the difficult decision to choose among the possible options, professional care in residential centres, with all the psychological and emotional burden that this entails.

In the same way, the **stereotypes** that are socially managed **around old age**, associating them with criteria of illness, deterioration, dependency, lack of life expectancies, etc., together with the negative perception that the elderly have developed about their group and in many cases about themselves, may be at the bottom of the normalization with which ill-treatment has been assumed in some situations, or rather, the lack of awareness of what should be considered as abusive conduct.

All this has brought with it **significant changes in family dynamics** as well as in affective ties towards the elderly. In many cases, the globalized society, the uprooting or even the social conception that the elderly constitute a potential source of problem-situations, as they need care that the family environment currently cannot always cover, has increased the percentage of older people who are found themselves in situations of defencelessness, abandonment or lack of social and family support.

Therefore, it is essential that both, civil society and public authorities, join forces to **guarantee compliance with the rights of older persons as well as ensure the maintenance of their quality of life**. This will only be possible if actions are coordinated to prevent and to act effectively in the event of knowledge or suspicion of a situation of abuse towards this sector of the population.

5.1. Ageing

In 1969, Butler defined “ageism” as discrimination against individuals or groups based on their age.

This discrimination is made up of three parts:

1. Attitudes towards the elderly and ageing
2. Discriminatory conduct
3. Institutional practices that favour the presence of these stereotypes

Ageism is a consequence of the lack of knowledge about whom the elderly are. It reflects fear and rejection of ageing, not accepting ageing as another stage, it could be said that it is used as protection, as an armour that protects us from getting older, and from presenting all those negative characteristics that are associated with ageing.

Ageism is considered **the third great form of discrimination**, after racism and sexism. Due to the subtlety of ageism and the lack of awareness, it may be present in a greater proportion than the other two phenomena, hence the importance of influencing its prevention and intervention.

In our society there have been changes of various kinds (demographic, social, etc.) and this has also caused changes in the perception and attitudes towards older people. A few years ago, older people had a high status in society and in families; their increased experience and wisdom were considered “a degree” and were very positive. Nowadays, only negative characteristics are associated with ageing, which also influences the presence of discriminatory beliefs, attitudes, and behaviours towards older people; they are considered a burden and even in some cases second-class citizens.

Manifestations of ageism

At the linguistic level

In addition, ageism can manifest itself in different ways, for example through verbal or non-verbal communication. Previously, the role of language in infantilization was commented on. Depending on how communication is used, it can provide benefits or harm. It causes damage and suffering when it **serves to humiliate, harass, damage the integrity of the person**. As Paniagua (2013) points out, linguistic neglect and linguistic mistreatment can take place.

Linguistic negligence consists of **omissions**. When they are not listened to, their demands are not heeded, they are not made to participate in conversations, they are not looked at, they are not expressed affection, they are not allowed to express their feelings, their arguments are not believed when there is competition for it, information about medical, property and/or family issues that concern elderly directly is omitted, decisions are made without consulting them, their presence is ignored at medical, notary, and banking appointments.

On the other hand, linguistic abuse refers to **insults, disqualifications, shouting, humiliation, threats, lies, deceit, disrespect, coercion, excessive use of technical terms**, expressing in front of other topics corresponding to their privacy.

Many terms used to refer to ageing and/or the elderly have very negative connotations. Therefore, it is important to change these concepts for more appropriate ones:

- ✓ Instead of "third age" or "elderly person" use older person.
- ✓ Instead of "asylum" or "geriatric" use a residence for the elderly.
- ✓ Instead of "nursery for the elderly" use a day-care centre for the elderly.
- ✓ Avoid expressions with paternalistic or infantilizing connotations such as “our elders", "grandparents", "my children", "my grandparents", etc. Even if the intention of the use is to show affection, it is necessary to suppress them since they are not respectful.
- ✓ Avoid globalizing and labelling terms, for example: "people with disabilities" instead of "disabled", "people with dementia" instead of "insane".

The use of this type of communication ridicules, infantilizes, depersonalizes older people, "objectifies" them and makes them lose value in society.

In addition, this causes some professionals to prefer to inform others about issues related to the life of the older person because they are considered not to be capable of understanding, because they are deaf for instance, and so, they make decisions for them without counting on their opinion, even in cases in which the older person maintains their cognitive capacity and skills intact.

At the professional level

Ageism is also manifested in professionals who work with the elderly, such as doctors. The quota of most frequent users are people of 65 years or more.

Many professionals maintain a negative and stereotyped view of older patients. For example, they consider that they are depressive, senile, untreatable, and rigid. This image is based on beliefs such as the following: “ageing cannot be stopped”, “the disease that accompanies ageing is not important, it is a natural part of the ageing process”, “ageing as a state of continuous physical and cognitive decline ”, “a treatment has less value for an older person”, “the health resources used will not have a social return, since they are unproductive”.

Again, these beliefs have consequences in dealing with the elderly. For example, they focus on treatment to **manage the disease instead of promoting prevention and health promotion**; training in geriatrics is undervalued; therapeutic nihilism appears.

For example, if a young person presents symptoms of psychological distress, they are quickly referred to mental health for an appropriate evaluation, while this is not the case with older people. This nihilism leads us to think that psychological treatments with the elderly are not appropriate and are inefficient since there is no possibility of change or improvement, and this leads to the use of a greater amount of pharmacotherapy and less presence of therapy in treatment with older people.

Another consequence is **age limitations in treatment protocols** (hypertension, cancer, etc.); or that in certain cases older people are excluded from clinical trials, which leads to a lack of knowledge of the efficacy and tolerance of treatments in this population group. They are considered a burden on the health system. Health systems are not adapted to the changing needs of the population. Hence, the need to overcome all these barriers.

Factors influencing ageism

There are many factors that influence the presence of ageism such as: age, gender, level of knowledge, frequency, and type of contact with older people, cultural and social influences.

Gender

A person's gender could influence how older people are perceived. In general, men show less favourable attitudes towards older people than women, although not all studies support these results. In addition, the studies carried out also indicate that older men and women are perceived differently. In some of them, it is found that women are evaluated more negatively than men and are considered older than men. However, other studies find contrary results, so it is necessary to carry out more research in this regard. In some cases, this may be due to cultural representations, expectations regarding gender, as well as ageing.

Age

There are contradictory results for this variable as well. While some studies suggest that older people hold more positive attitudes towards ageing than younger people, other studies find opposite results.

Education level

The results of some studies show that the level of education is a protective factor with respect to negative stereotypes, so that while people with a lower educational level present more frequently negative stereotypes about old age, people with a higher level of education and/or training in gerontology present them to a lesser extent.

Knowledge about ageing

Again, ambiguous results are found. While some studies find education and training are the best strategy to deal with ageism, others fail to maintain this conclusion.

Contact with older people

Contact with older people also influences ageism. Interaction with older people could take place in a personal, educational, or professional setting and there could be different levels of contact depending on frequency and intimacy. Some researchers point out that contact helps promote positive attitudes and acquire a more precise understanding of ageing. The interaction between individuals of different generations: young and old allows people the opportunity to learn about healthy ageing, to challenge stereotypes and to see beyond prejudice and glimpse the positive qualities of older people.

Society and culture

Finally, society and culture can influence the perception of older people. That is, family beliefs, social and cultural factors, the media, literature, and even the environment can affect this perception. The results of different studies show that the perception of old age is not the same in all cultures and is even different within the same country. For example, while in some cultures, where the principles of autonomy and independence prevail, older people have a lower status than other age groups; in other cultures, where collective values and interdependence are emphasized, older people are admired and respected for presenting two characteristics that age can confer: experience and wisdom.

<u>Practical case</u>

Read the following text and answer the questions.

Mr. Stephan O'Brien, a 30-year-old man, goes to a clinical psychologist and after conducting an interview, the following symptoms are found:

- Memory problems: Difficulty remembering events that have just taken place.
- Sudden personality changes (apathy, withdrawal in social interaction).
- Difficulty thinking.
- Fatigue.
- Loss of interest in everything that has always interested you.

- Sadness.
- Loss of intellectual capacity.
- Impairment of your routine of daily activities.
- Feeling of undervaluation and personal incapacity.
- Concern about death.
- Difficulty making decisions.

☐ What diagnosis would you give based on these characteristics? Depression, anxiety, dementia, schizophrenia or without treatment. You can choose one or more options.

☐ Moreover, what treatment would be the most appropriate in this situation? Pharmacotherapy, admission to an institution, individual psychotherapy, group psychotherapy, no intervention.

Before showing the answer, reflect on another case.

Mr. Stephan O'Brien, a 75-year-old person, goes to a clinical psychologist's office and after conducting an interview the following symptoms are found:

- Memory problems: difficulties in remembering events that have just taken place.
- Sudden personality changes (apathy, withdrawal in social interaction).
- Difficulty thinking.
- Fatigue.
- Loss of interest in everything that has always interested you.
- Sadness.
- Loss of intellectual capacity.
- Impairment of your routine of daily activities.
- Feeling of undervaluation and personal incapacity.
- Concern about death.
- Difficulty making decisions.

☐ What diagnosis would you give based on these characteristics? Depression, anxiety, dementia, schizophrenia or without treatment. You can choose one or more options.

☐ What treatment would be the most appropriate in this situation? Pharmacotherapy, admission to an institution, individual psychotherapy, group psychotherapy, no intervention.

This case was applied to psychology students and the following results were observed.

✓ In the first case, a 30-year-old person, the diagnosis was depression and the treatment included pharmacotherapy, individual and group psychotherapy.
✓ While in the following case, a 75-year-old person, various diagnoses were found such as depression, dementia and without disorder and the chosen treatment was pharmacotherapy, admission to an institution or without intervention.

What is the difference between the two cases? Only the age, the rest of the information is the same and, while in the case of the young person their symptoms are considered, in the case of the older person they are associated in many cases with their age, which even leads to nothing is diagnosed, or intervened.

5.2. Malignant Social Psychology

Kitwood (2003) within the context of the person-centred care model, and linked to the previously described psychological needs, creates the term *Malignant Social Psychology* (MSP). This concept refers to automated behaviours that work teams have in residences and that generate physical or psychological damage to the older person. This mistreatment is exacerbated given that the worker is not aware that what he is doing may entail a violation of the rights of the elderly person. Take, for example, something as common as "moving a wheelchair without notifying the person sitting in it or entering a room without knocking".

It is in these aspects that we must first work on to achieve good practice in these centres, in cultural change, in raising awareness of the detractors who facilitate mistreatment.

As previously mentioned, workers do not do so with the express intention of harming, on the contrary, malignant social psychology episodes are never questioned and end up being an integral part of the fabric of the care culture and, therefore, of the organization. The presence of these attitudes is based on the fact that they go from one staff member to another very easily.

When someone starts working in a nursing home, they learn to communicate based on what their co-workers do. "If the communication style tends toward infantilization, paternalism, or disempowerment, newcomers will adopt it" (Kitwood, 2003).

The success of psychological intervention to improve the well-being of people with dementia will depend on the process that is planned to introduce changes in the organization, that is, in the system. The malignant social psychology can be identified, that is, all the staff and the work team of a residence can create the indicators that help make it visible to transform it into a favourable environment.
It can be empirically evidenced that frequent episodes of malignant social psychology involve the person, lower well-being and increase the degree of discomfort and, in the worst of cases, cause a radical depersonalization of people with dementia and reinforce the perception of society that they are not entirely human (Brooker and Surr , 2005).

Identifying this situation is the essential element to transform it and ensure that relationships are personalized and reinforce everything that gives status to the person.

Kitwood defined these elements and classified them as follows:

- **Intimidate.** This category would include verbal threats or physical force that can make the person feel scared or fearful and in this way be able to comply with what is ordered by the centre where she lives.
- **Avoidance.** It can be defined as not paying the required attention at the right time, not covering the need at the right place in the right moment.
- **Improper rhythm.** The times of the residential centre are not designed for residents with dementia or with a high degree of dependency, showers in less than ten minutes, going to bed at nine at night, "standard" rhythms without considering what the person needs.
- **Infantilize.** Activities, language, tone of voice and infantile vocabulary, without considering the person's life history, infantilization facilitates depersonalization and paternalism in care, promoting an increase in dependence in activities of daily living.
- **Label.** Use labels to be able to classify residents, the first of which is the excessive use of the word "Sick" as opposed to the word "Person". Categorize a person based on their behaviour "Aggressive, escapist, walker…" can be some usual labels to refer to the behaviour of residents.
- **Disavow.** Eliminate the wishes, dreams, goals, tastes or preferences of the residents by means of clear and short orders "You cannot eat what you want, whether you like it or not, you have

to take a shower or therapy is mandatory and if you do not want to go, we tell your daughter" are some phrases the elderly are disavowed with, underestimated and their decision-making capacity is limited, reducing their self-concept.

- **To accuse.** Blaming residents for their actions, and for the repercussions of those actions for something the person has done or omitted. "Because of you we're already late, he always messes it up the same, what he really wants to know."
- **Manipulate.** Excessive use of so-called "white lies", manipulating information in order to get out of a compromising situation "If you eat this, I'll take you to sleep first, tomorrow when the shift is over we'll take the train, and we'll go to your people…"
- **Invalidate.** The person with dementia lives in his/her world, in a different reality. That is why it is essential to recognize this aspect to give meaning to his/her life. "He has insomnia (without wondering what time he got up)".
- **Disempower.** Prevent the person from enhancing all the abilities that he/she still retains. In this sense, a change in the internal language with which we refer to certain concepts would be important. Changing the "Dependent for" to "Needs help for" would greatly help to improve the skills of the resident "Not letting them choose clothes, button them instead of doing it to save time"
- **To impose.** Activities, programs that are necessary for nursing homes or for their relatives, but not for the resident, forcing people to do or stop doing something "Ordering someone who is wandering to sit down or to get up someone who is sitting". On many occasions, the imposition comes from pressures external to the centre, such as the families themselves. Hence, it is necessary to work with them so that they can understand this whole situation and improve the quality of life of users.
- **Interrupt.** Break the thread of a conversation in which a person is, interrupting their story to gain time or because of boredom. "Come on, don't talk about what you have to eat, you've already told me a hundred times, finish now...".
- **Reify.** The excess of terminology to classify residents according to their health needs "Diabetes, autonomous, valid, assisted, semi-assisted, hypertensive" objectifying excess in labels facilitates depersonalization.
- **Exclude.** Isolating the person because of their behaviours or capacities, usually happens with people with GDS 6/7, with bedridden people, with people with strong behavioural disorders who run the risk of becoming socially isolated, considering that in this way the group behaviours.
- **Derision.** Relate to the person from humour, humiliation, or excessive jokes that the person is unable to understand since, due to his dementia, he/she has lost the ability to have a double meaning. Use nicknames or nicknames to refer to them, bite them with an insinuation or a lack of promise, tell colleagues something related to the patient's intimacy in a burlesque tone.

With all these points and situations, it becomes fundamental to be able to intervene, carry out interventions that are based on the promotion of good practices, on awareness, on life history. We must raise awareness, open our minds to be able to identify these daily errors and, thus, be able to take a first step towards good practices, the cornerstone for the development of good treatment in residential centres.

6. PSYCHOLOGICAL NEEDS OF INSTITUTIONALISED PEOPLE

6.1. Psychological needs of people with dementia. Kitwood's model

Kitwood (2003) pointed out that there are **five types of basic psychological needs** in people with dementia. These needs are not only typical of people with dementia, but are, with greater or lesser intensity, in every human being. However, when dementia is present, it is the responsibility of professionals and informal carers to help keep it covered. Otherwise, and following the Kitwood model, the person will not be able to maintain an optimal state of well-being. Each modality (Brooker and Surr 2005) can be enhanced or counteracted depending on the attitudes that are promoted (positive or negative) from the institution, so it is vitally important to be aware of them and work on attitudinal change in caregivers.

The five needs identified from the person-centred care model are the following (Brooker and Surr , 2005):

1. Comfort:

Making people feel comfortable is much more than physical comfort, for Kitwood (2003) it acquires the emotional component, as well as "the need for affection and proximity with others", to feel loved and supported by those around them. Covering the need for comfort means gaining in emotional security and therefore in quality of life.

Negative attitude	Positive attitude
Exclude/deny the older person the possibility of having physical contact or their emotional needs attended. For example: when she is screaming and is left alone, or the light goes out; when you are sitting in a wheelchair and raise your arms to call, and no one comes to the call.	Being close to them, offering a smile, showing affection, a hug or simply speaking calmly at times when we notice that they are afraid; leave a small light on in case of night disturbance, go to touch it and smile at its call.

2. Identity:

All people need to continue knowing who they are, they need that in case of amnesia, as occurs in people with dementia, those around them help them to remember, to keep emotional memories alive (music, beliefs, anecdotes), their life (hobbies, work, life...). To know basic data about their life (year of birth, place of birth, places where he has lived), they therefore need to know their life story, to know which person they are caring for, to worry about their personal identity.

Negative attitude	Positive attitude
Go with the flow when they are telling us a story of their life; not stopping the necessary time when the language is blocked, or we see that the words do not come out. Not paying attention to their physical appearance, dressing them without prioritizing her tastes...	Try to listen to them; give them time to express themselves; remind them of their name at all times; know the year in which they were born; see with them photos of their past; work common memories; dress them according to her life story...

3. Attachment:

In dementia, there are many situations in which the person will feel fear, insecurity. This insecurity can lead the person to situations of anxiety, and anxiety lead to agitation and aggressiveness. Broker (2005) defined attachment need as “the need to establish a secure affective bond with caregivers or, at least, with the reference caregiver”. Surround the person with caregivers who know their life, their pathology, the consequences of these on their day to day, minimizing situations of anguish and conflict. Attachment is closely related to affective bonding.

Negative attitude	Positive attitude
Change routines, teams; not giving information between work shifts; not knowing their tastes or hobbies; be attending the person in a hurry, thinking about other things without the adequate emotional presence at that moment.	Knowing the life story of the person, their tastes, their hobbies, being present in the care relationship. For example: when taking a shower, knowing that, for that person, it means something very intimate and personal, given that almost no one has surely seen her naked.

4. Occupation:

Occupation could be established as the need to feel involved in activities of personal interest. In this place, the residence must consider whether the activities offered to residents are based on their life history, their tastes and priorities, or if, on the contrary, they are focused on the needs of the service. If the activities have the objective of continuing with the life and rhythms that people had before their admission, at home, respecting the right of people to participate or not participate in them and valuing at all times if these activities help and contribute, if they are therapeutic for them, or if they are a requirement to comply with a series of specifications requested by the public administration on duty or even due to pressure from the families themselves. For example, is a cognitive stimulation group with more than eight people therapeutically effective? The occupation satisfies the deep need that people have to have an impact on the world and on those around us.

Negative attitude	Positive attitude
Do things for those older people that they can continue to do for themselves: button them when they can button themselves, feed them while they can still put food in their mouths, force them to participate in activities they don't want to be in.	Enhance their abilities and decision-making, even if this is reduced by cognitive loss; think about what activities are pleasant and promote them; leave, even if it takes much longer, to continue doing those things that you can still do.

5. Inclusion:

The human being needs to interact with others regardless of their physical or cognitive capacity, they need to be part of a group. In this sense, people with dementia (especially those in severe stages) run the risk of being socially isolated. A good practice in this sense would be for the nursing homes to reflect on the following question: Are we offering any programs or activities for people with GDS 6/7 stages? How many bedridden people or people with reduced mobility living in bed/chair live in the centre, and what activities are carried out with them? From this dimension, we not only appeal to physical inclusion (“I sit down to eat with others”), but we also appeal to psychological inclusion (“As with whom I want to eat, or with whom the centre needs me to eat”).

Negative attitude	Positive attitude

Leaving the person alone or isolated; taking him/her out of a place or an activity as punishment for a behaviour, noticing that the person is often alone and doing nothing to avoid it, leaving him/her watching television without any company nearby, in a wheelchair for hours without being moved to another chair comfortable	Carry out joint activities; include the person when we detect that he/she is alone; advise the family on new forms of communication with them, develop activities with the most impaired people so that they notice our closeness, caress and speak meaningfully, transfer the person from the wheelchair to a comfortable place

This contribution of the group from the University of Bradford led by Kitwood was a turning point in care in psychogerontology.

6.2. BEHAVIORS THAT LEAD TO ELDER ABUSE

The physical or economic damage generated to the older person (maltreatment), can be a consequence of various actions or omissions that can be classified as follows (Etxeberria, Goikoetxea, Martinez, et. Al. 2013).

- **Obstinacy in care**, which can occur both, in assessment/diagnosis and in care. For example: drug overtreatment, obstinacy in recovering mobility without reasonable expectations of achieving it, etc.
- **Insufficient or inappropriate care** generated by a lack of care or by a wrong or incomplete assessment of the needs of the older person. For example: poor management of expenses or payments, non-indicated restraints, lack of continuous monitoring of treatments, prescribed plans and interventions, absence of oral-dental care, insufficient nutrition...).
- **Negligence**, which involves any act of omission, intentional failure (active) or not (passive), in meeting the vital needs of an older person. For example: non-indicated restraints, poor management of their financial resources, lack of assessment and errors in the treatment of physical illnesses or symptoms such as pain
- **Abandonment and lack of protection** of the older person in some of his/her dimensions or as a whole by the person who has assumed responsibility for their care or who has custody of him/her. For example: absence of a personalized care plan, abandonment in a health centre.
- **Deceit and manipulation** to use or instrumentalize the older person without his/her consent. For example: insufficient or incomprehensible information on the management of assets and/or health, deception about expenses or to change the will…
- **Credible threat to the older person** to get them to perform actions or accept certain interventions coercively; For example: threatening to hold you down if you use the phone or to admit you to a centre if you do not agree to sign certain documents...

6.3. Protocol in cases of elder abuse

A protocol is a document that brings together a set of instructions or rules that allows all professionals to work in coordination and in the same direction.

It should serve as a guide when determining the actions to be carried out and the decisions to be made. In the case at hand, it is aimed at acting with greater speed and efficiency, reducing the damage and consequences, and ensuring the greatest well-being of the older person who suffers abuse.

The protocol that we present here is a work proposal for the different areas of intervention and care for the elderly, to respond to those situations of abuse that they may suffer.

The objectives of the protocol are:

- Detect older people at risk of suffering abuse
- Identify situations of abuse in older people.
- Intervene, adjusting to the characteristics of the person and the specific case.
- Monitor the situation of the older person.

This entails the following actions:

- Collect in an orderly and systematic manner the actions to be carried out in the event of mistreatment of the elderly.
- Protocolize the work in the different areas of intervention and work teams.
- Coordinate information between services to improve care for people.

This intervention protocol is a basic outline of the actions to be carried out. These are related to each other and do not have to follow the marked linear direction, but their evolution will depend on the characteristics of each case and the urgent needs to be addressed at each moment.

As a starting point for carrying out this protocol, we rely on the model shown below.

When we are faced with the possibility of finding ourselves face to face with a situation of abuse in a nursing home, we have to start from a basic scheme, a protocol that guides us where to look, what to observe and analyse and how to proceed, how to intervene in depending on who the alleged abuser is.

A. Prevention of abuse

When we talk about elder abuse, the key word is *prevention.* Prevention must begin with the so-called *primary prevention,* that is, with the promotion of positive social attitudes towards everything related to old age and the ageing process, with a modification of the stereotypes that we have been handling about the elderly for too long and that labels them as a group that needs continuous care, protection and that the decline in their cognitive abilities does not allow them to make decisions about their own lives.

The group of older people is heterogeneous. We must try to look at each older person from his/her singularity and individuality, avoiding falling into homogeneous interventions, which contributes to increase depersonalization and not perceiving the older person from his/her abilities, and the right to continue developing the vital project they choose based on their wishes, tastes and preferences.

When we talk about **primary prevention** within nursing homes, we must include the values and culture of the organization itself and the promotion of a positive image of the elderly, giving value to the needs they present, but also to their capacities. Older people can contribute in the development of the different programs that professionals are implementing, since the content of these programs must be based on the life stories of the people they are aimed at.

The next level of prevention that we are going to refer to and to which we must also pay attention in institutions is **secondary prevention**, which is directed towards the population at risk with whom we

are working, the elderly in the centre. This type of prevention would consist of acting on the risk factors that we have identified in the centre and that we know are present, without the possibility of eliminating them, and, at the same time, promoting protective factors towards the elderly.

B. Detection of abuse

The few studies that exist on elder abuse indicate that a not insignificant percentage of situations of abuse that occur in institutions go unnoticed by professionals.

The detection of a possible situation of abuse is usually given in two ways: either by the complaint of an older person, which is usually the most sensitive indicator that something may be happening and therefore must be listened to and valued, or by the presence of indicators, already mentioned, that act as warning signs that advise us that situations of mistreatment may be taking place in the centre.

Any member of the interdisciplinary team who detects or suspects the existence of a situation of abuse must notify the residence director or manager to initiate the appropriate investigation. Before classifying a situation as abuse, the frequency and severity of the consequences produced must be considered.

C. Intervention

Interventions that we can implement at this level of action are:

- **Listen to the residents**, how they feel, how they perceive that we are taking care of them, what kind of activities they would like to do, etc. To do so, we can plan weekly:
  - Emotional support workshops within the centre's therapies.
  - Monthly meeting's assembly of the residents, in which they evaluate issues such as the menus (quality and quantity), the scheduled activities, missing information; welcome to new residents, planned trips, etc.
  - Periodically invite professionals to give them a talk on topics that they choose to be of interest to them, including abuse.
  - Organize intergenerational activities inside or outside the centre.
  - Assess animal therapy activities, virtual reality, etc.
- **Expose them their rights**, the ways and means through which they can express their concerns, their complaints, and their expectations, so that we can anticipate possible situations that may generate discomfort within the centre. To do this, we can plan regular sessions with the centre's therapist or social worker, in which their needs and desires are discussed.
- **Monitor the following healthcare tasks**:

- **Food:** supervise that they take the necessary intake amounts, serve the food at the appropriate temperature, and take care of its presentation, prepare special diets according to pathologies, do not skip any of the four minimum daily intakes, distribute the intake schedules appropriately throughout of the day, respect the necessary rhythm according to the needs of each user, etc.
- **Clothing:** use clothing or footwear of the appropriate size and according to the season of the year, put the resident to bed without pyjamas or nightgown if that is their wish, etc.
- **Hygiene:** use disposable sponges, do not use the same towel or comb for several people, change the absorbent pads necessary for each person, do not leave them sitting in the toilet for an excessive amount of time, etc.
- **Physical restraint:** do not restrain in an unjustified way or without being prescribed and authorized by the doctor and relative respectively, to prevent getting up or falling, do not restrain due to lack of personnel, keep an updated record of these measures.
- **Health care:** inform the family member of all health changes or important incidents (falls, accidents...), check that they are wearing glasses, hearing aids and dental prostheses, provide scheduled medical treatment, make scheduled postural changes, pay attention to the state of general physical and psychological, carry out cures with the established periodicity, consider their opinions if the person maintains preserved capacities.
- **Privacy:** say hello when entering the room, close the toilet door when they are using it, allow private spaces to be alone with their partners, provide a key to the room closet, etc.
- **Security:** maintain facilities in good condition: water, heating, electricity, do not block emergency exits, protect stairs, adapted spaces free of obstacles, leave accessible bed bells and headboard lights provided if the resident requests it.

- **Raise awareness and train the professionals** of the centre on issues such as ageing and on abuse, so that they are able to recognize behaviours of abuse. Nursing homes are contexts where there is a great variability of professionals who come from very different cultures and forms to understand ageing and the elderly. Assuming that abusive behaviours are a reality in the centres will help maintain the necessary level of alertness among team members, so that they can carry out an early detection of potentially harmful situations. Include in the annual continuous training plans other topics for all professionals, such as normal and pathological ageing, so that they know how to differentiate and recognize the signs and symptoms of the different types of dementia, geriatric syndromes, bioethical principles, person-centred care model, etc. Likewise, propose specific training by departments: for physios, therapists, nurses, doctors, social workers, maintenance, etc.

- Have an **abuse protocol available** to professionals that contains a checklist of possible situations of abuse to observe.

- **Keep a record of conflictive cases** that can be coordinated by the centre's psychologist or social worker.

- **Schedule regular meetings with the team** to discuss and analyse conflict situations that may have arisen in the centre, whether with residents, family members or other professionals.

- Have an **Ethics and Good Practices Manual**.

- **Promote the functional independence and self-determination of the elderly** in the centre, making more flexible the time that each one needs to carry out the basic activities of daily life and allowing them to carry out at their own pace the tasks that they are still capable of doing by themselves.

- Have a **protocol for the management of psychological and behavioural alterations**.

- Periodically **review the organizational measures and care plans** to reduce the possibility of situations potentially susceptible to abuse. In other words, review the distribution of residents per assistant, and depending on the degree of dependency of the residents, to make a balanced distribution among the assistants and prevent some professionals from feeling that they have a greater workload.

- **Carry out periodic individual interviews with residents** to find out their degree of well-being-discomfort in the centre. This task can be performed by the therapist, psychologist, or social worker. Leave a record in the resident's follow-ups.

- **Promote intergenerational relations activities** in order to help transmit to the younger generations values such as respect for the dignity and fundamental rights of the elderly. To do this, joint activities can be planned inside or outside the centre with groups of children or young people, whether from schools near the centre, institutes, university students...

- **Working with the model of comprehensive care centred on the person** and working based on the assignment of **reference professionals for each group of residents**, constitutes a good protection tool against mistreatment since it contributes to increasing the feeling of responsibility and involvement of said towards the elderly they care for, as well as facilitating the control and supervision of the care they receive.

- Any other type of action that contributes to **improving the quality of life of the elderly**.