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Against violence in elderly care

Module 2:

Improving our understanding of the impact of ageing-related factors on the attitudes and behaviours of elderly persons, their families and the professionals that work with them

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Adopt the right position in the support relationship with an elderly person in order to prevent violence

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CONTENTS

Part 1

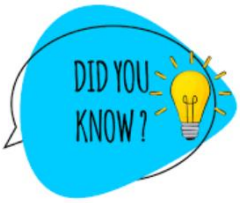
IMPROVING OUR UNDERSTANDING OF THE IMPACT OF AGEING-RELATED FACTORS ON THE ATTITUDES AND BEHAVIOURS OF ELDERLY PERSONS, THEIR FAMILIES AND THE PROFESSIONALS THAT WORK WITH THEM

IMPROVING THE UNDERSTANDING OF THE IMPAIRMENTS RELATED TO NORMAL AGEING

1. PHYSICAL AND PSYCHOLOGICAL, SENSORY, COGNITIVE CHANGES RELATED TO NORMAL AGEING

Ageing will induce changes in the person, with consequences on his or her behaviour, but also on those around them. It is important to gain a better understanding of interactions and their resulting effects so that we can anticipate certain aggressive reactions and offer appropriate support.

A. The effects of normal ageing on the body: the resulting functional consequences and changes



Normal ageing takes the form of gradual changes in bodily structure and function, resulting from the interplay of genetic and environmental factors throughout the person's lifetime.

It is accompanied by a reduction in the body's functional capacities to different degrees in different organs and varying from one individual to another of the same age. These changes are generally most apparent in situations that call on functional reserves (effort, stress, acute illness). This reduction in functional reserves means that the body is less able to adapt to challenging and stressful conditions.

Metabolism

- Changes in body composition: reduction in lean mass (bones, organs and muscles), proportional increase in bodyfat (particularly in the abdominal region);
- Changes in carbohydrate metabolism, lower tolerance to glucose loading, insulin resistance;
- Reduction in the volume of water in the body.

Nervous system

- Numerous neuropathological and neurobiological modifications of the central nervous system: reduction in the number of cortical neurons, rarefaction of white matter (circulation of information in the nervous system) and reduction of certain intracerebral neurotransmitters;
- Resulting consequences: longer reaction time, moderate reduction in memory performance, mainly for immediate memory;
- Reduction and destructuring of sleep: fragmentation of sleep, micro-arousals, changes in quality of sleep;
- Reduction in sensation of thirst (osmoreceptors);
- Increased vulnerability of the brain to insults with risk of delirium;
- Reduction in proprioceptive sensitivity (hypopallesthesia) leading to postural instability.

Sensory organs

Sight

- Reduction in visual acuity, contrast sensitivity and visual field;
- Reduced accommodation (long-sightedness) making close reading difficult;
- Progressive opacification of the lens beginning in older age and affecting the vision (cataract);
- Change in colour sensitivity;
- Changes in the structure of the eye (cornea, lens), loss of elasticity of the skin of the eyelids, decrease in production of tear film causing dry eyes;
- Other ocular pathologies: Age-related macular degeneration (AMD), glaucoma, blepharitis…

Hearing

- Ageing of the cochleovestibular system: gradual and natural wear of the auditory cells of the ear at the origin of presbycusis;
- Difficulty in detecting high-pitched sounds and certain consonants that include high-pitched sounds. When those sounds are not perceived, it can give the impression that words are being mumbled. Over time there is also an effect on low tones;
- Distorted comprehension due to inability to understand well. Elderly people struggle to follow a conversation;
- Other auditory pathologies: hyperacusis (sounds are exacerbated at night), tinnitus (sensation of continuous unwanted noise in the ear).

Taste

- Loss of taste (gustin) associated with the decrease in number of taste buds, with reduced sensitivity of sensory receptors, and with zinc deficiency;
- Loss of enjoyment of food and desire to eat, loss of appetite, risk of malnutrition;
- Atrophy of salivary glands giving a dry mouth, a metallic taste in the mouth;
- Progressive loss of salt taste followed by loss of sweet taste; bitterness persists: elderly people therefore use more salt because their food seems blander;
- Changes in food preferences: the elderly person will leave anything rich in trace minerals and vitamins and choose desserts and foods high in starch, which has an effect on gastrointestinal function.

Smell

- Significant decrease in olfactory sensitivity and ability to identify odours, which can lead to severe hyposmia or even anosmia.

Touch

- Alteration of tactile acuity due to the reduction in the number of mechanoreceptors: the vibrations felt by the skin on contact with an object are less intense;
- Changes in the nerve fibres connected to the mechanoreceptors, slowing down the transmission of nerve impulses. Reactions to skin stimuli are slowed down and the resulting movements are therefore less precise;
- Possibility of hypoesthesia (decrease in tactile sensitivity) gradually making it impossible to grip everyday objects that are too small or too thin, to write or to manipulate various objects. Elderly people also suffer from a lack of perception of sharp, spiky or cutting things… They no longer have the sensation of bearing weight on their feet and can therefore lose their balance more easily.

Cardiovascular system

- Increased cardiac mass, stiffness of the arteries leading to insufficient filling of the left ventricle, loss of contractility of the heart muscle, slowing of blood microcirculation and sometimes heart failure;
- Cardiac output reduced by 30–40% and lower exercise tolerance (ability of heart to adapt to exercise by beating faster or more powerfully);
- Thickening and rigidity of arterial and arteriole walls (due to an increase in collagen and a decrease in elastin), loss of elasticity of blood vessels leading to an increase in systolic blood pressure.

Respiratory system

- Reduced ventilatory capacity due to changes in the rib cage and in lung volume (shorter and wider thorax, thoracic rigidity, compression of vertebrae, fusion of the pulmonary alveoli reducing the volume of air that can be mobilized and making mobilization more difficult), weakening of the respiratory and abdominal muscles;
- Reduction in oxygen diffusion capacity;
- More common bronchial congestion due to the decrease in mucociliary clearance (self-cleaning mechanism of the bronchial airways), accumulation of respiratory secretions;
- Higher risk of lung infections.

Musculoskeletal system

- Ageing of skeletal muscle:
    - in the muscles: reduction in the density of muscle fibres, reduction of muscle mass (sarcopenia), decrease in muscle strength,
    - in the bone tissue: decrease in bone density, decalcification, reduction of bone turnover (osteoporosis, fracture risk), thinning of cartilage and mechanical strength of bone, increase in marrow fat,
    - In the joints: tendency to ankylosis (stiffness);
- Between the ages of 30 and 70, we lose 30% of our bone mass and half of our active muscle mass. From the age of 25, muscles are losing their speed and their power of contraction (1% per year);
- Loss of strength and endurance;
- Slower movements;
- Loss of reflexes, balance and coordination.

Digestive system

- Changes in the oral system, decrease in salivary flow;
- Decrease in digestive secretions (bile, pancreatic juices, intestinal secretions, hydrochloric acid in the stomach…) with slower intestinal transit and/or constipation;
- Reduced anorectal sensitivity (decrease in sensation of need and accumulation of stool in the rectum);
- Assimilation of essential nutrients is less effective, resulting in nutritional deficiencies.

Urinary system

- Decrease in the size, weight and volume of the kidneys leading to a progressive decline in the rate of filtration of blood by the kidneys (poor elimination of waste and accumulation of toxins). Kidneys struggle to purify the blood by removing waste products and to provide another essential function: maintaining the salt/water balance;
- Loss of capacity for urine concentration and dilution;
- Decreased bladder capacity: bladder emptying is less complete with a post-void residue that increases with age. Consequences: a need to urinate more frequently and a higher risk of urinary tract infections;
- In women, shortening and thinning of the urethral wall increases the risk of urinary incontinence.

Sexual organs

- Decrease in DHEA allowing the production of sex hormones;
- Changes in the sexual organs. In women, end of ovarian secretion of oestrogens, and of menstrual cycles (menopause). The mammary glands, uterus and ovaries gradually involute and the vaginal mucosa atrophies and becomes drier. In men, progressive decrease in testosterone secretion, increase in prostate volume, progressively blocking the urinary flow;
- Reduction in sexual activity (which does not disappear!). In the man, erections are less strong and require longer stimulation. In women, a decrease in vaginal lubrication that can hinder sexual relations.

Immune system

- Loss of effective immune system function and ability to resist microbes and infections due to the body producing fewer antibodies;
- Slower immune response: white blood cells become less reactive and effective; elimination of abnormal cells and foreign bodies becomes less effective.

Skin, hair and nails

- Change in elastic tissue, fibrous thickening of the dermis and decrease in the number of melanocytes (contributing to the greying of the hair);
- Decrease in activity of sebaceous, sweat, eccrine and apocrine glands, contributing to drying of skin and mucous membranes;
- These changes result in thinner, paler skin, marked by wrinkles and fine lines and more prone to degenerative lesions;
- Appearance of deposits of pigmentation: brown spots called ‘age spots’;
- Reduction in the growth rate of hair (hair is thinner) and nails;
- Decrease in the number of cutaneous nerve endings leading to reduced sensitivity;
- Changes in thermoregulation.

Simulate ageing to improve understanding of the consequences of sensory deficiencies on the behaviour and attitudes of an elderly person

The simulation experience consists of putting on a special bodysuit and accessories in order to experience the effects of ageing. This process promotes awareness among professionals and can help to improve their understanding of the needs and difficulties encountered by elderly people in all activities of daily life.

This tool offers an opportunity to feel the effects of the physiological deficiencies related to old age, such as:

- opacity of the lens of the eye
- narrowing of the visual field
- eye diseases (cataract, glaucoma, macular degeneration, etc.)
- high frequency hearing loss
- limited head mobility
- joint stiffness
- loss of strength and reduced agility
- reduction in coordination of movements
- unsteady gait and tremors

Using practical exercises, this tool allows the user to experience the social, relational and emotional consequences of the ageing of the motor and sensory organs and of certain cognitive functions.

Experienced situations simulating sensory and mobility impairments:

- Actions requiring fine motor skills
- Actions requiring movement
- Movements in different environments: dining room, bedroom, corridors, etc.
- Activities of daily life: washing, dressing, undressing, putting on shoes, getting up, going to bed, eating, reading, activities, etc.
- Communication and social connections

B. The effects of normal ageing on cognition

Executive functions, attention, concentration and learning abilities

- General slowness of execution: difficulty in performing a task requiring speed and coordination, etc.;
- Reduced attentional resources and concentration, particularly with regard to sustained attention and divided attention;
- Difficulty in processing and providing several pieces of information at the same time;
- Reduction in learning ability;
- Slowing down of thought;
- Impaired mental flexibility (difficulty in switching from one item of information to another);
- Finding it more difficult to solve problems;
- Reduced ability to adapt to one's environment.

Memory

- Slowing down of memory performance due to many factors (decrease in information encoding and retrieval capacities, decrease in auditory and visual perception, mood disorders, anxiety, medication intake, fatigue, lack of cognitive stimulation and sleep, environment…);
- Short-term memory impairment;
- Impairment of working memory (intellectual operations) because it is dependent on attention abilities;
- Impairment of explicit episodic memory;
- Preservation of semantic memory.

Visual-spatial skills

- Impaired visual-spatial abilities.

Language, comprehension

- Difficulty in speaking with words and thoughts delayed or slowed down;
- Understanding of individual words is not impaired, so much as comprehension of words in longer sentences and narrative structures.

2. THE PSYCHOLOGICAL AND SOCIAL CONSEQUENCES RESULTING FROM THE LOSS OF AUTONOMY

A. Ageing, a process synonymous with a series of broken connections, losses and bereavements for the elderly person

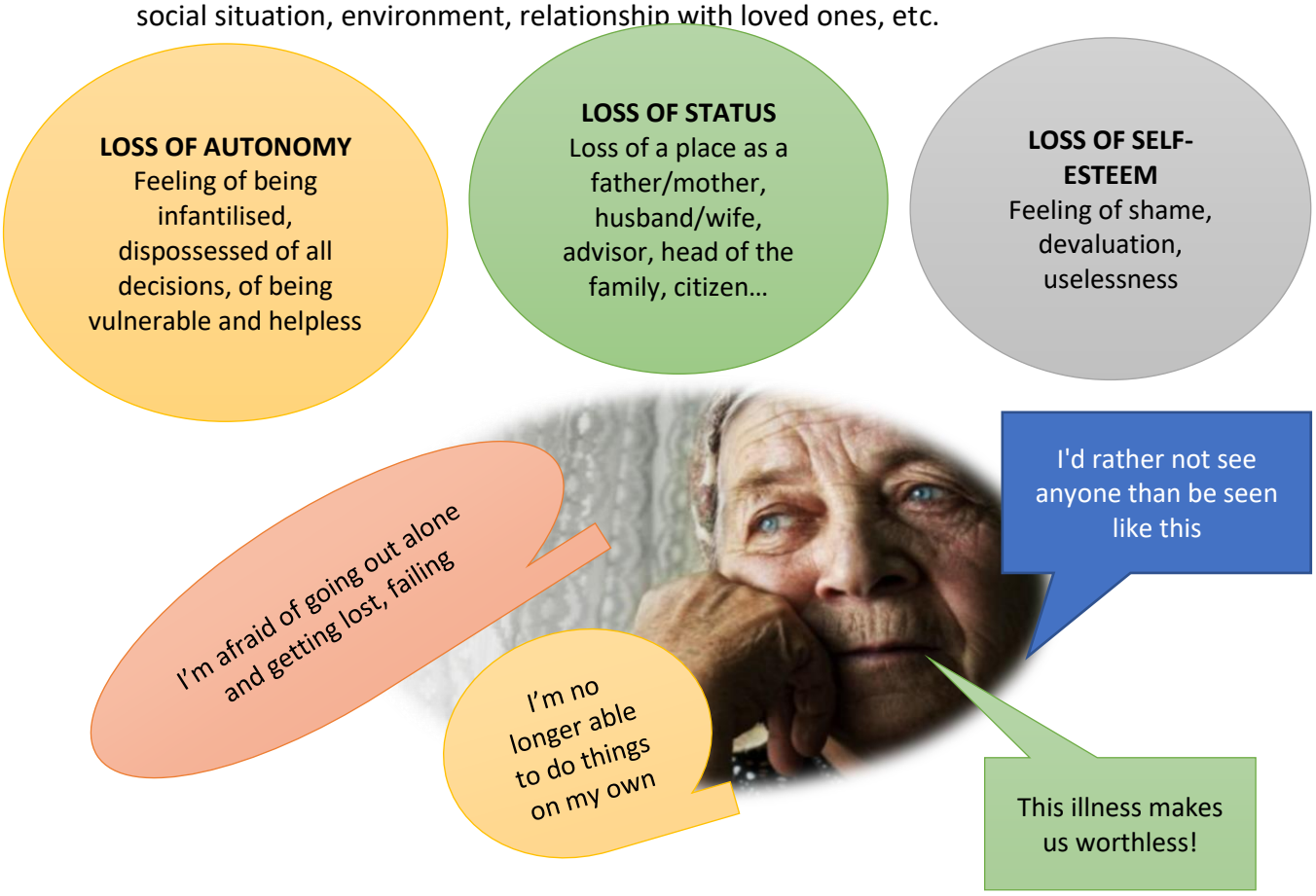
Ageing brings about several successive broken connections and losses for the elderly person. Loss is an extremely painful thing, which will be handled differently by different elderly people.

Ageing may involve the loss of:

- control of one's own life,
- one's identity,
- one's self-esteem,
- one's autonomy (physical losses),
- social reference points (social and family status),
- one's loved ones,
- one's living space.

All these losses have consequences on the balance of the human psyche. The onset of age-related pathologies disrupts the life of the elderly person and their ability to meet their own basic needs, sometimes making them feel a painful sense of having lost their independence.

The elderly person will need to go through a grieving process in order to be able to cope better with these losses, which will differ according to their personality, experiences, life history, social situation, environment, relationship with loved ones, etc.



B. The different psychological and social stages of ageing

age 60-74

- Physical deterioration leads to a change in self-image…
- Retirement from the workforce, gradual distancing from active people, loss of social rhythms (long day)
- Broken connections, sense of loss experienced as grief, grieving process for one's past life, one's work…
- Egocentrism, the elderly person becomes focused on the self to try to stay active

age 75-90

- The person will give up this struggle to continue being part of society
- Communication with others will become more difficult due to sensory changes
- Loss of capacity resulting in physical and mental discomfort
- One's scope of activity becomes narrower
- Resignation: period of fear, feeling useless, unwanted, a burden, begins grieving
- Feeling of loneliness, of being excluded from society

age 90+

- Withdrawing into oneself more and more
- Refuses contact with others and paradoxically complains of loneliness
- Resigned, immobile, melancholic
- Often oppositional, aggressive (death anxiety)
- Deeply unhappy with life
- Extreme apathy (resignation/giving up on life) is often encountered

C. Psychological manifestations commonly observed in elderly people: better identification can make for better understanding

- ***Loss of adaptability***
  The elderly person has difficulty adapting to change, to daily life and to situations that generate stress.
- ***Psychological rigidity***
  This may be the consequence of changes, fear of death, pathologies, the death of somebody close, an unresolved experience, a misunderstanding, anxieties… The elderly person clings to their reference points and the habits that they find reassuring.
- ***Anxiety***
  Anxiety is omnipresent and can have several causes: awareness of ageing and of one's finiteness, progressive loss of autonomy, misunderstandings linked to impaired communication, numerous changes related to one's environment, isolation…
- ***Denial***
  This is an unconscious defence mechanism that takes the form of ignoring any painful or embarrassing idea such as the idea of one's own death or the death of loved ones, the loss of one's abilities, etc.
- ***Psychological regression***
  This is often the result of a coping mechanism in response to concerns about the impact of ageing.

In an elderly person, this may take the form of retreating from life to protect oneself from external reality, refusal of care or activities, and aggressive behaviour. It may be linked with extreme apathy (resignation/giving up on life).

- ***Changes in self-esteem, image and identity***
  The self-image of an elderly person may be changed because of the limitation of their physical and social functioning. This takes the form of a daily feeling of inferiority, uselessness, lowering of self-esteem and loss of identity.

- ***Hypochondria***
  Hypochondria is characterised by excessive fear about the health of one's body. For elderly people, it is often linked to a fear of death and ageing. These people are more affected by this syndrome, which may be triggered by neurological shocks. In addition, some studies state that the more psychological suffering a person has been through during their life, the more they will feel the need to complain about their body as they age.

- ***Depression***

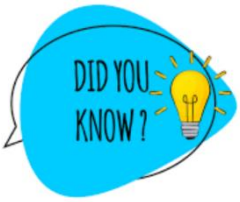
  The WHO (World Health Organization) estimates that depressive disorders represent the top factor contributing to morbidity and disability worldwide!
  In France, according to the Directorate for Research, Studies, Evaluation and Statistics (DREES), 18% of elderly people living in specialised institutions report that they suffer from depression, compared to 7% of elderly people living at home. Suicides of people over 60 years of age represent 30% of all suicides.

  This concerns people who are unable to cope with their grief for their past life and who will tend to become demotivated and depressed.

IMPROVING THE UNDERSTANDING OF THE IMPAIRMENTS RELATED TO PATHOLOGICAL AGEING

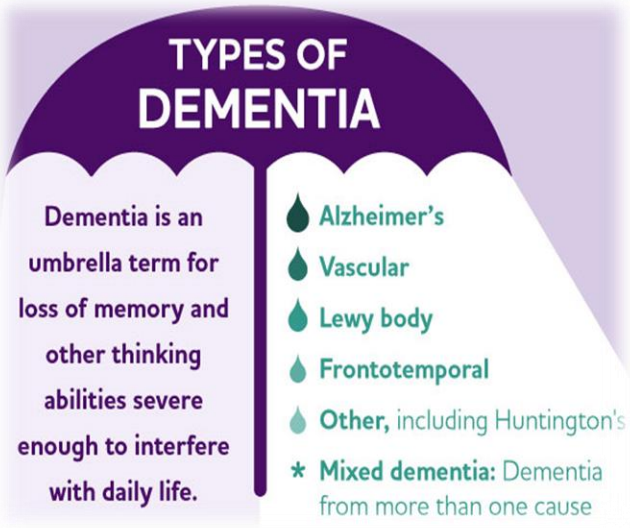
1. THE MOST COMMON NEURODEVELOPMENTAL PATHOLOGIES IN ELDERLY PEOPLE: CHARACTERISTICS, DEVELOPMENT, CAUSES, AFFECTED AND PRESERVED FUNCTIONS

The term pathological ageing means ageing that is accelerated by the emergence of various chronic pathologies. A neurodegenerative disease corresponds to a progressive pathology affecting the brain, or the nervous system more generally, leading to the death of nerve cells (neurodegeneration). Neurodegenerative diseases cause cognitive-behavioural, motor and sensory disorders.



A. List of the main neurodevelopmental pathologies encountered in nursing homes and at home

Among the most common neurocognitive pathologies, we can list:



- Alzheimer's disease;
- Vascular dementias;
- Lewy body dementias;
- Frontotemporal lobar degeneration: frontotemporal dementia (Pick's disease), cortical atrophies (progressive primary aphasias, progressive anarthria, semantic dementia, mental confusion, etc.);
- Parkinson's Disease;
- Huntington's disease (also known as Huntington's chorea);
- Multiple Sclerosis (MS);
- Amyotrophic Lateral Sclerosis (ALS);
- Other diseases and syndromes (chorea)…

Mixed dementia

Mixed dementias occur when vascular damage occurs in addition to the degenerative damage. Dementia is considered to be mixed if there is at least one vascular ischaemic disease combined with a systemic or visceral condition that can lead to dementia.

B. Characteristics, development, causes, affected and preserved functions

Focus on Alzheimer's Disease

Alzheimer's disease is the most common neurodegenerative disease in elderly patients. It is the result of a slow degeneration of neurons beginning in the hippocampus (a brain structure essential for memory) and then spreading to the rest of the brain. It is characterised by disorders related to short-term memory, executive functions and orientation in time and space. The patient gradually loses their cognitive faculties and autonomy. INSERM

- Prevalence

Source Fondation Médéric Alzheimer

The proportion of people with illnesses (prevalence rate) increases with age.

AVANT 70 ANS	ENTRE 70 ET 79 ANS	ENTRE 80 ET 89 ANS	APRÈS 90 ANS
< 1 personne sur 100	1 personne sur 25	1 personne sur 5	1 personne sur 3

This disease affects 1 in 4 women and 1 in 5 men over the age of 85.

Alzheimer's disease in numbers:

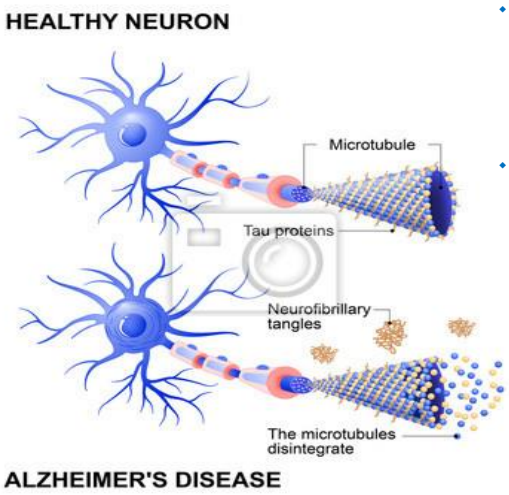
- 1.2 million people in France are affected by Alzheimer's disease and/or similar disorders and 9.7 million people in Europe, according to Alzheimer Europe (Yearbook 2019). By 2050, it is predicted that 18.8 million people will be affected in Europe.
- The disease affects about 16% of octogenarians and 41% of nonagenarians according to Alzheimer Europe.
  55.2 million people worldwide have Alzheimer's disease or a related disorder, according to the WHO. It is estimated that this number will reach 78 million by 2030 and 139 million by 2050. Each year, there are nearly 10 million new cases worldwide.
- In 2019, the global cost of dementia was estimated at US$1.3 trillion. It is expected to reach US$1.7 trillion by 2030, or US$2.8 trillion if the rising cost of care is included.
- Dementia is the most expensive disease of the 21st century for society.

- Characteristics, physiopathology

Three mechanisms are involved in the disease:

- **Synaptic loss, neuronal death and inflammation**

Two types of damages are observed in patients' brains:



- *amyloid plaques around the neurons or senile plaques*: the amyloid beta protein, naturally present in the brain, accumulates on the outside of the neurons forming plaques called amyloid plaques or senile plaques, which are toxic for the neurons;
- *neurofibrillary degeneration:* the Tau protein, naturally present in the body, normally contributes to the formation of the cell skeleton. In Alzheimer's disease, this protein changes and the structure of the neurons is disorganized, which produces neurofibrillary degeneration leading to the death of neurons.

These abnormalities progressively invade the whole brain, starting from the hippocampus (the area in the brain's temporal lobes involved in the phenomenon of memorisation), and destroy the neurons.

In addition to these lesions, there is inflammation:

- within the lesions, there are immune cells responsible for inflammation that appears early before the first signs and symptoms of Alzheimer's disease and that seems to play a complex role with effects that are harmful in some ways and beneficial in others.

The lesions affect:

- firstly, **the hippocampus,** involved in memory processes (recording, retrieval and organization of memories);
- then the **limbic system,** which manages the emotions and the links between memories and behaviours;
- then **the cortex**: the parietal cortex involved in the mastery of space and control of movements; the temporal area of the cortex involved in language and memory; the frontal area of the cortex controlling the executive functions (anticipation and planning of behaviours)

- Symptoms

Memory loss is often the first symptom of Alzheimer's disease, which helps to guide the diagnosis.

Next come **executive function disorders, spatio-temporal orientation disorders**, followed gradually by **language disorders (aphasia), writing disorders (dysorthographia), movement disorders (apraxia), behavioural disorders, mood disorders (anxiety, depression, irritability) and sleep disorders** with insomnia.

Source Urgent Team

To summarise these symptoms, we also start with the 7 'A's of Alzheimer's disease:

Amnesia	Memory loss
Agnosia	Inability to recognize objects by utilising the senses
Aphasia	Loss of ability to speak or understand language
Apraxia	Loss of ability to initiate purposeful movement
Altered perception	Misinterpretation of sensory information
Anosognosia	Loss of ability to recognize illness
Apathy	Lack of interest in activities or ability to stay involved in a task

The France Alzheimer's Association describes the combination and/or repetition of several of the 10 signs below that are associated with Alzheimer's disease

Source: https://www.francealzheimer.org

1st sign of Alzheimer's disease: memory loss
The person begins to forget recent events more and more often, whilst old memories are retained and remembered very well.

2nd sign: increasing difficulty in performing familiar tasks
Preparing a meal, shopping, managing medication… The tasks of daily life become increasingly problematic for the person with Alzheimer's disease.

3rd sign: loss of motivation
The person with Alzheimer's disease loses all sense of wanting to do things, even for activities that were once a passion.

4th sign: language problems
The person with the illness has difficulty finding simple words and uses others that may not be so appropriate.

5th sign: disorientation in time and space
Sense of direction is reduced: the person with Alzheimer's disease may get lost in familiar places or may get seasons mixed up.

6th sign: reasoning difficulties
The deterioration of cognitive functions is a characteristic sign of Alzheimer's disease. The person encounters barriers and requires assistance with administrative formalities or simple tasks of daily living.

7th sign: losing objects
Frequent loss of objects is also a manifestation of Alzheimer's disease. The person develops a tendency to place objects, sometimes important ones, in unusual places and never finds them.

8th sign: impaired judgement
A person with Alzheimer's has difficulty evaluating situations and, for example, may wear winter clothes in the summer or make excessive purchases of food…

9th sign: changes in mood or behaviour
Those close to the person with Alzheimer's may notice the appearance of mood or behavioural disorders, generally in the form of a depressive tendency or manifestations of anxiety, irritability, etc.

10th sign: changes in personality
The person becomes completely different from who she/he was and loses her/his own character.

- Progression

The life expectancy of a person with Alzheimer's disease varies from eight to twelve years from the time of diagnosis. However, for a period of 10 to 20 years, the person with the illness does not show any clinical signs and does not express any complaints, although the destruction of neurons in the brain has already begun.

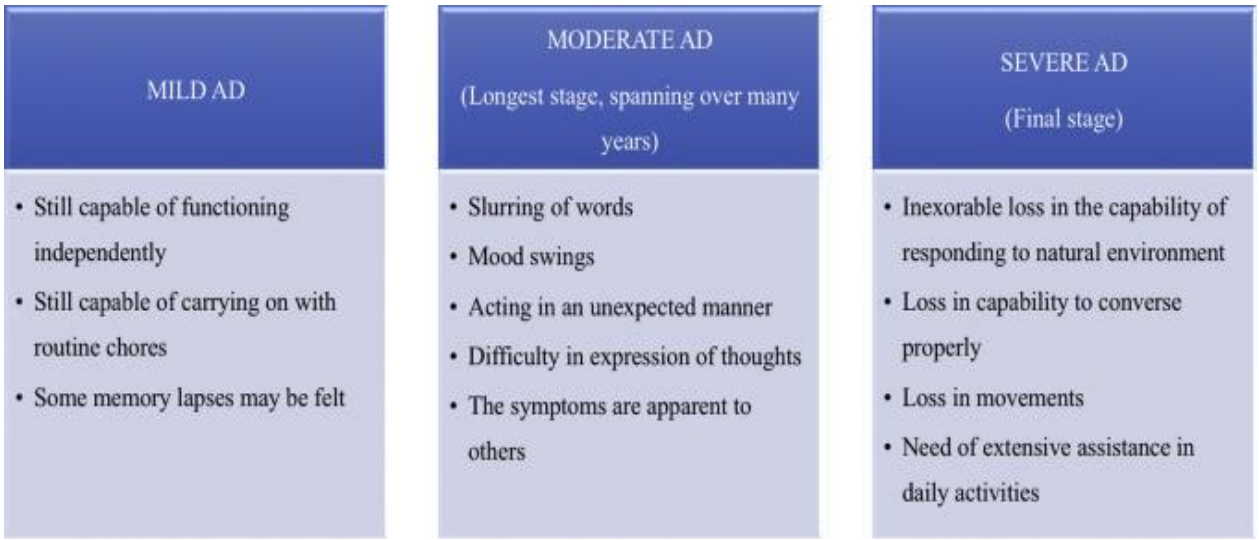
The disease then becomes symptomatic, i.e., clinical signs (episodic memory disorders, profound fatigue with general indifference, disinterest) appear. The diagnosis is made on average two to three years after the first signs appear, often at an advanced stage of the disease.
But this is only an average. It is important to consider the age of the person at the time of diagnosis. This is a consequence of the slow progression of lesions in the brain. It varies significantly from one patient to another: the speed of cognitive decline is specific to each person; the symptoms and their order of appearance may differ.

The latest international classification proposed by the American Psychiatric Association (called DSM-5, for Diagnostic and Statistical Manual of Mental Disorders) proposes a new nomenclature for dementias, including Alzheimer's disease.

It thus distinguishes two grades that follow each other in time:

- *minor neurocognitive disorders*: these correspond to the early stage of the disease, when symptoms do not affect the activities of daily life. However, these activities do require more effort. Cognitive decline is moderate;
- *Major neurocognitive disorders* (which correspond to the medical term 'dementia'): when autonomy is compromised. Cognitive decline is significant, the patient needs help with executive functions (anticipation and planning, adjustment to situations).

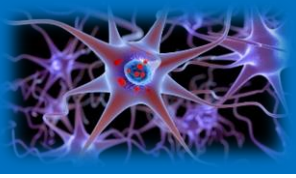
There are **three main stages** of Alzheimer's disease:



Source ScienceDirect.com

- the mild stage: about 25% of the hippocampus decreases in volume and the link between short-term and long-term memory is more difficult to establish. There is a subtle cognitive deficit: the patient has mild forgetfulness of names or recent events, which intensifies over time;
- the moderate stage: other areas of the brain are affected, resulting in behaviour, movement, language and recognition disorders. The person with Alzheimer's disease needs help with certain activities (getting around, managing a budget, cooking…);
- the severe stage: the lesions progress and retrieval of information is almost impossible: past events and information disappear from the memory. Brain cell failure is severe. The patient has lost autonomy for almost all the activities of daily life.

LEWY BODY DEMENTIA

Physiopathology 	**Lewy body disease, also known as Lewy body dementia, is a progressive loss of cognitive function characterised by the development of Lewy bodies in nerve cells.**
Prevalence	Lewy body disease is the second most common cause of dementia in the elderly. In fact, it represents 15 to 25% of all dementia pathologies. Statistics show that dementia with Lewy bodies is significantly more common in men than in women.
Causes	While the mechanism behind Lewy body disease is now well known, its cause remains unknown. Nevertheless, scientists know more and more about its biological and genetic characteristics. In particular, they found that the accumulation of Lewy bodies is associated with the loss of certain neurons in the brain. These are neurons responsible for the production of important neurotransmitters.
Characteristics	Lewy bodies are neuronal inclusions, usually spherical in form. They are mainly made up of neuronal filaments and a protein called alpha-synuclein, a presynaptic protein, which is thought to play a role in learning. **The abnormal accumulation of this protein inside the nerve cells of the brain, in the form of aggregates of insoluble filaments, leads to the formation of deposits that interrupt the messages transmitted by the brain.** The areas of the brain most affected are those related to cognitive functions and movement. Cognitive and motor disorders appear. In some respects, dementia with Lewy bodies is similar to Alzheimer's disease or Parkinson's disease.
Progression	**Dementia with Lewy bodies usually progresses more rapidly than Alzheimer's disease.** ▪ *Early stage* At the beginning of the disease, the patient experiences hallucinations and other distortions of reality (delusions, agitation, REM sleep behaviour disorder). They begin to have difficulty with some specific movements. Some people may seem to 'freeze' or get stuck when they're moving. Others will develop incontinence. Unlike Alzheimer's disease, the memory is still intact at the beginning of this form of dementia. Nevertheless,

	confusion and some slight cognitive changes may already be present. ▪ *Intermediate stage* As Lewy body dementia progresses, symptoms develop that more closely resemble those of Parkinson's disease. These signs include falls, an increasing decline in motor functions, speech difficulties, swallowing problems, paranoia and increasing delusions. Cognitive abilities also continue to decline. The attention span becomes shorter, and periods of confusion become longer. ▪ *Terminal phase* Lewy body disease in the terminal phase manifests itself by extreme muscle rigidity and sensitivity to touch. The patient needs help with almost all the activities of daily life. They have difficulty expressing themselves and may whisper. Some people stop talking altogether.
Psycho-behavioural symptoms	**Symptoms of Lewy body dementia include: memory loss, disorientation, and problems with memory, thinking, comprehension, communication and behavioural control.** ▪ Cognitive disorders: changes in memory and intellectual faculties, attention disorders, progressive loss of visual and spatial perception, reasoning difficulties, fluctuations in cognitive states with sudden changes in attention, concentration, alertness and vigilance, visual and sometimes auditory hallucinations. ▪ Motor disorders: muscle rigidity, shuffling gait, slow movements or frozen posture, tremors mostly at rest, balance problems and falls, stooped posture, loss of coordination, smaller than usual handwriting, frozen facial expression, difficulty swallowing, weak voice. ▪ Behavioural and mood disorders: agitation, apathy, anxiety, depression, paranoia, delusions (false perception of reality). ▪ Sleep disorders: nightmares, nocturnal agitation (REM sleep behaviour disorder), insomnia, excessive sleepiness during the day. ▪ Unexplained loss of consciousness. ▪ Extreme sensitivity to neuroleptics. ▪ Presence of parkinsonian symptoms.
Aggressive disorders	Patients with this condition are highly reactive because they are scared and/or in pain and/or feel sick of themselves. Aggressiveness is a defensive reaction to protect oneself: screaming, pushing away hands, hitting, spitting, biting… Alterations in brain function generate hallucinations and delusions that lead the patient into a world that is often distressing. In another way, brutally, unexpectedly and intrusively, visions occur (most often), but also sensations of

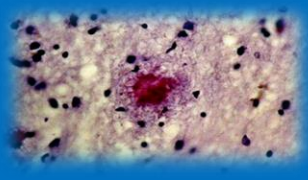
presence, touch and sounds that exist only in the mind of the patient.

Parkinson's syndrome always causes stiffness, cramps and ankylosis, which are extremely uncomfortable. The pain may be present and increase when walking; it is sometimes constantly present in a bedridden patient or in a patient who is not well positioned in a chair.

At the beginning of the illness, the ill person recognises that they are failing, that they are slowing down, limited; the slowing down of ideas means they are no longer able to express what they want. However, they remember their previous life very well and feel 'good-for-nothing': they feel angry at the whole world, especially when a loved one finds the slowness unbearable. They will therefore refuse help because it reminds them of their impairments. Next, swallowing disorders will take away the pleasure of eating.

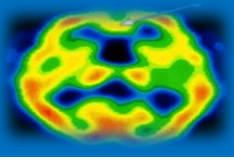
It is advisable to respect phases of low alertness. Significant fluctuations in alertness and cognition are characteristic of this disease. Pulling the patient out of deep rest can result in a violent reaction.

FRONTOTEMPORAL LOBAR DEGENERATION (FTLD)

Physiopathology 	**Frontotemporal degeneration (FTD), also known as frontotemporal dementia or Pick's disease, is a cognitive and behavioural neurodegenerative disease. It is caused by a dysfunction of the frontal regions (located in the front part of the brain) and the temporal regions (lateral parts of the brain).**
Prevalence	The prevalence of this disease increases with age; incidence is approximately 1.5% between 60 and 70 years of age, 5% between 70 and 80 years of age, 15% between 80 and 90 years of age and 40% over 90 years of age. It can affect both men and women and represents about 9-10% of dementias. The first symptoms usually appear between the ages of 50 and 65.
Causes	Three types of lesions can be observed in the brain of people with FTD. They consist of three different proteins (TDP-43, TAU or rarely FUS) that accumulate in the brain cells in each of these 3 forms. The cause of the disease and the composition of these lesions are not known in the majority of cases but sometimes a genetic cause can be identified.
Characteristics	**It manifests itself mainly through behaviour, language and emotions disorders.** Over the years, it also leads to cognitive and motor disorders. The parts of the brain that are destroyed or damaged in FTD are the frontal and temporal lobes. The frontal lobes of the brain are responsible for reasoning, planning and managing emotions and behaviours. In addition, one part of the left frontal lobe is used for conversion of thoughts into words, which may explain the presence of language disorders when a brain lesion is detected there. It should be noted that frontal lobe damage can also lead to motor disorders. The temporal lobes, on the other hand, are used in the recall of memories and the understanding of the meaning of words. This explains why people who suffer from damage to these lobes may have memory disorders as well as relational and social difficulties.
Progression	The condition of the patients deteriorates inexorably over several years. They gradually become unable to wash or dress themselves, they lose their understanding of the meaning of objects in their environment and sometimes have difficulty identifying their loved ones. Many patients are affected by urinary and sometimes faecal incontinence.

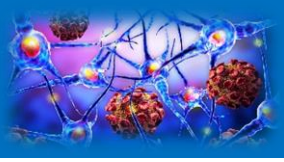
	They become unable to speak and no longer react to external noises, sometimes keeping their eyes closed. Unless someone helps them to stand up, they either sit or lie down. At this stage, patients have difficulty swallowing water and liquids properly (swallowing disorders). Eventually, their hands and sometimes their legs become paralysed. People with frontotemporal dementia most often die from complications of the disease (falls, complications caused by confinement in bed, choking on food that has gone down the wrong way, etc.). Life expectancy from time of diagnosis is on average about ten years. Nevertheless, it varies a great deal depending on the person and there can be slower progressions.
Psycho-behavioural symptoms	**Frontotemporal dementia initially manifests in the form of behavioural and language disorders, before later affecting other cognitive and neurological functions.** The main observations are as follows: ▪ apathy, inertia, loss of interest in usual activities, social isolation; ▪ physical neglect (care, hygiene); ▪ behavioural disorders marked by inappropriate social behaviour, loss of verbal and behavioural inhibition, especially sexual inhibition, irritability, psychological rigidity; ▪ eating disorders: rushing to eat, bulimia, change in food preferences, etc.; ▪ emotional control disorders: emotional instability, flattening of emotions, inappropriate emotionality; ▪ repetitive or stereotyped behaviours: incessant fiddling with hands, perseveration, ritualisation of daily life; ▪ language disorders (disorders with speech, verbal stereotypes, echolalia, mutism) and cognitive disorders (concentration and attention difficulties, reasoning and judgement difficulties, etc.).
Aggressive disorders	The so-called behavioural form, which is the most common, manifests in the ill person as a loss of a sense of social propriety, the appearance of familiarity, lack of inhibition, loss of empathy, often accompanied by irritability or aggressiveness. Studies have shown that people with frontotemporal dementia exhibit physically aggressive behaviour at an earlier stage of the disease than people with Alzheimer's disease. The language disorders, which are important in this pathology, can prevent patients from expressing themselves clearly, which can accentuate behavioural disorders (aggressiveness, anger, etc.). Antisocial behaviour and emotional control disorders are triggers for aggressiveness and violence. People with the illness lack patience and are easily irritated.

VASCULAR DEMENTIA

Physiopathology 	**Vascular dementia is a loss of cognitive function due to the destruction of brain tissue because the blood supply is reduced or blocked.** **The cause is usually a stroke, either a large stroke or several small ones.**
Prevalence	According to several studies, vascular disorders are the second leading cause of dementia in elderly people. Indeed, vascular dementia would represent between 15 and 20% of all dementias combined. Generally, it appears after the age of 70. The prevalence of the disease ranges from 1.2 to 4.2% in people over the age of 65.
Causes	Vascular dementia is the result of brain damage of vascular origin. It can occur: ▪ after a stroke or after several 'mini-strokes'. In fact, strokes either cause a haemorrhage in an area of the brain (haemorrhagic stroke) or, on the contrary, the stroke is caused by a clot that blocks a vessel and therefore the blood does not flow to certain areas of the brain (ischaemic stroke). These vascular accidents can produce lesions in the brain cells and thus lead to vascular dementia; ▪ in connection with hypertensive arteriopathy, which is a form of damage to the vessels leading to areas of damage in the brain; ▪ because of frequent hypotension. This hypotension means that there is no longer sufficient blood pressure, so the supply to the brain is therefore insufficient.
Characteristics	Vascular dementia is a decline in cognitive function that follows vascular damage to the brain. Each stroke results in brain damage and tissue loss. Thus, after several small attacks, symptoms similar to those of Alzheimer's may appear. While memory impairment predominates in Alzheimer's disease, vascular dementias are more likely to take the form of an overall slowing of brain function, a reduction in attention, planning and judgement. **When cerebral lesions (related to vascular dementia) appear in conjunction with neurodegenerative lesions (related to Alzheimer's disease), we speak of mixed dementia**.
Progression	Vascular dementia progresses in fits and starts. At times, symptoms will be stable and then suddenly worsen. We talk about development in steps. Alzheimer's disease is more of a gradual progression. In the long run, vascular dementia ends up strongly resembling late-stage Alzheimer's disease.

Psycho-behavioural symptoms	In some cases, the first symptoms of vascular dementia may appear within three months of a stroke. In other cases, they may appear suddenly and be related to other health concerns that affect blood flow. Unlike Alzheimer's disease, it is not the memory problems that predominate. The main difficulties experienced by a person with vascular dementia are in the area of executive function. **Vascular dementia is primarily characterised by:** ▪ a slowing down of thought (bradypsychia); ▪ difficulty in reasoning, planning actions and performing complex tasks (such as operating certain appliances); ▪ attention deficit disorders; ▪ visuo-spatial difficulties (perceptual difficulties) or some agnosia (difficulty in recognising objects or faces that are familiar); ▪ language disorders, whether in reading, speech or writing (although less severe than those found in Alzheimer's disease); ▪ memory disorders (although less severe than those found in Alzheimer's disease); ▪ behavioural and mood disorders (withdrawal, anxiety, irritability, lack of motivation, depression); ▪ greater fatigue; ▪ difficulty managing emotions (e.g., crying or laughing in inappropriate situations); ▪ neurological disorders: this may take the form of loss of strength in a limb, paralysis of part of the face, or swallowing disorders.
Aggressive disorders	People with vascular dementia may exhibit aggressive behaviours related to their condition, in particular as a result of: ▪ their language difficulties; ▪ their lack of control of their emotions; ▪ the mood disorders that make them more irritable; ▪ depressive and anxious states; ▪ brain damage related to stroke; ▪ loss of control of certain abilities.

PARKINSON'S DISEASE

Physiopathology 	**Parkinson's disease is a neurodegenerative disease characterised by the destruction of a specific population of neurons: the dopamine neurons of the substantia nigra of the brain. These neurons are involved in the control of movements.**
Prevalence	Parkinson's disease affects approximately 6.5 million people worldwide. With an ageing population, the incidence of the disease is increasing. The incidence and prevalence of the disease increases with age, occurring in approximately 1% of people over 65 years of age. It is the second cause of motor disability in the elderly after stroke. It affects slightly more men than women. The direct and indirect costs of caring for Parkinson's disease, including treatment costs (approximately 780 million euros), are considerable.
Causes	The exact causes of neuronal degeneration are uncertain, but age is the main risk factor. It is considered that the degeneration of dopaminergic neurons may be favoured by genetic and environmental factors and there are probably multiple mechanisms precipitating this degeneration. They could include the accumulation of free radicals, an energy or metabolic deficit, or an inflammatory process. Concerning environmental risk factors, the role of pesticide exposure is well established. Cohort studies have shown an increased risk of Parkinson's disease in farmers exposed to organochlorine insecticides. There are also environmental factors that appear to be protective. This is the case with nicotine or coffee, probably because of their stimulating effect on the dopamine neurons.
Characteristics	The disease is characterised by the combination of the three symptoms of parkinsonian syndrome: **tremor, akinesia (slowness of movement) and hypertonia (rigidity of the limbs)**. But these three symptoms are not necessarily all present at the same time. They may each vary in intensity, with one or the other predominating and often combined with other symptoms.
Progression	Parkinson's disease is a chronic disease that develops slowly and gradually, with an insidious onset and intermittent progression. Initially, only one side (right or left) is affected by the symptoms. Patients remain asymptomatic until 50-70% of the dopamine neurons are destroyed and the brain is no longer able to compensate for this loss. It is only later that they become bilateral, but they always remain asymmetrical (more pronounced on one side than the other). Additional neurological signs, which vary greatly, may be associated with the

	Parkinsonian syndromes. **There are four main phases described generally:** ▪ *the appearance of the first warning signs:* the appearance of the first symptoms of neurodegenerative Parkinson's disease: slowness of movement, tremors, blockages, digestive and intestinal disorders, pain, extreme fatigue, muscular stiffness, speech difficulties, loss of balance and falls, depression, excessive anxiety. They may appear five or ten years before it is possible to make a formal diagnosis; ▪ *the therapeutic equilibrium or 'honeymoon' phase:* during the second phase, Parkinson's disease continues to progress, but the symptoms become calmer. During this phase, the patient still lives a relatively normal life. This can range from three to eight years. This is the period when the patient responds very well to dopaminergic treatment; ▪ *motor complications or fluctuation phase* (after 5 to 10 years of treatment): during this fluctuation period, there is a progressive worsening of Parkinson's disease. The bodies of Parkinson's disease patients stop responding to treatment. This therefore causes motor difficulties in the patients, which periodically make them suffer. We refer to this as alternating between ON phases where the symptoms are well managed, and the person feels quite well and OFF phases where the effect of the treatment is no longer sufficient, and the symptoms reappear in a very disabling way. ▪ *the advanced phase of the disease:* this is the last phase of neurodegenerative Parkinson's disease. During this phase, the symptoms become more severe, and the disease seems irreversible. People with Parkinson's disease shake, and the disease affects their psychological state, which can cause cognitive and behavioural disorders. The person with Parkinson's may lose his or her memory and become depressed. At this stage, Parkinson's disease can also cause dementia and certain physiological disorders.
Psycho-behavioural symptoms	▪ Resting tremor: this appears when the person's muscles are completely relaxed (at rest) and it disappears during movement. The tremor is slow, relatively regular and not very large. Most often, it affects one upper limb: the hand and the wrist, but it can affect just one finger, for example; ▪ Akinesia, or slowness of movement: difficulty

	initiating movements requiring precision and semi-automatic movements such as walking or writing, feeling blocked, numbness, fatigue; ▪ Rigidity of movement or hypertonia: excessive tension of the muscles that can lead to muscle pain (cramps) or tendon pain and a feeling of stiffness. This is frequently observable in the patient's posture at rest: tense, hunched forward, head down and more rarely to one side (Tower of Pisa phenomenon); ▪ Other motor disorders: walking difficulties, loss of balance, falls, swallowing disorders; ▪ Fatigue and other non-motor signs: significant fatigue, sleep disorders, daytime drowsiness, sexual disorders, pain, digestive disorders, urinary disorders; ▪ Cognitive disorders: decreased memory capacity, attention disorders, slowing down of thought; ▪ Psychological disorders: hyperemotivity and stress, anxiety, depression, apathy.
Aggressive disorders	Emotions can easily overwhelm people with Parkinson's disease. This heightened sensitivity is due to the disease but may also be a side effect of the medication. The slightest annoyance can thus take on unusual proportions and have serious consequences on the person's condition by generating aggressive behaviour. It is the cause of mood and behavioural changes. Dopamine plays a role in mood regulation. The resulting degeneration can lead to depressive but also aggressive behaviour. Furthermore, according to an American study (JAMA Internal Medicine), the dopamine-based drugs used to treat Parkinson's disease are responsible for compulsive and addictive behaviours and various behavioural disorders, including aggressiveness.

Source France Parkinson

Differential diagnosis of different neurocognitive pathologies

Alzheimer's disease	Disorders with memory and orientation, altered thinking, judgement, language, behavioural changes	Cortex, hippocampus, brain stem
Parkinson's disease	Tremors of the limbs at rest, slowing down of the speed of execution of movements, reduction in spontaneous mobility, muscular stiffness	Substantia nigra, cortex
Vascular dementia	Slowing down of thought and practical abilities	Cerebral vascular network
Lewy body dementia	Memory, language and attention disorders, apathy, visual hallucinations, symptoms like those of Parkinson's	Basal ganglia
Cortico-basal degeneration	Slowing down of the speed of execution of movements, involuntary contractions of muscles	Basal ganglia, cortex
Frontotemporal degeneration and Pick's disease	Behavioural disorders, personality changes, aphasia, apathy, loss of inhibition, language disorders, rigidity of movement, impulsiveness	Frontal and temporal cortex, hippocampus
Charcot's disease or Amyotrophic Lateral Sclerosis (ALS)	Progressive muscle paralysis, muscle atrophy, spasticity, breathing and swallowing disorders	Motor cortex, spinal cord
Huntington's disease	Motor disorders (chorea), breathing difficulties, speech and swallowing disorders	Striatum and other basal ganglia
Hereditary ataxias	Muscle hypotonia, loss of movement coordination, loss of balance and ability to maintain posture	Cerebellum, spinal cord

Source Planet-Vie

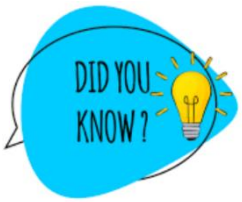
C. Illustration to improve differentiation between the various disorders in one's professional practice and to aid understanding of the changes involved

Link the neurodegenerative pathology with the scenario presented, according to the psychobehavioural symptoms described

Scenario 1	*Ms. C. is having difficulty recovering from an ischaemic stroke. She has difficulty speaking, which irritates her.* *She is a very good cook but has difficulty making simple recipes and operating her appliances. A film lover, she seems to have lost all interest in this activity that she enjoyed so much. Her relatives who come to visit her at her home are unsettled by her behaviour. She has regular mood swings; she can go from laughter to tears.*
Scenario 2	*Mr. R. is often tired. He used to love writing so much but now has difficulty holding a simple pen, his fingers are shaking. He complains of muscle pain that is hurting him and has balance problems that cause him to fall when moving around his home.*
Scenario 3	*Ms. D. is no longer washing. She is increasingly inappropriate and uninhibited with friends and family. She speaks rudely and has a significant interest in sex. She has an irrepressible need to pick up and handle random objects and put them in her mouth. She eats excessively and is focused on the yoghurts she wolfs down all day.*
Scenario 4	*Mr. O. has forgotten that his daughter came to see him yesterday. He needs help to dress himself properly. He sometimes dresses warmly in summer. He hardly goes out anymore because he gets lost going to places that are sort of familiar to him. He needs help to carry out the simple activities of daily life and the administrative procedures that are becoming too complex for him.*
Scenario 5	*Ms. F. is very distressed. She thinks she sees rats in her kitchen. Her memory is increasingly failing her. She has difficulty doing her crossword puzzle. She has gradually become isolated, particularly because of her speech difficulties. She walks with difficulty and very slowly feeling a certain muscular stiffness. She sometimes falls because of her blood pressure problems. Her sleep is very restless, and she often has insomnia.*

2. THE MOST COMMON PSYCHIATRIC PATHOLOGIES IN ELDERLY PEOPLE: CHARACTERISTICS, DEVELOPMENT, ASSOCIATED BEHAVIOURAL DISORDERS

A mental illness is a set of disturbances in thought, emotion and/or behaviour that reflect a biological, psychological or developmental disorder of mental function. A mental illness inevitably brings distress to the individual and/or in their social relationships. It is caused by the interaction between biological, genetic, psychological and social factors that lead to disturbances in the brain.



There are several ways of classifying and presenting psychiatric pathologies. Usually, in conventional terms, we differentiate between neurotic disorders and psychotic pathologies.

A. List of the main psychiatric pathologies encountered in nursing homes and at home

Neurosis or neurotic disorders

Although there are difficulties with the controversial distinction between neurosis and psychosis, it has been continued as the conventional practice. The new DSM-5 classification (Diagnostic and Statistical Manual of Mental Disorders) from the APA (American Psychiatric Association) is used, and we more commonly refer to neurotic disorders.

Neurotic disorders is the term used for psychiatric disorders in which the person is aware of and complains about their psychological suffering.
These are generally personality disorders, mild in severity, which rarely lead to serious behavioural disorders.
The person is aware of their disorder and has an accurate perception of the reality surrounding them. The illness is often also linked to recent or old psychological trauma.

They are therefore non-psychotic psychological disorders. Behaviour may be very disturbed although generally remaining within socially acceptable limits, but the personality is not disorganized. ***The main manifestations are excessive anxiety, hysterical symptoms, phobias, obsessive-compulsive symptoms, depression.***

The origin of neurotic disorders is multifactorial. They are most often the result of an accumulation of social, environmental, biological and genetic factors. Ageing and the changes it brings about can lead to psychological decompensation and the emergence of neurotic disorders.

Major types of neurotic disorders include:

- **panic disorder**;
- **chronic anxiety**, which involves a long-term state of anxiety, i.e., lasting more than three months;
- **anxiety neurosis**, directly or indirectly related to acute or chronic anxiety and anxiety attacks;
- **phobic neurosis**, related to a state of uneasiness when dealing with a situation or a phobic element. The person sets up behaviours for avoidance, reassurance or escape. With advancing age, the symptomatology may be identified as stabilising or becoming aggravated;
- **hysterical neurosis**, relative to a hysterical psychological and physical state. It is characterised by the conversion of anxieties and psychological discomfort into physical symptoms (nervous breakdowns, somatic pain, discomfort, etc.);
- **obsessive neurosis**, which is a clinical situation in which people with this illness experience their consciousness being besieged by images, ideas or words, against their will. They then use rituals to try to defend themselves. The progression of this pathology in elderly people can be severe and some patients will only be diagnosed at the point that they are hospitalised.

The psychological disorders associated with neurosis are mostly emotional in nature. The patient is quite precisely aware, however, of the psychological discomfort that they face.

These disorders often take the form of:

- **mood disorders:** depression, bipolar disorder, emotional instability: sadness, anger, shame, panic, feelings of loneliness, etc.;
- **anxiety disorders:** generalised anxiety disorder, panic disorder, phobic disorder, post-traumatic stress disorder, etc.;
- **a disturbed perception of things**: questioning of one's personality, perception of non-existent voices, hallucinations, etc.;
- **obsessive-compulsive disorders (OCD)**;
- **personality disorders;**
- **unstable social relationships**: threatening or even violent behaviour towards their friends and family, etc.

Psychosis or psychotic disorders

Psychosis is a serious psychological disorder, of which the patient is unaware, characterised by a disintegration of the personality accompanied by disorders with perception, judgement and reasoning.

According to the DSM-5, psychotic disorders are defined by abnormalities in at least one of the following five areas:

Delusional ideas	*Feeling as though one can control the thoughts of others or that others are controlling one's thoughts;* *Feeling that one is being watched, followed or persecuted.*
Hallucinations	*Hearing a voice or voices that no one else hears;* *Seeing things that no one else sees;* *Smelling odours that no one else smells;* *Feeling unusual physical sensations, for example: having the feeling of being touched by an invisible person.*
Disorganized thinking	*Going from one topic to another;* *Giving answers that are not very relevant to the topic of the question.*
Grossly disorganized or abnormal motor behaviour (including catatonia)	*Being agitated or, conversely, being less reactive to the environment;* *Having difficulty organizing actions towards a goal.*
Negative symptoms	*Experiencing a decrease in emotional expression;* *Experiencing a drop in motivation;* *Experiencing a decrease in the ability to experience pleasure;* *Lack of interest in social interactions.*

Source CAMH

The symptoms can be distressing for the person. For example, they may feel insecure all the time.

Acute psychosis affects up to 1 in 100 elderly adults. Among people with dementia, psychotic symptoms occur in **1 in 3 to 1 in 2**.

The risk factors that can trigger the onset of a psychotic state are highly diverse:

- certain diseases, including neurodegenerative diseases, that can disrupt the functioning of the brain;
- psychiatric disorders (such as depression, bipolar disorder, mania…) can also lead to psychosis;
- people with certain psychiatric disorders (such as schizophrenia) experience repeated and/or prolonged psychotic episodes;
- use of certain substances or medications can also cause a psychotic break;
- excessive fatigue or stress can lead to psychosis in people who are prone to it.

The main psychotic symptoms may occur individually or simultaneously.

The main forms of psychotic disorders are as follows:

- **schizophrenia** defined by the manifestation of several symptoms of psychosis leading to significant difficulties in functioning. Symptoms (hallucinations, delusions, disorganized speech and behaviour, negative thoughts) are present for at least one month;
- **schizoaffective disorders:** the person has symptoms of schizophrenia and mood disturbance that may occur at the same time or alternately;
- **manic-depressive psychosis** or bipolar disorder: the psychotic symptoms of this type of illness disrupt mood more than thoughts. Bipolar disorder is normally characterised by symptoms of depression alternating with symptoms of euphoria. The term 'hypomanic' is used to describe the episode of mild euphoria and 'manic' when the euphoria is more pronounced.
  During the manic episode, the mood is euphoric or exaggerated, although in some cases it may be irritable;
- **delusional disorders** affecting mainly thoughts and ideas. The person with a delusional disorder is convinced that their ideas are true, even when there is evidence to the contrary;
- **psychotic depression**: the person experiences severe depression with psychotic symptoms without the manic phase characteristic of bipolar disorder;
- **brief reactionary psychosis** with the same disorders as schizophrenia (delusions, hallucinations, disorganization of speech and behaviour). However, they appear suddenly and are often triggered by significant stress. The brief psychotic episode does not last more than one month. Thereafter, the person returns to functioning normally;
- **substance-induced psychotic disorders**: in this disorder, the loss of contact with reality occurs during or shortly after the use of substances such as alcohol or medication;
- **organic psychosis:** psychotic symptoms may occur as a result of physical illness or head injury.

The most common psychotic disorders in people over 65 are **schizophrenia and delusional disorder**.

Borderline personality disorders

This term defines personalities with great instability of interpersonal emotional relationships and self-image associated with marked impulsiveness.

The convention is that there must be five of the following criteria present to retain this diagnosis:

- frantic efforts to avoid real and imagined abandonment;
- intense and unstable interpersonal relationships alternating between idealisation and disappointment;
- disturbance of self-image;
- impulsivity leading to behavioural disorders;
- affective instability due to a certain emotional lability, or even variations in mood (boredom, anxiety…);
- chronic feeling of emptiness;
- intense, unreasonable anger or difficulty controlling and managing anger;
- poor information processing leading to errors in thinking (cognitive distortions).

These people have difficulty controlling their emotions, especially sudden anger, which makes them very unpredictable. These intense and rapid changes in their judgements and their emotions often result in impulsive behaviours that they are unable to control and later regret.

The most commonly observed characteristic that guides the diagnosis is undoubtedly a visceral fear of abandonment, sustained by the fact that these people have a negative self-image and a profound lack of self-esteem. They spend a lot of energy trying to fight the risk of abandonment/rejection, whether real or imagined.

Symptoms evolve very quickly with calm and then pathological periods marked by an increase in addictions, self-mutilation and sometimes suicide attempts. The disorders may be combined with other mental disorders such as depression, anxiety or eating disorders, etc. Social relationships are often affected by the high level of impulsiveness and intense emotional quest of the person with the disorder.
Diagnosis can be difficult at first because of the highly fluctuating nature of the symptoms, and borderline personality disorders can be confused with psychotic or bipolar disorders.

The causes of these disorders are related to:

- family psychiatric history;
- variations in brain substances called neurotransmitters;
- environmental parameters: history of physical maltreatment, abuse, emotional neglect, etc.

Focus on depressive disorders

Depression is an important condition in the elderly because of its frequency but also because of its consequences for the individual, their family and society.

According to the WHO, depression affects 4.4% of people worldwide, which represents approximately 300 million people. Prevalence increases with age, peaking at around the age of 60-65 (when people enter retirement). Depression affects between 8 and 16% of people over 65 and 12 to 15% of people over 85.

The definition of depression in the elderly is the same as that of a young person, but each criterion has more specific characteristics in the elderly.
Diagnosing depression in the elderly is difficult because the signs of ageing, the side effects of (often many) medications, the inevitable grieving processes and the presence of comorbidities largely confuse the issue.

According to the DSM-5, a diagnosis of depression is confirmed when at least 3 of the following symptoms are present for a period of more than two weeks:

- depressed mood (sadness, pessimism, gloom). Attention, this symptom is sometimes absent in the elderly;
- a loss of motivation and interest (abulia). It is sometimes difficult to distinguish this symptom from age-related loss of functional abilities;
- difficulty in experiencing pleasure and emotions in general (anhedonia);
- loss of self-esteem;
- sense of guilt;
- fatigue, weakness;
- indecision and/or reduced ability to concentrate;
- recurrent morbid thoughts, which should be differentiated from the existential questions and reflections considered natural at the end of life;
- weight variations. Most commonly, it is a loss of weight that is observed in the elderly;
- sleep disorders. Generally, depressed people suffer from early awakening and drowsiness and more rarely from hypersomnia;
- psychomotor disorders. It most often consists of agitation or slowing down.

Where 5 (or more) of these symptoms are present, we refer to it as **a major depressive episode**.

Sometimes there are other related symptoms: isolation, somatisation, delusions, physical pain, aggressiveness, etc.

Depression should not be confused with the reactionary and transient sadness that occurs after a painful event (e.g., after a bereavement).

There are several forms of depression in the elderly, the main ones being:

- melancholic depression, which is manifested in emotional distress, dejection and mutism (evoking extreme apathy – resignation, giving up). The risk of suicide is high in this type of depression;
- hypochondriacal depression associated with somatic preoccupations and physical pain (fatigue, diffuse pain…);
- delusional depression associated with delusional episodes with various themes: paranoid delusions, delusions of jealousy, delusions of incurability, delusions of organ denial (also called Cotard's delusion: the person claims that some of their organs are rotten or have disappeared);
- pseudo-dementia depression, which is associated with significant cognitive impairment;
- hostile depression marked by aggressive behaviour and verbal or physical abuse, or harassment;
- anxious depression, which is associated with generalised anxiety (constant worry and concern). It is often complicated by a drug dependence on anxiolytics (benzodiazepines in particular) and sometimes on alcohol;
- conative depression, which is centred on a loss of motivation and substantial emotional and relational disengagement.

B. Illustration to improve differentiation between the various disorders in one's professional practice and to aid understanding of the changes involved

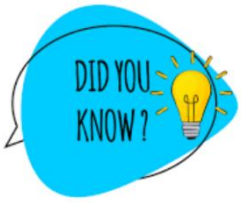
Link the psychiatric pathology with the scenario presented according to the psycho-behavioural symptoms described

Scenario 1	*Ms. V. is usually a calm resident. Today she is going through quite a few moments of disorientation. She's more and more agitated. She expresses great anxiety and explains that she doesn't understand what's happening around her. She looks haggard and perplexed. She's moving about a lot, in all directions, with an unknown purpose.*
Scenario 2	*Mr. D. is afraid of social contact. He stays in his room as much as possible and dreads group situations (such as indoor activities).*
Scenario 3	*Ms. R. is hyperactive. She hasn't slept for two nights. She always seems to have something to do. Her speech is fast (logorrhea), she moves from one subject to another.*
Scenario 4	*Mr. A. is convinced that everyone is angry with him. In particular, the neighbour of his home who seems to be responsible for what happens to him. His speech seems to be well reasoned even if he doesn't always provide any proof of what he says.*
Scenario 5	*Ms. C. speaks to you in a monotone. Her view of things is gloomy. She says she doesn't feel like anything anymore. She accuses herself of being responsible for her condition and of no longer having any value.*
Scenario 6	*Mr. G. is provocative. He seems indifferent to the effects this has on those around him. We notice that he has a strong propensity to lie and to invent events that tend to make him look good.*
Scenario 7	*Ms. F. cannot stand to have anything moved in her environment (especially in her room). The presence of a person in her space tends to increase her verbal and behavioural repetitive behaviours.*

3. THESE DISORDERS THAT DISTURB US: DECIPHERING THE DISORDERS USUALLY OBSERVED IN NURSING HOMES AND AT HOME

A behaviour can be defined as 'an ordered sequence of actions intended to adapt the individual to a situation as he perceives and interprets it'

Jean COTTRAUX, French psychiatrist and psychotherapist, specialist in Cognitive Behavioural Therapy



Internal experiences, needs and anxieties are difficult to express and behavioural manifestations are often the 'enacted expression' of mental life.

There's nothing random about the patient's behaviour: it is the result of a lack of understanding of their own environment and of what is expected of them, related to the progression of the disease, of which they are often unaware.

A. Understanding of the concept of behavioural disorder

Questions and answers on the concept of behavioural disorders

- What is a behavioural disorder?
- Can it affect anybody?
- Does it always have a meaning?
- What does it express?
- What is its origin?
- What is a positive or a deficit behaviour disorder?

B. Definition of the concept of behavioural disorder and the associated terminology

Definition

The World Health Organization (WHO) offers the following definition of behavioural disorders:

'Mental and behavioural disorders are clinically significant conditions characterised by a change in thinking, mood (emotions), or behaviour associated with psychological distress and/or impairment of mental functions.'

To qualify as a behavioural disorder, the following three characteristics must be present:

- inappropriate or aberrant conduct in places and situations with reference to commonly accepted social and/or cultural norms;
- break with the person's previous behaviour;
- impact on the activities of daily life.

The disorders may be a result of functional changes related to dementia pathologies:

- reduced inhibition of inappropriate behaviours;
- misinterpretation of visual and auditory signals;
- impaired short-term memory;
- reduced ability or inability to express needs.

In addition, residents with dementia often do not adapt well to the rules of institutional life. Mealtimes, bedtimes and needs are not always adapted to their habits. Among these individuals, psycho-behavioural symptoms appear or worsen in conjunction with a more demanding, less familiar environment.
Physical disorders may aggravate psycho-behavioural symptoms, in part because people who are ill are unable to communicate normally about their condition. They can cause delirium which, combined with the pathology, may aggravate the behavioural disorders.

Meaning and significance

Some behaviours may nevertheless be meaningful for the person, even if they are not meaningful to those around them (a priori and if one does not take the time to try to understand them). These behaviours become maladjusted for them (in their reality according to their norms, values, social conventions…) but can be adapted for the person. The disorders can therefore be a real means of expression of the person, particularly in the case of verbal communication disorders.
Behavioural disorders can have a wide variety of causes. In order to know what action to take, the process of understanding the origin of the disorders is fundamental if we want to be able to support the person as well as possible and react in an appropriate way (e.g., to avoid aggravation of the expression of the disorders).

To improve the way professionals deal with these patients, the following considerations should be kept in mind in practice:

- *Is the behaviour really inappropriate?* Elderly people with cognitive impairments lack the ability to analyse, understand and react appropriately to unusual situations. The behaviour may be appropriate and consistent with the reality of the person perceiving the situation. A normal behavioural disorder is above all *'An abnormal reaction in an abnormal situation'* (according to Viktor FRANKL).
- *The elderly person has the disorder, but who is being disturbed? (Daniel GENEAU).* It is important to consider whether the behaviour is more disturbing to the family, the professional or to the elderly person themselves.

Aetiology

Behavioural disorders are the result of a very complex interplay of possible causes. It is vital to try to understand the origin of the disorder if we want to be able to support the person in the best possible way.

It is necessary to consider the possible causes of a behavioural disorder:

- **Identify somatic causes**
  - An infection (especially urinary or dental);
  - Urinary retention;
  - Faecal impaction;
  - A metabolic disorder;
  - A yeast infection (especially oral);
  - A decompensation of a chronic pathology;
  - Neurological comorbidity (stroke, subdural haematoma, nonconvulsive coma, etc.);
  - Pain (Doloplus®, Algoplus®, ECPA® scales);
  - Dehydration…

- **Identify a psychiatric cause**
  - Depressive syndrome;
  - Severe anxiety attack;
  - The decompensation of a pre-existing psychiatric pathology…

- **Identify the predominant cognitive factors** that have the greatest impact on the elderly person's adaptation to daily life
  - Memory, orientation, judgement, communication, praxis, executive functions, etc.;
  - Vulnerability, especially emotional, with sometimes irrational reactions.

- **Identify signs of unstable somatic comorbidities**, especially pain, and reassess treatments.

- **Search for, treat or compensate for any potential sensory deficits.**

- **Identify personality factors**
  - Life history, character, previous reactions to stressful situations or health problems, etc.

- **Identify interpersonal factors**
  - Attitude and mood of caregivers, other residents and relatives;
  - Level of information and training of professionals;
  - Their ability to communicate, empathise, anticipate the person's needs and adapt to their symptoms;
  - Phobia of mobilisation, of close physical contact sometimes experienced as aggressive, intrusive (defensive reflexes);

- **Identify factors related to the environment**
    - Imposed locations, types of facilities;
    - Noise, light, smells;
    - Organization of the day, etc.;
    - Organizational changes in support and care;
    - Changes in living space;
    - Change of contacts involved with the person;
    - Situation of interpersonal conflict or pressure experienced;
    - Family events…

Procedure for considering and analysing disorders

- Stages of care
    - The diagnostic approach (NPI-ES, Cohen Mansfield scale…)
    - The therapeutic approach
    - Monitoring and prevention

- The basic elements of care
    - Precise description of disorders, taking account of what the person says about them;
    - Research into their causes and the meaning to be given to them (means of expression of the person, defence mechanism, etc.);
    - Analysis of previous attitudes of professionals and relatives towards these disorders.

- Objectivise the disorders
    - What is the disorder?
    - When does the disorder appear: at what time of the day, of care and support…?
    - Where: in the bedroom, in the hall, in the bathroom…?
    - With whom…?

C. Deciphering the main disorders observed in neurodevelopmental or psychiatric pathologies to improve their identification and management in one's practice

Generally speaking, a distinction is made between two main types of behavioural disorders:

- **positive or productive disorders:** these are seen by friends and family as disruptive, disturbing, or dangerous for people and property around them: agitation, wandering, aggressiveness, shouting, impatience, running away, culturally inappropriate behaviours, sexual disinhibition, removal of or damage to drips or dressings. The frequency of 'positive' behavioural disorders is high in dementia pathologies.
- **negative or deficit disorders:** these manifest in the form of withdrawal, apathy (emotional indifference), adynamia, a general lack of motivation, and even almost constant drowsiness. There may also be: mutism, sadness and peaceful insomnia. These are sometimes neglected by professionals, as the elderly person may be perceived as calm or assumed to enjoy solitude, but in fact they quickly lead to unlearning, and therefore eventually to extra dependence.

Classification of Symptoms or Behavioural and Psychological Disorders of Dementia (BPSD)

- **Affective and emotional**

    - Depression: long-lasting sad mood with loss of interest and pleasure in most of the activities that the person usually enjoys;
    - Anxiety;
    - Apathy: characterised by flattening of emotions, loss of initiative and loss of interest;
    - Elation;
    - Emotional disturbances;
    - Regressive behaviours.

- **Psychotic**

    - Hallucinations: sensory perceptions without object (visual or auditory);
    - Perceptual Disorders;
    - Delusional ideas: erroneous perception of reality (most often on themes of persecution, theft, jealousy, abandonment, deception, etc.).

- **Behavioural**

    - Agitation (excessive verbal or motor behaviour), shouting;
    - Aggressiveness;
    - Psychomotor instability;
    - Compulsion;
    - Opposition;
    - Disinhibition, inappropriate behaviour in relation to social or family norms;
    - Loss of social meaning;
    - Aberrant motor behaviour (repetitive, stereotypical activity that is inappropriate or has no apparent purpose).

- **Basic Conduct Disorders**

    - Sleep-wake rhythm;
    - Eating behaviours.

Types of disorders	Behavioural manifestations
Apathy	Motivational disorder characterised by flattening of emotions, loss of initiative and loss of interest. This is the most common behavioural disorder in Alzheimer's disease (60%).
Anxiety	Nervousness, avoidant behaviour, somatic symptoms (palpitations, sore throat, shortness of breath). The person is anxious and unable to relax.
Depression	This is characterised by a long-lasting sad mood and/or loss of momentum, interest and pleasure in most activities, pessimism and suicidal thoughts. This depressive syndrome is common at the beginning of the disease. It is associated with greater functional impairment, more rapid cognitive decline, higher mortality… It is under-diagnosed because it affects at least half of those who are ill.
Opposition	Verbal or non-verbal refusal to accept care, to eat, to ensure hygiene, to participate in any activity.
Agitation	Excessive and inappropriate verbal or motor behaviour. This is a common disorder especially in advanced forms of the disease. It is characterised by inappropriate verbal (repeating the same words) or physical motor behaviours. In terms of motor function, agitation may take the form of incessant stomping about with wandering behaviour. Agitation may or may not be combined with aggressiveness.
Aggressiveness	Physical or verbal behaviour that is experienced as threatening or dangerous to people around or to the individual.
Aberrant motor behaviours	Repetitive and stereotypical activities with no apparent purpose or for an inappropriate purpose (wandering, incessant movements, clinging attitudes, etc.) The behaviours may have different motivations or causes in response to anxiety, exploratory behaviour, may occur exclusively at night or at a certain time of day, related to a maladjusted goal in relation to the elderly person's life.
Disinhibition	Inappropriate behaviour in relation to social or family norms (e.g., rude remarks, inappropriate gestures, incongruous sexual attitudes, immodest or intrusive behaviour).
Shouting	High-intensity and repetitive vocalisations that may or may not be comprehensible.
Elation/euphoria	A sensation of feeling too good, too happy relative to one's usual state. Familiarity, childish sense of humour, childish pranks. Boastfulness, exaggeration, bravado.
Irritability/Unstable mood	Nervousness, mood swings, sudden outbursts of anger. Cranky, irritable behaviour, difficult to live with, seeking out arguments.
Delusional ideas	Misperceptions or misjudgements of reality, not viewed critically by the person. The most common themes are

	persecution (theft, damage), non-identification (delusions of the presence of an impostor or doppelganger), abandonment, jealousy.
Hallucinations	Sensory perceptions without any real object to be perceived, most often visual and auditory (mice walking under the bed…). Impression of unusual sensations: smells, tastes in the mouth, bodily sensations (something crawling under the skin or touching the patient). Delusional and hallucinatory disorders would be present in moderate forms in 25 to 30% of cases and would be associated with a more rapid cognitive decline. They can also cause CDPS with agitation, aggressive behaviour and opposition.
Sleep-wake rhythm disorders	Sleep disorders with the duration and quality of sleep. Nocturnal wandering, inappropriate night-time activities (dressing, planning to go out). The day-night cycle may be inverted (nychthemeral cycle): excessive daytime sleepiness…
Eating disorders	Loss or increase of appetite. Weight loss or weight gain. Changes in eating behaviour (too much food in mouth, repetitive and stereotyped eating…).

Characteristics

Psychological or behavioural disorders take the form of a break with the way the person behaved previously:

- they may be preceded by minimal changes often perceived by professionals well before the crisis;
- in the presence of cognitive impairment, no change in behaviour is considered trivial.

They fluctuate in intensity or are episodic. The response to non-drug therapies also fluctuates. They are interdependent and often combined.

They have major consequences:

- risk of abuse or neglect;
- worsening of the functional prognosis of the disease;
- risk of inappropriate medication being prescribed;
- increased risk of hospitalisation;
- risk of exhaustion of professionals and caregivers, and suffering of loved ones.

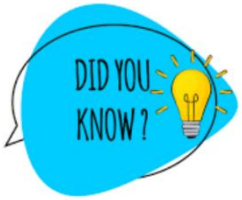
D. Illustration using concrete examples to improve identification of and differentiation between the various disorders in one's professional practice

Link the behavioural disorder with the scenario presented, according to its description

Scenario 1	*Ms. O. talks to television actors as if they were people in the room.*
Scenario 2	*Mr. M. becomes belligerent. He constantly quarrels with another resident and regularly insults the professionals.*
Scenario 3	*Ms. B. interacts very little with those around her. She isn't interested in any new activity.*
Scenario 4	*Mr. Z. sleeps a lot during the day in his armchair. He wanders a lot at night.*
Scenario 5	*Ms. C. no longer recognises her mother. She speaks rudely and behaves in a very embarrassing manner in public.*
Scenario 6	*Mr. G. is very calm and serene but alternates these phases with periods of verbal and even physical violence.*
Scenario 7	*Ms. F. does not pose any problems during the day. At bedtime, she seems very anxious for no apparent reason and demands attention.*
Scenario 8	*Ms. L. spends her time rummaging, opening and emptying the cupboards in her home.*
Scenario 9	*Mr. J. plays childish pranks that are only amusing to him. He pinches other residents or takes their things without giving them back just for fun.*
Scenario 10	*Ms. S. is losing weight. She no longer has any appetite. Even the meals that she used to love no longer interest her. Meals have become a nightmare. She plays with the food on her plate. When the caregivers force her to eat, she turns away and spits out the food.*

4. AGGRESSIVENESS/VIOLENCE AND BEHAVIOURAL DISORDERS

Aggressiveness is a common behavioural disorder in people with dementia. Although up to 80% of people with dementia exhibit aggressive behaviour, this is not an inevitable disorder.



A. Behavioural disorders and aggressiveness/violence are not necessarily synonymous

Just because an elderly person has a neurodegenerative disease does not mean that they will necessarily become aggressive. When a change in mood or behaviour is observed, somatic problems or an unsuitable environment need to be ruled out first.

If aggressiveness is a symptom of dementia, it is important to emphasise that it is also a natural human defensive reaction, in response to a threat when facing a supposed danger and also a means of expression in the sense that the person does not necessarily have other means of self-expression.
Indeed, the elderly person suffering from cognitive disorders loses their ability to understand and communicate due to their pathology.

It is also important to remember that aggressiveness is a fundamental component of human nature. It is not necessarily synonymous with violence. Aggressiveness is a common behaviour that all professionals must deal with regardless of the context in which they find themselves.

It is during personal care (grooming, dressing) that aggressive behaviour is most prevalent, when there is minimal distance between the caregiver and the person being cared for, and when the elderly person is likely to experience pain or anxiety.
An elderly person with cognitive impairments gradually loses their ability to speak, to interpret and to adapt to environmental stimuli, due to the disease. They can therefore only express themselves through aggressiveness.

The origin of aggressiveness in elderly people with dementia is therefore multifactorial and may be the result of suffering (physical or psychological), an unmet need and associated frustration, an unsuitable environment or behaviour, anxiety or a call for help.

As with any behavioural disorder, it is important to identify the cause and not to stigmatise the person.

B. Identification of factors of aggressiveness and violence in behavioural disorders

Aggressive disorders may emerge specifically from:

- individual factors related to the elderly person: personality, inappropriate behaviours and demands, addictions, frustrations with unmet needs, etc.;
- physiological, somatic and neurological factors: neurodegenerative or psychiatric pathologies and associated psycho-behavioural disorders, acute medical pathologies, painful states, drug interactions, etc.;
- factors related to professionals: defensive attitudes, failure to respect the elderly person's rights and freedoms, inappropriate behaviours for the situational context and for the elderly person, abuse, poorly identified needs, stress, professional exhaustion, lack of motivation, lack of training, etc.;
- environmental factors: unsuitable architectural and social environments, noise pollution, family conflicts, etc.;
- factors related to the organization of work: long waiting times, work overload, restrictive and/or constraining measures, tendency to trivialise acts of violence, lack of support from the institution, etc.

In order to improve identification of aggressive behaviours to improve the treatment of the cause, there are several tools for assessing aggressive behaviours, including:

- the Ryden Aggression Scale, a scale for assessing aggressive behaviour in a person with dementia;
- Cohen-Mansfield Agitation Inventory, a specific assessment scale for agitation observed in institutions.

C. Manifestations, characteristics and specific features of 'problem behaviours'

The concept of 'problem behaviours' is not necessarily easy to define in a clear and definitive way.

They manifest in the form of aggressive, violent and highly disruptive behaviours. Different terminologies are used in the literature:
aggressive behaviours, aggressions, aggressiveness, anger, destructive behaviours, challenging behaviours, conduct disorders, behavioural disorders, severe behavioural disorders, violence, dysfunctional and disruptive behaviours.

These are particularly common in the acute phases of psychotic, neurotic or personality disorders. Lastly, there are some organic diseases that can be revealed by a behavioural disorder (tumours, stroke, epilepsy, metabolic disorders, etc.).

'Problem behaviours' can be multifactorial and manifest in a variety of ways and in different environments. It is important to remember that not all socially maladaptive or unusual behaviours are 'problem behaviours'.

In order to improve their identification, reference systems have categorised them in the following way:

Fields/categories	Behavioural manifestations
Self-harm	*Biting oneself, pulling one's own hair, banging one's own head, etc.*
Aggressiveness to others	*Hitting, pushing, punching, kicking, slapping, pulling hair, etc.*
Obstructive self-stimulatory behaviours – excessive verbal and motor stereotypy	*Swaying, fiddling with a thread, repeating the same words, making noise incessantly, pacing, hand movements, etc.*
Destruction of the physical environment	*Throwing and breaking things, ripping clothes, breaking windows, crockery, knocking over furniture, etc.*
Maladjusted social behaviour	*Screaming, running away, undressing in public, constant opposition, massive inhibition or disinhibition, etc.*
Eating disorders	*Hyper selectivity, food obsessions, vomiting, constant search for food, etc.*

Source HAS

The 'problem behaviour' is considered a serious problem when the person's actions are particularly severe, intense, persistent and repeated and either:

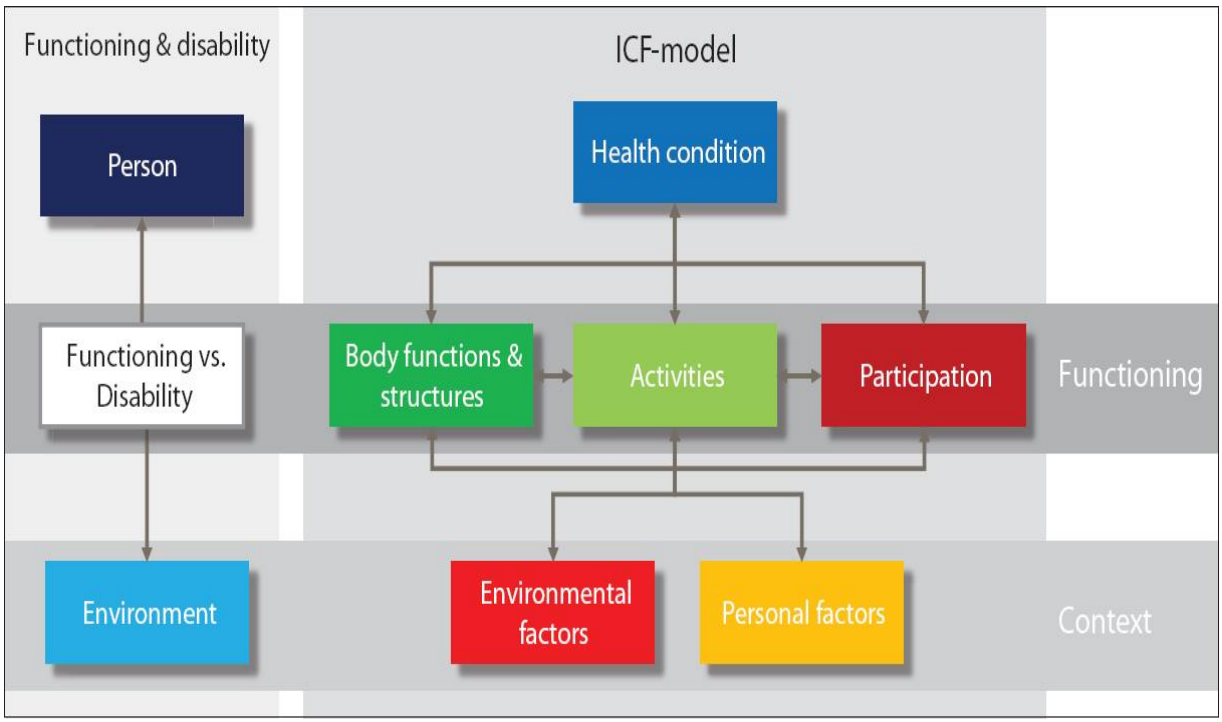
- they interfere with or make impossible the learning that is supposed to be happening;
  and/or,
- they compromise the integrity and safety of the person and those around them (the person being cared for, family, professionals, loved ones, caregivers);
  and/or,
- they require continuous monitoring.

The 'problem behaviours' are analysed according to the new WHO International Classification of Functioning (ICF). As ICF indicates, the interaction between the following factors must be considered: **personal factors and environmental factors**.

The person's environment can be a trigger for 'problem behaviour'. Indeed, the person may have a perception/understanding of their (physical and social) environment that influences the onset or maintenance of a problem behaviour. Similarly, the perception of the person held by the social environment can generate problem behaviours.

This is a paradigm shift that entails no longer focusing on the person and/or the form of the behaviour, nor on the pathology, the deficiencies, the disability, but considering the problem behaviour in the interaction and interrelation between the individual and his environment.

International Classification of Functioning (ICF), Disability and Health, and the interaction of a person with a health condition and the environment



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5. OTHER PATHOLOGIES OF OLD AGE

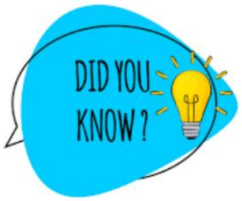
A. List of other ageing-related pathologies and their consequences on the elderly person

- Cancers
- Rheumatological pathologies
- Cardiovascular pathologies
- Respiratory pathologies
- Oral and nutritional pathologies
- Dermatological pathologies
- Urological pathologies
- Digestive pathologies

B. Specific characteristics related to drug iatrogenesis

Although the prescribed medications treat certain targeted pathologies, they also have adverse effects, sometimes serious, on the body and the psyche of the person. This is what is known as drug iatrogenesis.

Drug iatrogenesis refers to all the adverse effects that can be caused by a medical treatment, whatever the effects, from the most benign to the most harmful for the body. These side effects are called 'iatrogenic effects' when a patient's medical treatment triggers symptoms different from those it is originally targeting and treating.



Elderly people form a population that is particularly exposed to the iatrogenic consequences of drugs. They are traditionally considered to be at risk.
Indeed, some studies (Fourier A. et al. Sociodemographic characteristics and polypharmacy in elderly people: data from the Paquid study) have shown that the average number of medications taken per person over 65 years of age, per day, is 4.5.
90% of this population takes at least one drug and drug prescriptions for people over 65 years of age (15% of the general population) represent one third of all prescriptions. This level of consumption is an undeniable risk factor for iatrogenic accidents.

As the use of medication has become commonplace, these risks of iatrogenesis are too often underestimated. In particular, they are the result of:

- errors in taking the medication. Drugs taken at the wrong time, in double doses, etc.;
- interactions between different drugs in the same treatment.

These iatrogenic adverse effects appear as a function of the dose, the duration of treatment or with polymedication, reaching 58% with 5 drugs and 82% with 7 or more drugs.

The most common manifestations of these iatrogenic effects are dehydration with functional kidney failure, orthostatic hypotension often complicated by falls, digestive haemorrhages and delirium. The main therapeutic classes involved are cardiovascular drugs, anti-inflammatory drugs and psychotropic drugs.

In addition to delirium, it has been shown that neuropsychiatric disorders, including agitation, can occur as a result of drug iatrogenesis in the elderly.

IDENTIFYING THE RESPECTIVE NEEDS AND EXPECTATIONS WITH REGARD TO THESE CHANGES AND/OR DISORDERS IN ORDER TO BE BETTER PREPARED TO HANDLE SITUATIONS OF VIOLENCE

1. ANALYSING THE INFLUENCE OF THESE AGEING-RELATED CHANGES/DISORDERS ON THE ATTITUDES AND BEHAVIOURS

A. Understand the impact of these changes from the point of view of the elderly person, the family or loved ones, the professionals or external people involved

As we have seen previously, the loss of autonomy linked to normal and pathological ageing will have consequences on the behaviour of the elderly but also on the attitudes of the professionals and those around them.

In order to analyse each situation objectively and to guard against aggressive attitudes, it is important to position oneself in the shoes of all those involved, in order to better understand the impact of these changes and/or disorders on them.

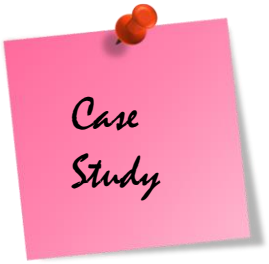
Position yourself in the shoes of each of those involved, by identifying…

- the effects and impacts of each disorder or change on the elderly person, their families or loved ones, and the professionals
- the aggressive behaviours that can result from it

	Elderly person	Family or loved ones	Professional
Loss of balance, falls			
Sensory limitations			
Memory disorders			
Agnosia			
Acute anxiety			
Repetitive behaviours			
Depression			
Mood disorder			
Language disorder			
Attention deficit disorders			
Eating disorder			
Hypertonia			
Loss of autonomy			
Difficulties in adapting			

B. Bringing in a new point of view by analysing specific aggressive situations

By taking account of some specific situations in which aggressiveness occurs, we can observe that aggressiveness may be due in particular to poor understanding of the situation induced by ageing-related changes, incorrect identification of needs, a misunderstanding of the person, an environment unsuited to their needs. Let's take a few aggressive situations experienced in an institution or at home: how would you interpret them?

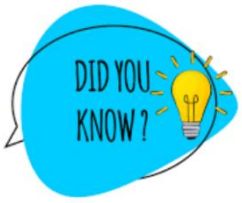


Analysis of aggressive situations: What are the consequences of ageing on the elderly person, the people around them, and the professionals

Scenario 1	*Ms. G. suffers from dementia pathologies, particularly including agnosia. Eve, her caregiver, approaches her and starts to undress her.* *Ms. G. becomes aggressive, seizing Eve's arm very violently making care impossible, despite the fact that Eve usually provides personal care for her every day.*
Scenario 2	*Mr. M., who suffers from Alzheimer's disease, wanders through the corridors of the nursing home looking for his wife. He enters Ms. X's room. She starts to insult him and to shout. Valerie, a care assistant, very annoyed by the situation, takes him by the arm to accompany him to his room, reminding him that his wife died a few years ago. He reacts very violently towards Ms X. and Valerie.*
Scenario 3	*Ms. C. is gradually losing her physical abilities. Usually very careful about her appearance, she refuses any offers of help from the caregivers to carry out her personal care, which triggers irritation in her. This refusal of help leads to poor body hygiene leading to embarrassing smells for those close to her, who complain about it. Ms. C's family is very unhappy with the professionals, believing that they are doing their job poorly.*
Scenario 4	*Mr. C. takes many medications during his meals and because of swallowing problems, they are mixed in with his food. He now refuses to eat, blaming the professionals for the food tasting bad. They are annoyed by this, considering the food to be very good and by his fussy attitude. They are losing patience and are thinking of starting artificial feeding.*

2. IDENTIFY THEIR RESPECTIVE NEEDS AND EXPECTATIONS IN ORDER TO BE BETTER PREPARED TO HANDLE SITUATIONS OF VIOLENCE

Aggressiveness in particular comes from frustration of unmet needs. Before finding out individual needs, it is important to know the basic needs common to all human beings in order to improve one's understanding and accept each individual with their various feelings (which come from satisfied or unmet needs) and potentialities.



A. For a better knowledge of needs to minimise frustrations and defensive reactions, and to provide appropriate responses

For living beings, a need is a feeling of lack, deprivation or dissatisfaction, which pushes them to accomplish acts perceived as necessary, even indispensable. The goal of these acts is to make this feeling of lack disappear: the satisfaction of the need.

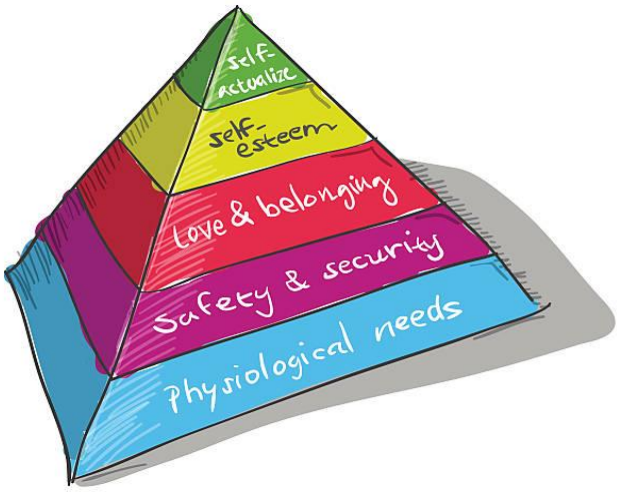
The basic need is essential for human beings in order to maintain their life and ensure their well-being. Needs change with age and circumstances. They may be physical and physiological, psychological and emotional, social and cultural. If an elderly person experiences a complete loss of autonomy, they cannot perform the appropriate actions to meet their needs on their own.

The hierarchy of needs according to A. MASLOW

Created by Abraham Maslow, Maslow's pyramid (the pyramid of needs) functions to organize human needs according to priority. **It lists 5 needs in the areas of essential needs (physiological and security), psychosocial needs (belonging and self-esteem) and the need for self-actualisation.**

This ranking corresponds to the order in which the needs appear for the person concerned, the satisfaction of the needs on one level generating the needs on the next level.

However, this prioritisation is questionable in some cases. Experience shows us that, for an elderly person, the failure to satisfy the needs in the higher levels may lead them to sink into apathy. Aristotle said that 'man is a social animal', i.e., human beings have a social need by nature just as important as their physiological needs. Today, advances in neuroscience, clinical and social psychology are moving in this direction: psychological balance is also necessary for survival.



- *Physiological needs*

Physiological needs are the foundation slab of the pyramid. They are basic needs directly related to the survival of the individual. These are typically concrete needs (eating, drinking, clothing, reproduction, sleeping, etc.). A priori, these needs are met for the majority of us, however we do not all have the same appreciation of these needs. This difference in appreciation can lead to a situation that will be considered unsatisfactory for the person and in turn the need to be satisfied will give rise to a motivation for the person.

- *The need for security*

The need for security comes from the aspiration held by each of us to be protected physically and mentally. It is complex, because the feeling of insecurity manifests differently depending on the individual.

- *The need to belong*

The need to belong represents the third level of Maslow's pyramid. It revolves around the need for affection, love and socialisation. The individual then feels the need to love and be loved. They also feel the need to join groups or communities or to develop their circle of friends and relationships.

- *The need for self-esteem*

The need for esteem is defined by a need for personal accomplishment and self-confidence. The individual wishes to accomplish things that will give rise to respect from those close to him, his acquaintances, but also from strangers.

- *The need for fulfilment*

This need consists in self-realisation as an individual, by exploiting one's potential to the maximum. It can only be considered if the four previous needs are met.

In the context of meeting these needs for elderly people, we consider that the whole pyramid will mobilise knowledge related to understanding the elderly and their environment. Levels 1 and 2: expertise concerning assistance with daily life, meals, maintenance of the environment, hygiene and comfort; levels 3, 4, 5: knowledge related to expertise concerning the relationship of support and listening.

The 14 basic needs according to V. HENDERSON

In 1960, an American nurse, Virginia Henderson, who was very committed to caring for the sick and to good treatment, drew up a list of 14 basic needs that are essential for a good quality of life and care for the patient. Her goal was to improve the treatment conditions for patients in hospitals. However, this conceptual model applies to the autonomy of elderly people and is still in force today. It has even become a reference.

The 14 basic needs function like a pyramid, where one need must be validated and satisfied in order to move on to the next. In practice, it is necessary to analyse whether each need is satisfied or whether there is an obstacle to satisfaction.

They fall into Maslow's five categories because each need is dependent on physiological, psychological, social or cultural factors.

In the context of the care approach, it is necessary to be vigilant in meeting the needs of the elderly at all levels and not only in the register of primary physiological needs.

These needs are defined in detail in a grid format that allows us to evaluate the needs of the elderly person and to provide them with the best possible support by promoting their autonomy. This tool is used by professionals in the personalisation of the assistance and care relationship.

Other approaches to needs

The Basal Stimulation approach, conceived in Germany by **Andréas FRÖHLICH** (professor in specialised education), aims to support people experiencing a loss of autonomy, including elderly people suffering from dementia, as closely as possible to their particular needs, taking account of their skills and resources, particularly in the fields of perception, movement and communication.

Starting with Maslow's needs, he breaks them down as follows:

Maslow's Hierarchy of Needs

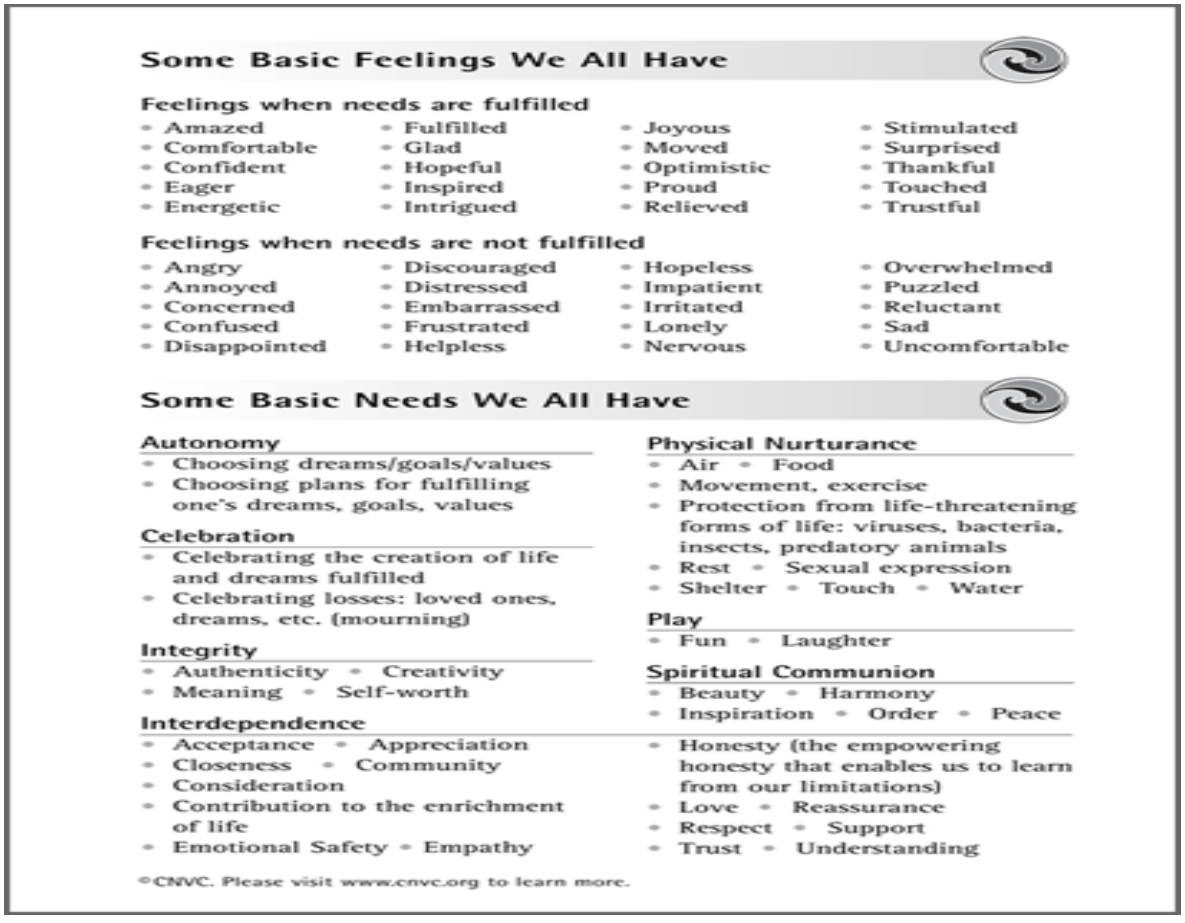
Andréas FRÖHLICH (basic needs)	**Andréas FRÖHLICH** (specific needs)
Independence **Autonomy, self-determination** **Recognition and self-esteem**	Need for people who understand one, even without verbal language, and who take account of one's skills
Connection, acceptance, tenderness **Communication**	Need for close physical proximity to perceive other people
Safety, stability **Securing relationships**	Need for close physical proximity to facilitate basic approaches to the environment and to live one's experiences
Need for stimulation, change and movement **Need to avoid hunger, thirst and pain**	Need for a third party to move or change position Need for a third party to take care of one

Marshall ROSENBERG (founder of Non-Violent Communication) proposes a classification in 7 categories of needs (sometimes 9, but they are just different categories). This is not a pyramidal classification (as presented by Maslow), but a coexistence of these needs:

- Autonomy (choosing our dreams, goals and values and our strategies to achieve them);
- Celebration (celebrating life and the fulfilment of one's dreams, marking loss and grief);
- Integrity (creativity, authenticity, meaning, self-esteem);
- Interdependence (love, acceptance, appreciation, consideration, community, trust, understanding, support, honesty);
- Nourishment on the physical level (air, food, physical exercise, protection, rest, water, shelter, touch…);
- Play (fun, laughter, artistic expression);
- Communion of spirit (beauty, harmony, inspiration, order, peace).

A link is proposed between needs and emotions. According to his theory, when we are able to identify our emotions, we should ask ourselves what need they express. It is therefore useful to look for the unmet need behind the anger, because anger is a distorted expression of our unmet needs.

According to Marshall Rosenberg: 'every message, regardless of its content or form, is an expression of a need'.



Some Basic Feelings We All Have

Feelings when needs are fulfilled

• Amazed	• Fulfilled	• Joyous	• Stimulated
• Comfortable	• Glad	• Moved	• Surprised
• Confident	• Hopeful	• Optimistic	• Thankful
• Eager	• Inspired	• Proud	• Touched
• Energetic	• Intrigued	• Relieved	• Trustful

Feelings when needs are not fulfilled

• Angry	• Discouraged	• Hopeless	• Overwhelmed
• Annoyed	• Distressed	• Impatient	• Puzzled
• Concerned	• Embarrassed	• Irritated	• Reluctant
• Confused	• Frustrated	• Lonely	• Sad
• Disappointed	• Helpless	• Nervous	• Uncomfortable

Some Basic Needs We All Have

Autonomy
- Choosing dreams/goals/values
- Choosing plans for fulfilling one's dreams, goals, values

Celebration
- Celebrating the creation of life and dreams fulfilled
- Celebrating losses: loved ones, dreams, etc. (mourning)

Integrity
- Authenticity • Creativity
- Meaning • Self-worth

Interdependence
- Acceptance • Appreciation
- Closeness • Community
- Consideration
- Contribution to the enrichment of life
- Emotional Safety • Empathy
- Honesty (the empowering honesty that enables us to learn from our limitations)
- Love • Reassurance
- Respect • Support
- Trust • Understanding

Physical Nurturance
- Air • Food
- Movement, exercise
- Protection from life-threatening forms of life: viruses, bacteria, insects, predatory animals
- Rest • Sexual expression
- Shelter • Touch • Water

Play
- Fun • Laughter

Spiritual Communion
- Beauty • Harmony
- Inspiration • Order • Peace

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Back to the idea of satisfied/unmet/individual needs

The motivation for the behaviour of an individual is satisfaction of their needs, their awareness of which may vary.
While failure to satisfy these needs causes physical and psychic sufferings, lack and frustrations.
The regular and continuous satisfaction of needs tends to prevent certain aggressive and violent behaviours.

It is therefore essential to respect the basic needs of all persons receiving support in a situation with loss of autonomy, but it is necessary to take account of the individual needs and desires of each elderly person.

Link between needs, emotions and self-esteem

In line with the work of Marshall ROSENBERG, emotions never occur randomly. They are the messengers of our unsatisfied needs and of our self-esteem.

Behind every unpleasant emotion, there is an unmet need. It may be the need to be heard, to be respected, to be valued, to be safe, to be loved, to be recognised, etc. Satisfying a need is very important because it marks the way in which the individual is attentive to themselves, respects themselves and values themselves. Moreover, the more vital the unmet need is, the stronger the feeling of malaise is and the more it is expressed physically. It is important to know how to decipher it, because as long as we do not manage to discover and satisfy the desperate need, the emotion will return.

Needs are not our only emotional triggers. Indeed, our needs are directly aligned with whether our values are respected or not, whether we can enjoy our pleasures or not, and whether our beliefs are realised or not. All of these are also related to our self-esteem. For example, if my value of ‘respect’ is violated, I will express the need ‘I need to feel respected’. Similarly, the lower our self-esteem is, the more strongly we feel the so-called negative emotions: ‘I consider myself worthless, I feel sad, I need reassurance that I have value, that I am lovable and loved’.

The failure to satisfy a need will provoke an emotion that takes energy such as anger, sadness, fear, disgust. Understanding our emotions and seeking to nourish and satisfy our needs is fundamental to our well-being, our fulfilment and our self-esteem.

Basic needs versus the needs of the elderly person: examples of reconciliation of these needs in support practices

PRIMARY NEEDS	
To be clean	- Identify usual hygiene-related habits and rituals. - Respect interest in self presentation: hairstyle, nails, make-up, perfumes, moisturising cream.
To be well dressed	- Get the person to choose their clothes instead of imposing your choice on them. - Ensure that their laundry is clean.
To eat, drink, sleep	- Ensure that the food provided is appropriate for the person's specific needs or difficulties, ensure that they have hydration and sleep. - Identify lifestyle habits and rituals. - Respect his tastes and food preferences. - Adapt as much as possible to the person's rhythm.
To feel safe	- Minimise obstacles in the environment, when moving around, reassure the person about other elderly people. - Use empathetic communication.
INTELLECTUAL NEEDS	
To have and know one's position within one's own story and within the world	- Find out about the person's path through life. - Communicate about their past and present story. - Inform them about events within the establishment and also outside.
To develop areas of interest	- Find out about their various areas of interest and incorporate them into the caregiver/care receiver relationship. - Develop relationships and local life. - Introduce new areas of interest through facilitation and conversation.
PSYCHOLOGICAL NEEDS	
Respect of privacy	- Respect their modesty, their personal space and their environment.
Recognition of oneself and one's identity	- Develop professional investment by recognising the uniqueness of each person.
RELATIONAL NEEDS	
To re-establish verbal communication	- Understand and accept differences between individuals and between generations. - Develop all modes of communication.
To build new relationships	- Encourage meetings with other elderly people. - Introduce all those involved with the person.
EMOTIONAL NEEDS	
To maintain links with family and friends	- Develop a trusting relationship with their loved ones. - Integrate family members into the caregiving relationship.
EXISTENTIAL NEEDS	
To reduce physical suffering and emotional distress	- Take account of the person's complaints. - Work to control pain and discomfort. - Pass on information about any changes in attitude. - Develop all modes of communication.

B. Identification and tracking of real needs and expectations

Analysis of real needs and expectations according to the Valorisation-ESMS® method of Paul VEROT

Paul VEROT, trainer and consultant, former director of an establishment for elderly and disabled people in France, developed and tested a method called Valorisation-ESMS® aiming to improve analysis of the needs and expectations of the elderly person in order to provide them with appropriate and satisfactory responses.

It is based on several tools, including ***the Compass***, which allows professionals to structure their questioning when supporting the elderly person, by focusing on their real needs and aspirations.

The compass consists of the following cardinal points:

- **Cardinal point 1: List of aspirations and needs of the elderly person**

This list is produced by analysing the real needs of the elderly person (explicit or implicit, expressed or not), their wishes and desires, taking account of their abilities and skills: we then try to identify the real need of the person with regard to their difference, their uniqueness and the situational context.

- **Cardinal point 2: Verification and prioritisation of the aspirations and needs of the elderly person**

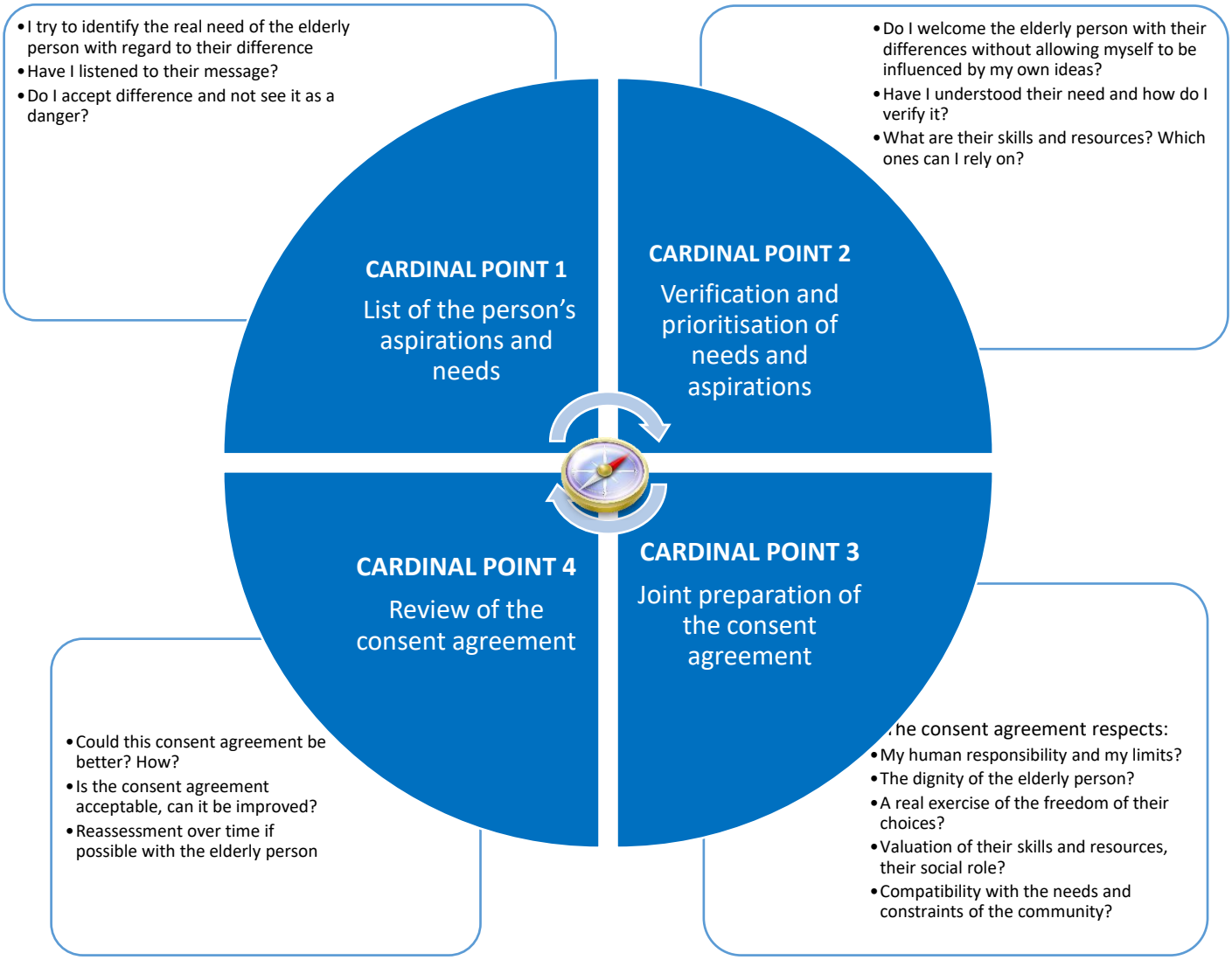
This step leads to a necessary investigation of the good understanding of the needs and aspirations of the elderly person by the professionals, and of the evaluation of their capacities and skills.
These first two cardinal points lead to the recognition of the person and the objectification of their opinions and choices.

- **Cardinal point 3: Joint preparation of the consent agreement**

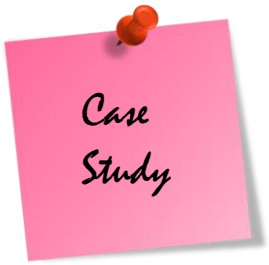
The aim is to provide a satisfactory response to the real needs of the elderly person that is compatible with the needs and constraints of the community. It is based on the recognition of the elderly person as an individual in their own right and of the human responsibility of the professional based on the principles of dignity for the elderly person, valuing of their abilities and respect for their rights.

- **Cardinal point 4: Review of the consent agreement**

This involves readjusting the responses provided to the needs of the elderly person according to the situational context by relying on additional questions resulting from observation by professionals, requests from the person or their family, documents such as life history, and collection of wishes.



The compass, source PVF Formations



Analysis of a need with the compass tool for an aggressive and violent resident

Fatoumata, a caregiver, reports that in the morning she discovered Mr. A., who is visually impaired, in a soiled room: Mr. A. had removed his protection, urinated and defecated on the floor; he himself was soiled. In these circumstances, he showed very violent reactions towards this professional who suggests going to the toilet. He insulted her, saying that he didn't like to be washed, that it's her fault he's soiled because the incompetent staff didn't come to see him often enough, nor quickly enough to accompany him to the bathroom. In this situation, Mr. A. made racist remarks about Fatoumata in particular. Faced with Mr. A., this caregiver wondered what attitude to adopt because explanations and attempts to reason with Mr. A. only increased his aggressiveness. On the other hand, Fatoumata felt that she did not have to put up with Mr. A's insults and racist remarks towards her.

Analysis of respective needs and expectations with the compass tool

ITEM 1 / Analysis of needs and expectations	
Physical needs	Fatoumata explained to us that Mr. A. needed: - to be clean; - safety, because this visually impaired resident was at risk of falling on the soiled floor.
Psychological needs	Mr. A. explained that he needed to be escorted to the bathroom and accused staff of not responding quickly enough to his calls; he stated that the staff were incompetent. Fatoumata thinks that for Mr. A., presenting himself as a victim of staff incompetence allowed him to legitimise his attitude and to remain in control of the situation. Mr. A. was in denial about the fact that he has soiled his room; Fatoumata believed that this denial may be due to a sense of shame that Mr. A. may feel about the situation.
Expressed/unexpressed needs	Fatoumata indicates that she did not go further in her analysis of this point during her face-to-face meeting.
ITEM 2 / Understanding/verifying needs	
Beyond the needs of hygiene and security, Fatoumata considered that it was the psychological needs that were the most glaring: she reports that, in her opinion, it was the way the professional explained to Mr. A. that his room and himself were soiled that triggered the violence.	
Personal representations from the professional	Fatoumata refrained from making any value judgement or answers to Mr. A.'s insults.
Objectification of the person's choices	Fatoumata stated that she did not address this point during the incident because for her, it was obvious that Mr. A.'s wish was to be clean.
What skills and abilities could Mr. A. draw on to help him accept the toilet?	Fatoumata indicated that she had not addressed this point.

ADOPT THE RIGHT POSITION IN THE SUPPORT RELATIONSHIP WITH AN ELDERLY PERSON IN ORDER TO PREVENT VIOLENCE

ACQUIRING THE FUNDAMENTAL PRINCIPLES OF CARING SUPPORT FOR VULNERABLE ELDERLY PERSONS WITH REDUCED AUTONOMY

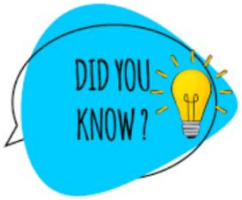
1. THE PRINCIPLES UNDERPINNING THE SUPPORT RELATIONSHIP BASED ON A PERSON-CENTRED APPROACH

A. The helping and supportive relationship: a relationship based on communications and reciprocal influences

The helping relationship – a definition

The helping relationship is defined as psychological support, whether provided professionally or not, most often taking the form of one-to-one conversations, for people under conditions of mental anguish or in need of support.

According to Carl ROGERS, the helping relationship is 'a relationship in which at least one of the parties has the intention of promoting the growth, development, maturity, improved coping with life of the other (individual or group)'.



In a care setting, the helping relationship is generally defined as *'the potential ability of a caregiver to induce any person in difficulty to mobilise his or her own resources to cope better with a situation – this is relational care'*. It requires a reciprocal commitment. It is based on trust and empathy. It is a relationship for therapeutic purposes, aiming to provide help for a patient, in the short term or for an extended period.

The purpose of the helping relationship is to bring the following to the persons being helped:

- a feeling of being welcomed and understood;
- clearer perception of their own situations and identification of their own needs;
- recognition of the meaning they ascribe to their cognitive and affective experiences, which alter their lives and result in some needs not being met;
- recognition of their abilities and shortcomings and discovery of internal or external resources;
- ability to initiate changes or to adapt to the situation.

Helping and support relationship

Supporting elderly persons means taking care of them. It entails getting to know them better in order to adapt the care and services provided to suit their individual needs and thus to implement a consistent approach to working with them.
It isn't necessarily a matter of spending more time with the person, but rather making better use of the time spent and more effectively sharing the information gathered about the person, between professionals.

This definition goes beyond the health vision to reconcile *cure* with *care*. These two words share the same original root, yet they have come to represent two different concepts. The first word refers to the concept of a technical action, whereas the second implies that the professional person is paying attention to the elderly person and seeing value in their interaction, in the little things of everyday life. Indeed, there is now a general expectation that any professional working in the health and social care sector will go above and beyond the vision of purely technical treatment or care procedures.
'To support someone means to walk with them, leaving the direction and the pace to the choice of the person being supported'. Abbé DAGENAIS

This approach is not concerned with making up for the person's deficiencies but with:

- drawing on their own resources;
- adopting an empathetic attitude rather than actually standing in for the person;
- focusing on positives and believing in one's own abilities;
- bringing out the person's independence and initiative;
- initiating – guiding – supporting.

Ethics in support or the ethics of care

We can associate this with *the ethics of Care* (Carol GILLIGAN).
The aim of the ethics of care is to provide support according to the following principles: attention to others, care, responsibility, thoughtfulness, mutual assistance, taking account of needs, relationships and specific circumstances, working and focusing on people's vulnerability and dependence. Thus, for example, when working with an elderly person who has Alzheimer's disease, or any other form of psychological or cognitive disorder that affects one's awareness of oneself and of the world, by continuing to perceive and consider them as a person when you address them, you are allowing affirmation of who they are as a person and at the same time preserving their dignity in your perception of them. It is therefore the relationships established between people that bring them that sense of being a person themselves as well as bringing out that same feeling in others.
Within a helping relationship, it is important to distinguish between the following principles:

Caring about: attention to needs Taking care of: responsibility Caregiving: skill Receiving care: ability to respond

Support with an ethical perspective allows the professional to:

- analyse their professional practices;
- bring meaning to their actions;
- find a better focus on the elderly person as a whole person in their own right;
- adjust their view of the person and their actions and behaviours toward the person.

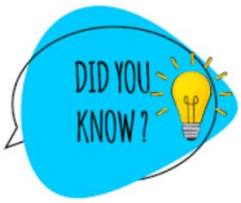
The professional must be guided by ethics on a daily basis in his actions and behaviours:

Reflection	⇒ Questioning one's professional practices when facing a dilemma
Positioning	⇒ Attitudes of the professional in relation to the problem
Decision	⇒ Searching for good practice – the 'fairest' and most respectable solution

B. The person-centred approach as proposed by Carl ROGERS

The principle of the approach

According to Carl ROGERS, the American psychologist, founder of the person-centred approach: 'the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, basic attitudes and self-directed behaviour; these resources can be tapped in only if a definable climate of facilitative psychological attitudes can be provided'.



This is an interpersonal relationship for the purpose of promoting growth, maturity and a greater capacity to face life by mobilising one's own resources.

The 5 facilitative attitudes at the heart of the person-centred approach

These facilitative attitudes at the heart of the person-centred approach are based on several essential components:

Congruence: this concerns professional caregivers and what they bring to the helping relationship. They need to know how to remain genuine, authentic and true to themselves, in front of the person being helped, with open expression, in their attitudes, of the feelings that motivate them, without hiding behind a mask.

Empathy: this requires one to put oneself in the place of the person, to understand their life and to feel their emotions, without identifying with their experience. This attitude provides comfort.

Unconditional positive acceptance: this means accepting the other person just as they are, as a human being with all their facets (qualities, faults, resources, limits, etc.). This requires building an atmosphere of acceptance, respect and trust, with a positive, non-judgemental attitude. The person being cared for is seen as a unique and free individual, capable of making their own decisions, even if help is sometimes needed for that process.

Presence: the relationship is first and foremost a presence to the other, 'being there' and available. This concept can be defined as the ability to be there physically and the ability to be with the person psychologically. It represents a combination of the strength that will generate confidence with the reassurance and gentleness required for a sympathetic and humane approach.

Attentive listening: this must be sympathetic and non-directive. It does not involve giving advice, expressing one's own ideas, or making interpretations, but instead entails creating conditions for the person to be able to solve their own problem and find their own solutions. Listening is active: the professional shows their level of attention, to help and encourage the person's development. It requires personal involvement. This active listening includes the technique of reformulation i.e., summarising the person's story, as well as silence at times.

2. CONSIDERATION OF THE ELDERLY PERSON AS A RESPONSIBLE, CIVIL-MINDED ADULT

A. The elderly person, a person who has rights, freedoms and expectations

Regulatory framework

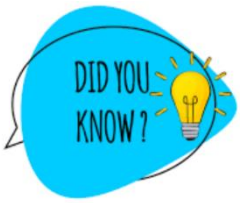
The protection of the fundamental rights of elderly people is based on a set of international and European texts (ratified by France) designed to protect all human beings and in particular the most vulnerable among them.
At European level, the elderly can avail themselves of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), which enshrines, in particular, the right of all persons to respect for their private and family life, prohibition of all discrimination, and respect for property.
The revised European Social Charter also affirms the right to health protection and the right of elderly people to social protection, including, for those living in institutions, the guarantee of appropriate assistance with respect to privacy and participation in determining the living conditions in the institution. These rights must be exercised without discrimination.

In French law, Law 2002-2 of 2nd January 2002, restructuring health and social care actions, sets out **fundamental principles**. It reaffirms the importance placed on the users themselves and intends to promote independence, protection of persons and exercise of their civic rights. In particular, Article 7, codified in Article L 311-3 of the Code of Social Action and Families, stipulates that *'the exercise of individual rights and freedoms is guaranteed for all persons in care in health and social care institutions'*.

It is thus specified that the person is entitled to:

- be treated with respect for their dignity, integrity, privacy, intimacy and security;
- come and go freely;
- free choice between the appropriate services offered to them, particularly in the context of admission to a specialist institution;
- good-quality personalised care and support, with respect for the person's informed consent;
- confidentiality of the information concerning the person;
- access to information about their care;
- information about their fundamental rights and the legal and contractual protections available to them, and about the means of redress available to them;
- direct participation in the admission and support plan.

Exercising these rights in practice



In order to ensure that these rights are exercised effectively and in particular ***to prevent any risk of abuse, the legislator has put various tools in place,*** intended to:

- inform the person of their rights (welcome booklet, operating regulations, charter of rights and freedoms of the person admitted for care, residence contract, institution plan);
- contribute to the operation of the institution (Conseil de Vie Social - Social Life Council);
- help the person admitted for care to defend their own rights (recourse to qualified person);
- strengthen controls and inspections to ensure good care;
- assist professionals in their practice using recommendations of good professional practice;
- evaluate the activities and services provided by the health and social care institutions.

The system used for the evaluation, with objectives defined in law, must take account of the following, in particular:

- the personalisation of support by continuous evaluation of the needs and expectations of the supported persons; the methods used to develop and update the personalised plan; the collation and circulation of information around the personalised plan;
- the guarantee of users' rights and participation through the effective implementation of rights in day-to-day operation; the process implemented to take account of collective expression; the practical organization for integration of friends and family and legal representatives.

Related tools

- *The Charter of Rights and Freedoms*

Each health and social care organization must issue a Charter of Rights and Freedoms in order to try to guarantee that the supported person can exercise their rights and freedoms, by affirmation of a certain number of fundamental rights and principles.

The rights set out in the Charter are intended to constitute references for good treatment in the care of the user because they are there to avoid any abuse.

Respecting the charter **means treating the user well by placing them at the centre of the care system**, taking account of their needs and individuality, and seeking to maintain or develop their independence, family relationships and social integration.

The principles of the Charter are as follows:

Article 1: Principle of non-discrimination (on basis of ethnic or social origin, political or religious opinions, disability, age, sexual orientation, etc.).
Article 2: Right to appropriate (and personalised) care or support.
Article 3: Right to information (about the care requested, the organization and operation of the institution, the form of care, any user associations working in the same field, etc.).
Article 4: Principle of freedom of choice, informed consent and participation of the person.
Article 5: Right to waive (or request a change in) services provided.
Article 6: Right to respect for family relationships (aiming to encourage maintaining of family relationships and to avoid separating families).
Article 7: Right to protection (respect for confidentiality of information, right to security including health care and food security, right to care, right to appropriate medical monitoring).
Article 8: Right to independence (subject to a court decision), right to freedom of movement, encouragement of visits inside and outside the institution, along with the possibility of keeping one's personal belongings and disposing of one's own assets and income.
Article 9: Principle of prevention and support (there are potential emotional and social consequences of care, the role of families or loved ones needs to be facilitated, the moments at the end of life must be given appropriate support with respect for the religious practices or beliefs of both the person and their loved ones).
Article 10: Right to exercise the civil rights attributed to the person admitted for care.
Article 11: Right to religious practice (and mutual respect for faiths, beliefs and opinions). This right is exercised provided that this does not entail disruption of the normal operation of the institutions.
Article 12: Respect for the person's dignity and privacy.

- *Welcome booklet*

The welcome booklet is a genuine information and communication tool for the elderly person. It is a brief document presenting the institution, given to the person on admission in order to facilitate their integration and to encourage informed choices regarding the use of services.

- *Residence contract and Individual Care Document*

The residence contract – or the Individual Care Document (DIPC) – formalises the relationship between the user and the health or social care institution or service. It defines the objectives and nature of the care or support in accordance with ethical principles, recommendations for good professional practice and the institution or service plan.

- *Qualified person*

The qualified person is an individual, appointed jointly by the representative of the State, the Regional Health Agency and the President of the Departmental Council, to support any person in the care of a health or social care institution and service, to advocate for their rights.

- *Operating regulations*

These regulations define the rights of the person admitted for care and the obligations and duties required to respect the rules of collective life within the institution.

- *Conseil de Vie Sociale (Social Life Council)*

This is a body elected by the residents and families of a health and social care institution in order to reinforce the rights of the residents. It promotes the expression and participation of residents and their families in the life of the institution.

- *Institution or service plan*

This plan defines the objectives of the institution or service, particularly in terms of coordination, cooperation and evaluation of activities and quality of services, as well as its

organizational and operational procedures. This plan is prepared for a maximum period of five years after consultation with the CVS or, if necessary, after implementation of another form of participation. It formalises the identity, values, organization, objectives and future prospects of the institution or service. It is an information tool for the users, and for supervisory and funding bodies and partners.

B. Focus on the dignity of the elderly person

The dignity of the human person is the principle that a person must never be treated as an object or a means to an end, but as an intrinsic entity. The person deserves unconditional respect, regardless of their age, gender, physical or mental health, social standing, religion or ethnic origin.

The right to dignity is now a fundamental right, with a set of deontological principles that combine professional requirements with respect for the elderly person as a human being. It is included in Article L. 1110-2 of the French Public Health Code (CSP). This covers recognition of both one's own dignity and mutual recognition of the dignity of others. The dignity felt by an elderly person depends on how they see themselves, especially if feeling threatened, but also on how they are viewed by others.

Hence the fundamental role that professionals play with regard to the elderly person who is both one of their fellow human beings and also a vulnerable person with a loss of independence. The latter will not always have the means to ensure they are treated with respect and to see themselves as worthy, as a fully competent person in relation to professionals and also to their loved ones.

Thus, the health professionals should *'carry out their work with respect for the person, for human life and dignity'* (French Code of Medical Ethics).
Dignity means reconciling privacy, confidentiality and respect for the elderly person in the actions of everyday life.

C. Focus on the civic rights of the elderly person

The elderly person is a civic in their own right, with their own history, which needs to be recognised in social and societal terms.

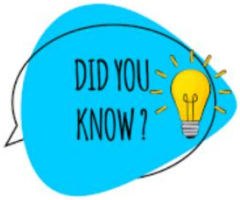
Regardless of their age, disability or health status, living environment, or standard of living, every person must have the following:

- the ability to express their civic rights;
- the benefits of officially shared and recognised rights;
- the ability to express their choices in every moment of their life;
- recognition in their participation in social life;
- the right to be listened to and to take part in decision-making for all matters that concern them.

3. ADAPTATION OF THE SUPPORT TO PROVIDE RESPONSES APPROPRIATE FOR THE ELDERLY PERSON'S INDIVIDUAL ABILITIES, NEEDS AND EXPECTATIONS

A. Knowledge of the elderly person to better identify and meet their needs

Data collection



Data collection takes the form of searching for, collecting and collating information from the elderly person or their family and friends in order to know more about them, to encourage their independence and to adapt the proposed support. This will promote the well-being of the elderly person who will feel heard and understood and will avoid frustrations or inappropriate behaviour.

This is a fundamental element to contribute to the process of defining, implementing and adjusting the person's personalised programme. The frequency for assessment of requirements must be adapted in accordance with any changes in the health condition of the elderly person or any other events.

The aim is:

- to offer personalised support that meets the person's needs, expectations and lifestyle habits;
- to help maintain their independence according to their capacities by mobilising their own resources and retained skills;
- to maintain their social life and define appropriate activities;
- to adjust their personalised plan continuously.

Data collection will therefore include the following information about the person:

- their life history/biography;
- their personality;
- their social, family and professional environment;
- their habits, pace of life;
- their past and present interests and preferences;
- health status and medical history;
- their needs and expectations;
- their satisfaction with the services offered;
- their religious beliefs and practices, etc.

Getting the elderly person to speak: encouraging speech on a daily basis

It is necessary for professionals to **include time** for the elderly persons to **express themselves** at various points in everyday life:

- during care procedures;
- at mealtimes;
- during group activities with the social life facilitator;
- during individualised mediation;
  with their loved ones; etc.

The key thing is to do this at regular intervals, so that the elderly person will identify them as possible moments for expression.

These various moments must be coordinated in a way that **facilitates the expression** of every person:

- some people will not dare to express themselves in a group, so one-to-one conversations in an appropriate environment need to be encouraged;
- some will be more stimulated by discussions with other people (family or friends, other residents, etc.), so a careful approach will be needed for questioning them if they do not express themselves or letting them pass the floor to others if the exchange is too focused on the expression of some people.

Professionals will need to summarise what they take away from their interaction with the elderly person before moving on (paraphrasing at handover). This makes it possible to check that there is agreement on what has just been said and sometimes to clarify or qualify it.

Team meetings should allow professionals to:

- bring up what has been said by the elderly persons;
- identify specific details, common points, recurring elements;
- ensure that the services provided are personalised and consistent;
- find the answers to provide.

This produces a more concrete implementation of the quality approach on a day-to-day basis.

The time for expression available on a daily basis must also be a time for feedback to the elderly on previous discussions: solutions found, the constraints of the institution, etc.

B. Consideration of the personalised plan, a tool to ensure that elderly persons have agency in their own individualised support

Principle

The personalised plan is **a dynamic approach to supporting the elderly person**, based on a compromise between their needs and expectations, the expectations of their family and friends, the feasibility for the professionals and the institution's plan.

The personalised plan must therefore:

- do everything possible to facilitate expression of the needs and expectations of the elderly person;
- be worked on jointly with the person, as much as possible, with the help of their legal representative where necessary;
- respect the person's informed consent, which must be sought systematically where the person is able to express their wishes and to participate in the decision; failing that, consent must be obtained from their legal representative.

This participation in their own plan is **a right for the elderly person, not an obligation**; on the other hand, it is **an obligation for the professionals** to invite the elderly person to participate in the various decisions that concern them.

In most situations, the people being cared for are in a vulnerable situation when they meet with a group of professionals. The latter must therefore be attentive to their needs in order to seek out, encourage and support this participation to ensure that it is effective.
Each supported person has unique expectations and needs that the professional will try to integrate into the personalised plan. It is produced by **a dynamic collaboration** between the elderly person (and/or their legal representative) and the professionals.

The personalised plan offers a way to clearly set out the terms of the negotiation in support between respect for the elderly person's freedom of choice and the institution's duty to protect them.

The implementation of personalised responses to individual needs

In order to avoid the risks of depersonalisation and standardisation that can be generated by organizational and functional logic, the law of 2 January 2002 emphasises **the principle of personalisation**.

To illustrate this point, we can recount the situation of a resident who explained her hygiene routine to a new caregiver, and was then told by the latter that, as a professional, this was something she knew how to do and did not need to be told how to do it. The resident replied, *'It's good that you know how to wash, but I'm going to tell you how to wash me'*.

This principle of personalisation will be expressed, as we have seen, by means of the personalised plan and the exercise of the individual rights and freedoms of the person, and more particularly the respect of their intimacy and private life.

In institutions, this reconciliation between collective life and individualisation focuses on three topics (Source: HAS Recommendations 'Reconciling collective life and personalisation of care and support'):

- **Intimacy, privacy and personalisation**
- **The individual within collective life**
- **The collective living context in its environment**

- *Intimacy, privacy and personalisation*
  The following are recommended:
  - personalising support for the elderly person by working with them to prepare procedures for intervention and care, by explaining the welcome booklet to them, which should be simple, accessible and welcoming, and by introducing them to the professional who will support them in the early stages;
  - respecting personal space, by facilitating the person's sense of ownership of their room, by confirming the privacy that it offers, by arranging it and by guaranteeing confidentiality of correspondence;

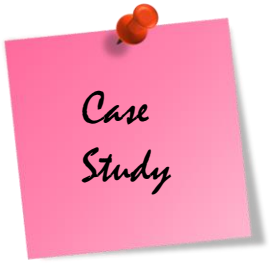
- respecting everyday life, with practical implementation of respect for intimacy in relation to care procedures and hygiene routines, protection of privacy and respect for confidentiality in relation to other residents, by facilitating visits and respecting their private character, by setting up an organizational structure and equipment to allow personalisation of individual domestic aspects.

- *The individual within the collective life of the institution*
  This second topic deals with the individual person within collective life, looking at:
  - collective everyday life – the layout of the space must allow different areas to be distinguished and identified to contribute to the way that the residents live together (better community cohabitation); mealtimes must be organized to allow for both group dining and meals eaten in private; the organization of getting up and going to bed, related to personal routines and lifestyle habits, must be personalised;
  - collective activities with specified content and group activity objectives, with proposed times for communication and interaction and activities that allow the residents to be more involved in organizing the collective life;
  - mediation in collective life by professionals, observing everyday life without being intrusive, by personalising their clothing, helping elderly persons to maintain their privacy, by being aware of how professionals address them, by supporting residents at transitional points in their daily routine, by ensuring flexibility in collective moments of conviviality, by talking through and explaining exceptional events for residents and by managing disruptions to collective life.

- *The collective living context in its environment*
  Finally, this last topic deals with the collective living context, considering:
  - overall organization and teamwork: development of guiding principles for the organization and definition of the operational outline, seeking to diversify modes of intervention and/or inclusion in a network, taking account of the size of the structure to organize the living units, clarification and specification of group compositions (similarity, diversity), setting up of meetings for the professionals to discuss and reflect;
  - development and communication of rules for collective life: identification of rules for collective life, arranging times for interaction and discussion around these rules and practical implementation of rights and freedoms, declaration of collective rules in a way that encourages empowerment of residents, support for their appropriation of these rules.

C. Analysis on a daily basis of the demand, expectations, needs and skills of the elderly person in order to offer them good quality appropriate support

This entails offering personalised support according to the **genuinely identified individual** needs of the elderly person. It should be noted that a person's needs will change regularly and that it is important to readjust their support according to their new needs.



Proposal of personalised support according to respective needs and expectations using the compass tool

Mr X. refused to eat, complaining that his food tasted bad; he objected to Julia, the caregiver, mixing his medication with his food. This practice was in place in Mr X.'s previous facility and was continued on the dual grounds that this lifestyle habit was included in the admission file and that Mr X. had difficulty swallowing when he took his medication with a little water. No one on the team had thought to question whether this practice suited this resident… until the point at which the resident objected suddenly and aggressively.

ITEM 1 / Analysis of needs and expectations	
Identification of aspirations or needs, desires, expectations, etc…	Physical needs: - Eating properly. - Taking his medication. Psychological needs: - Enjoying eating his meals. - Need to express his preferences and be taken into account.
Getting the elderly person to speak	Have I considered the unique individuality of the person? - [Julia] *'On one hand, I considered the risks of the possibility of food going down the wrong way.'* - [Julia] *'The practice of mixing medication with food had been continued and nobody had ever asked for Mr X.'s opinion.'*
Appreciation of what the elderly person says and their abilities	[Julia] *'I don't think personalised support could lead me to tell Mr X. that this is how it's been for years, that it's noted in his file and that we have to continue doing it this way.*' Which skills and abilities does Mr X. have that could be useful here? [Julia] *'Mr X.'s ability to express a choice or a wish clearly is a new element: it remains to be developed.*'
ITEM 2 / Understanding/verifying actual needs	
Understanding of his needs	Has the real need of Mr X. been correctly understood? How can I verify this?

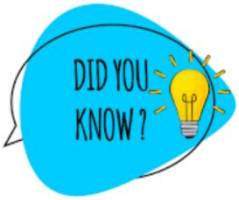
	- [Julia] *'I got Mr X. to do a blind tasting of the initial dish and the dish with the medication; the test was carried out several times and confirmed each time that he indicated that the dish containing the medication was bitter and not to his taste.'* - [Julia] *'I was guided by listening to the needs and wishes of Mr X. instead of by organizational constraints or current practices*.'
Objective verification of his needs	Have I considered the unique individuality of the person? - [Julia] *'I understand and hear what Mr X. is saying because this practice clearly does alter the flavour of the dishes*.' - [Julia] *'Did the weight of my personal representations influence my attitude? I didn't let myself be influenced by current working practices, nor by preconceptions about the situation.'* Has the person definitely made an objective choice? - Despite his speech deficit, Mr X. knows how to express his agreement or opposition (verbal and non-verbal expressions). - [Julia] *'Mr X. was able to express his wishes and preferences clearly to me; he nevertheless had to refuse food in order to be (finally) heard.'*
Appreciation of the value of the elderly person's abilities	Mr X. obviously has some tasting ability; moreover, his rather abrupt opposition to a practice that had taken place for a long time could represent a development and seems to offer an opportunity to be seized in order to increase *his power to make decisions and take actions*.
ITEM 3 / Collaboration on the personalised response	
Personalised support response proposed by Julia and the team: - Mixing the medication at the start of the meal with a small amount of stewed fruit with a strong enough flavour to cover the bitterness… Mr X. agreed and for a few days, Julia tested this method with him, trying several varieties of stewed fruit until she found one that suited him particularly. She proposed that: - This method of taking medication should be recorded and should be applied by all professionals for Mr X.	
ITEM 4 / Readjustment of support practices	
What other suggestions could be considered, based on the situation analysed?	

- Investigate other situations in which the burst of energy demonstrated by Mr X. could be used to envisage other achievements that would increase his independence (to be listed in his personalised plan).
- Rethink current medication dispensing procedures in relation to this practice and apply it with the aim of providing good care for the other residents.
- In future, when developing personalised plans, revisit and verify in greater depth that practices are definitely appropriate to the lifestyle habits taken from the admission file.

Source 'The Valorisation-ESMS Method: Thinking and acting differently in health and social care institutions and services' – Paul VEROT

4. EMPHASIS OF THE VALUE OF THE ELDERLY PERSON'S AUTONOMY IN EVERYDAY LIFE

A. Evaluation of their skills



The AGGIR grid is the French national reference tool for assessing the degree of dependence of elderly people. Measurement of loss of independence is used to determine the person's level of dependence (referred to as GIR for Groupe Iso Ressources – Iso Resource Group). This covers the basic actions of daily living with some other additional elements.

There are six GIRs classified from 1 to 6:

- Level 1 or GIR 1 corresponds to a total loss of independence;
- Level 6 or GIR 6, on the other hand, corresponds to complete independence.

Based on observations and a series of questions, the health and social care team completes the AGGIR grid and determines the **GIR group** to which the elderly person belongs.

The person in charge of the assessment, the observer, assigns an identifier (A, B, C) depending on whether the older person:

- A: does the action alone, correctly, completely, in the usual way;
- B: does the action partially, incorrectly, or not in the usual way;
- C: does not do the action.

The observer thus assesses **10 criteria related to loss of independence** in physical and psychological terms.

Only these 10 criteria, called 'discriminating variables', are used to determine the GIR:

1. Consistency: conversation or behaviour that makes sense;
2. Orientation: ability to get one's bearings in time and space;
3. Hygiene: one's ability to wash oneself;
4. Dressing: dressing, undressing, presentation of self;
5. Food: eating prepared foods;
6. Elimination: handling urinary and faecal hygiene;
7. Transfers: getting up, lying down, sitting down;
8. Indoor movement: spontaneous mobility, including with an appliance;
9. Outdoor movement: moving around from the front door without means of transport;
10. Remote communication: using means of communication, telephone, bell, alarm.

There are also grids and tools to use for observation of social skills as well as cognitive and memory functions, etc., such as the MMSE; IADL; NPI-ES, etc.
In addition to this ongoing assessment of the elderly person's abilities on a daily basis, the following elements should be added to the analysis of skills and potential:

- daily data collection;
- a process of asking questions of the elderly person and their family and friends;
- a process of active and continuous observation;
- written and oral handover communications.

B. Enhancing the sense of independence and participation of the elderly person

Independence or enhancing the sense of value of the retained abilities

The support must be focused on maintaining the person's independence. Independence is the capacity and the right of a person to make their own choices and decisions in respect of law and common practice.

It is important to distinguish between different levels of independence:

- ability to reflect on the situation and make a decision: decision-making capacity;
- ability to implement and execute one's decision: executive capacity.

We must never forget that each person is different and therefore has a different level of independence in the activities of everyday life. It is important to observe well in order to prevent failure, whilst insisting as much as possible that the person do the action him or herself.

The sense of independence will also be enhanced using physical aids and human assistance, and planning of the environment.

- *Independence with physical aids*

Appropriate equipment can allow the elderly person to continue to do things on their own. This equipment will compensate for reduction or loss of ability and thus allow the person to continue to do things on their own. Different types of equipment can facilitate many everyday tasks or actions:

- help with moving around, inside and outside: cane, walker, wheelchair, access ramp, etc.
- help with preparing and eating meals: cutlery with a large non-slip handle, assistive non-slip cutting board with nails, raised plate rim, glass with cut-out for nose, etc.
- medication assistance: pillbox, pill crusher and tablet cutter, etc.
- transfer assistance: hospital bed, lift chair, etc.
- hygiene aids: raised toilet seat, bath seat, etc.
- dressing aids: sock aids, long-handled grabber, bra dressing aid, etc.
- communication aids: hearing aids, big-button phones, etc.
- activity aids: weighted pen, giant cards, book holder, magnifying glass with light, etc.

- *Independence with human assistance*

Human assistance can provide support in everyday life for the elderly person experiencing loss of independence. Human assistance will provide help with or make up for what the elderly person can no longer do (or does not want to do) alone. The assistance will therefore help to encourage and motivate the person in the activities of everyday life.

Interaction will alleviate the difficulty by compensating for certain disabilities. It is based on enhancing the sense of retained potential by using the following professional approaches:

- OBSERVATION;
- verbal and active GUIDANCE (e.g., by taking the person's hand) depending on the type of disability;
- SUGGESTION but not imposition;
- ASSISTANCE/SUPPORT – not doing things in place of, but doing things WITH;

- AVOIDANCE of failure;
- EXPLANATION of actions;
- TAKING time;
- PROVISION of a graduated response appropriate to the level of independence.

- *Independence aided by the environment*

The environment will play a crucial role in the independence of the elderly person. The aim is to implement simple and comprehensive guidelines to facilitate the daily life of the elderly person. Some examples:

- Clear and simple signage to facilitate movements, and identification (pictograms, colour coding, large print, etc.) as appropriate to the abilities of the elderly person;
- Use of photos to create a familiar environment;
- Architectural design to create safe spaces: access ramps, grab bars, adapted lighting, contrast and colour schemes;
- Setting up of sensory cues: smells, sounds, textures…
- Installation of objects that facilitate reorientation of disoriented people…

Appreciation of the active participation of the elderly person

The accounts provided by elderly people, families and professionals about the practical details of active participation in the actions of daily life:

Participation occurs from day to day, in everyday life – a professional
Adopt a positive, appreciative attitude
'Placing appreciation on the retained abilities, not the failures'
'We talked about the dishes she loved to make'
'Using all the retained abilities instead of looking at what is missing' – professionals
Give the person time to do things for themselves
'Let those who can wash, and move do so themselves' – a professional
Encourage the person to express themselves with use of communication techniques such as open-ended questions, reformulation
'It feels good because you're being heard as a whole active person. It's knowing that people listen to us that makes us happy' – a resident
Helping people to understand: how the institution works, illnesses, etc.
'When we don't understand, we don't feel heard and then we tend to demand, to claim' – a family
Respect the person's own pace
'You have to adapt to the pace of the elderly person, be patient' – a professional
Adopt bodily positioning and posture to encourage interaction
'*I sat down next to him on his bed'* – a professional
'There are helpful postures: the way you smile, how you are with the person, putting yourself at the same level' – a professional
Respecting the person's choices in the helping relationship
'I put what the person wants first, that's the most important thing' – a professional
Get to know the person and see them in their entirety
'Not just her health issues but also seeing how she feels, what is important to her in life, her story' – a professional
'You need to encourage the person to "be", not "do". Make room for the person, consider them. Ensure that she remains a person' – a professional

Source: Promotion Santé Bretagne

C. Obtaining consent or agreement from the elderly person

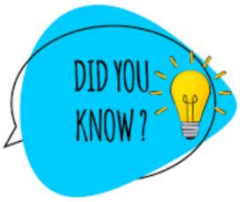
Consent

Definition

'Consent is the action of giving one's agreement, to an action, to a plan.'

Source Larousse

*Consent is **an agreement of intent**. It is a right based on information but also on the independence of the person, corollary to the principle of respect for the dignity of the person. When care is provided by any professional, this principle also ensures a relationship of trust.*
Forcing a person into care that they have not chosen is a serious violation of their individual freedom, except in cases expressly provided for by law.



Consent must be **'free and informed'**. This means that it must not be obtained under duress. The person must also give their consent after having previously received clear, complete, understandable and appropriate information about their situation from the professional.

Agreement

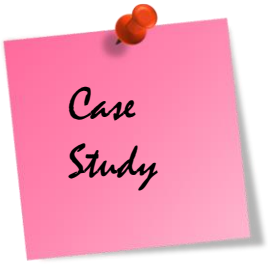
Definition

'Act by which someone expresses his support or his approval for an idea or proposition formulated by another person.'

Source Larousse

Adherence is relatively passive but nonetheless reflects adherence to a proposition that is explained and understood. The person does not object to the decision; they approve of it.

For a person who is elderly and, moreover, suffering from a neurodegenerative disease, it can be difficult to express their wishes. For this reason, the concept of **assent by absence of opposition** makes it possible to overcome this obstacle and to verify that, if there is not full agreement, then at least there is a lack of opposition. The difference between those conditions is subtle but very real. This has the merit of placing the elderly person at the heart of the decision-making process, whilst still taking account of their willpower, which remains capable of making decisions without giving full consent, nevertheless.



In your opinion, which professional attitudes and behaviours should be favoured in order to obtain the consent of an elderly person or the assent of a person with cognitive disorders?

D. Increasing the elderly person's power to make choices and decisions and to take actions

Focus on the concept of empowerment

The concept of *empowerment* corresponds to the basic idea that individuals have the right to participate in decisions that affect them. Empowerment is also based on the principle that the skills or abilities required to implement the change targeted by a social intervention are present in individuals, or at least that the potential to acquire them exists.

This term refers to a capacity for action as well as a process and seeks to support individuals so that they can acquire the power that they need.

The term power here refers to the ability possessed by an individual:

- to choose freely;
- to be able to turn a choice into a practical decision;
- to take action according to their decision, accepting the consequences.

The individual empowerment process is a personal development process that takes place in four different areas: **participation, skills, self-esteem and critical awareness**.
These four components interact with each other, each of them strengthening the others.
Indeed, the process of acquiring power at the individual level develops gradually.

In concrete terms, this concept aims to obtain the following benefits:

- having a good self-image;
- having a sense of personal satisfaction, self-efficacy;
- having a sense of internal control;
- feeling connected;
- being in a process of growth or development;
- experiencing hope;
- having a sense of social justice and an improved quality of life.

Procedure for implementation

This concept does not require any person, including those with impaired judgement, to have to face choices that could put them in danger or responsibilities that they cannot take on. It only involves taking the role of 'helping to make decisions' or 'teaching to make decisions', rather than 'making the decisions for the person', and also endeavouring to stimulate and encourage lifestyle choices and preferences, and then knowing how to respond to them.

The professional will need to ensure that value is given to the empowerment of the elderly person, by:

- favouring access to and use of the person's living space in accordance with their choices and pace of life, like any other citizen;
- valuing their experience, their experiential knowledge, in acts of support and care;
- encouraging them to participate in the activities of daily life in accordance with their retained abilities: partial hygiene and moving, help with meals, participation

in activities, gardening, DIY, etc.;
- valuing their expression despite their loss of independence;
- allowing them to receive personalised services that respect their choices, expectations and needs specifically;
- allowing them to decide on or refuse the services offered to them;
- allowing them to provide end-of-life instructions and living wills, with the certainty that they will be respected…

In my practice, how can I encourage an elderly person to take part in the activities of everyday life

	Actions to be carried out
Getting up	
Care procedures	
Getting dressed	
Meals	
Activities	
Travel	
Movement	
Bedtime	

5. ORGANISATION WHICH ADAPTS TO THE ELDERLY PERSON AND NOT VICE VERSA

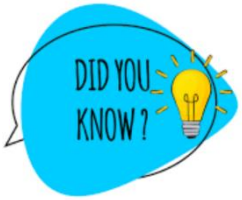
In France, the Caisse Nationale de Solidarité pour l'Autonomie (CNSA) advocates **the 'home-based' approach** to supporting elderly persons with loss of independence.
This consists in making a home as a principle regardless of where a person is actually living, in order to ensure full civic rights of the person.
It involves allowing each person in an institution to live in their own home, to be the master of their own place i.e., to define their own rules of practice and civility that apply to their private space, from access to organization of daily life, according to their own choices, preferences and aspirations.

The response to people's needs, according to this home-based approach, must take account of four major issues: **care, assistance and support, accommodation, and social presence.**
This is a matter of changing the perception from 'resident in care' to 'actively involved occupant' or from 'welcome to our home' to 'welcome to your home'. The practices of each professional must therefore evolve to take account of this aspiration: **home**.

PREVENTING THE ADOPTION OF HARMFUL ATTITUDES

1. THE DEFENCE MECHANISMS AND THEIR IMPACTS WITHIN THE SUPPORT RELATIONSHIP AND ON BEHAVIOUR

The term 'defence mechanism' was first used by Sigmund FREUD but it was Anna FREUD who ended up producing a whole book dedicated to the concept: 'The Ego and the Mechanisms of Defence'.
A defence mechanism is a defensive strategy that we tend to put in place without being aware of it, in order to escape an anxiety or an internal conflict.



The concept of defence mechanisms can be explained very simply: it is sufficient to replace 'mechanism' by **'reflex'** and 'defence' by **'protection'**.

Psychological defence mechanisms are a set of operations and strategies that are used to try to reduce or suppress any change that could jeopardise psychological well-being and integrity.

They are highly useful in everyday life and can be triggered in the event of:

- an unconscious impulse that wants to become conscious;
- a real or imaginary fear;
- an emotional outburst;
- a feeling of insecurity;
- a threat to integrity.

Defence mechanisms may have a large number of consequences for friends and family. They vary according to the defence mechanism(s) used.
For example, there may be:

- conflicts, disputes, disagreements;
- total devotion, excessive and inappropriate empathy;
- behavioural disorders, violence, irritability;
- isolation, withdrawal, etc.

Since defence mechanisms protect the psychological integrity of a person in accordance with their resources, they may be interpreted in different ways by the person's loved ones, who do not always understand them.

By identifying the defence mechanisms of elderly persons, of families and of the professionals involved, we can:

- improve communication in the helping relationship;
- improve understanding of the behaviours and attitudes identified as odd or inappropriate;
- prevent certain harmful and destructive behaviours.

The defence mechanisms of the professionals and/or friends and family in relation to the elderly person in the helping and care relationship

Lying	▪ The professional (or friend or family member) knowingly lies to the elderly person to avoid having to deal directly with their reactions. They retain the person's trust. ▪ The elderly person is living under an illusion and cannot start the process of accepting the situation.
Trivialisation	▪ The professional (or friend or family member) shows indifference to what the person says. They hide their emotional distress. This prevents them from feeling overwhelmed by emotion. ▪ The elderly person does not feel recognised or heard.
Side-stepping	▪ The professional (or friend or family member) does not enter into relational contact with the person, their response is out of step. This involves rejecting confrontation, avoiding having to accept their own distress. ▪ The elderly person feels helpless and their distress increases.
False reassurance	▪ The professional (or friend or family member) is too focused on making the best of the changing situation, talks too optimistically about things and gives the person false hope. ▪ The elderly person is out of step with reality.
Rationalisation	▪ The professional uses incomprehensible language, full of technical terms, preventing any genuine dialogue and providing no answer to the person's question. The emotional aspects are stifled behind logic. ▪ The elderly person does not understand, the relationship is strained, which increases their distress.
Avoidance	▪ The professional (or friend or family member) behaves evasively towards the elderly person (either physically, by not visiting them, or psychologically, by not paying any attention to them) in order to avoid having to deal directly with a difficult situation. For example, they never meet the person's eyes. The relationship is reduced to indirect and technical information. ▪ The elderly person experiences a sense of exclusion and loneliness.
Derision	▪ The professional (or friend or family member) does not communicate much and uses irony or cynicism. They cut themselves off from a genuine relationship and do not acknowledge the suffering, which is trivialised. They do this to distance themselves from their emotions. ▪ The elderly person withdraws into their distress, silence and solitude.
Rushing ahead	▪ The professional (or friend or family member) uses various tactics to avoid a frightening problem or situation. They do not allow the person to ask questions. ▪ The elderly person is stunned and their distress increases.
Projective identification	▪ The professional (or friend or family member) transfers their own emotions, reactions and thoughts onto the elderly person on the basis of a shared experience. ▪ The elderly person is under the illusion that their suffering is shared.

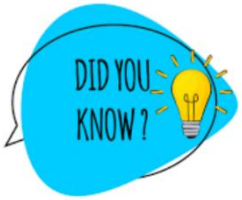
	They may feel guilty, or their distress may be increased if the suffering continues despite having followed the instructions given.

The defence mechanisms of elderly persons in relation to professionals or loved ones in the helping and care relationship

Repression	▪ The elderly person represses their desires, thoughts or disturbing experiences from their consciousness. Although inaccessible to consciousness, the repressed elements still remain active and are a relentless drain on mental energy, which can take the form of fatigue, inhibition, and a general depletion of the personality.
Refusal	▪ The elderly person has assimilated the reality but rejects and refuses it. They refuse to accept that what is being said has anything to do with them.
Denial	▪ The elderly person denies the reality of a perception experienced as dangerous, unbearable or painful (e.g.: denial of their illness or incapacity).
Aggressive projection	▪ The elderly person projects their distress in the form of aggression onto professionals or loved ones. ▪ They adopt demanding, even tyrannical, inconsistent and capricious behaviour. This may range from simple criticism to insults and even violence.
Regression	▪ The elderly person behaves like a child and does not use self-control, because they know that the professional or their loved ones are taking care of them. They lose independence. ▪ They will tend to ask for a lot more, using different emotional means to make people stay with them longer, to keep taking care of them.
Idealisation	▪ The elderly person attributes exaggerated qualities to himself or herself or to others. This process allows them to avoid having to face reality.
Isolation	▪ The elderly person talks about a sensitive subject accurately in detail, without emotion; they appear impassive, which impedes interactions.
Reaction formation	▪ An (unconscious) impulse that is unacceptable to the elderly person is transformed (in consciousness) into its opposite. As a reaction, the person will then manifest or adopt an acceptable behaviour that is diametrically opposed to their instinctive tendencies. For example, exaggerated kindness and altruism may represent a reaction formation against unconscious aggression.
Passive agitation	▪ The elderly person is unable to assert themselves in the relationship. With a passive-aggressive response, they try to mark their disagreement whilst giving the appearance of support.

There are many other defence mechanisms. There may be some of these mechanisms occurring in every stakeholder: the elderly person, the family or friends, and the professionals.

2. IDENTIFYING HARMFUL ATTITUDES



In the helping relationship between a professional and an elderly person, we can speak of an asymmetrical relationship because of the vulnerability and fragility of the latter, in particular due to their progressive loss of independence, loss of social status, isolation, institutionalisation, etc.
As a reminder, the concept of symmetry refers to the balance or similarity between two parts, while asymmetry refers to a lack of balance.
In their practice, the professionals may be led to adopt harmful attitudes that could reinforce the lack of balance in the relationship and lead to aggressive and violent behaviour.

A. Focus on certain harmful attitudes in the helping relationship

Infantilisation and 'elderspeak'

This attitude can be considered emotional abuse. It is an unconscious mechanism that nevertheless produces harmful consequences for the elderly person.
There may be multiple causes of this infantilisation, such as:

- cognitive impairments such as memory and perception disorders, slowing down of thinking and difficulties with problem solving;
- motor impairments that lead to a loss of independence;
- regressive behaviour by the elderly person, not corresponding to their age or their psychological maturity;
- the isolation and loneliness of the elderly person, which can lead to guilt or even pity;
- the emotional and family connections that make it difficult to maintain the 'right distance' with the elderly person.

Although language should be tailored to the elderly person's ability to understand, care should be taken to ensure that it is not too simplistic. **'Elderspeak'**, when used in the wrong conditions induces infantilisation: speaking too slowly, high-pitched voice, exaggerated intonation, replacement of pronouns (e.g., 'my', 'you', etc.), use of diminutives and repetitions ('my little lady', 'poor thing', etc.), inappropriate emotional language ('my lovely', 'my darling', etc.), stereotypes ('chief').

To the elderly person, this attitude is a sign of disrespect that reflects a belittling image of themselves. This places the professional and the elderly person in an unequal relationship. The elderly person becomes an object of care, a small fragile and vulnerable thing that needs to be mothered. This leads to a loss of independence, an impoverishment of oral expression, a drop in self-esteem and so begins the vicious circle.

It also represents a depersonalisation in the relationship that can result in aggression and violence. The University of Miami has shown that this infantilising attitude, and in particular 'elderspeak', can provoke a sudden and excessive reaction to an ordinary interaction, such as insults, shouting or an act of physical aggression towards the caregiver.

Power plays, manipulation, domination

Claude STEINER, an American transactional analyst, provides the following definition: *'a power play is a conscious transaction or series of transactions in which one person attempts to exert control over the behaviour of another.'*
It is therefore a behaviour or series of behaviours employed by the person to gain a hold or control over another person. A person thus tries to make the other person do, say, think or feel what they want them to do, say, think or feel, against their own will or without their knowledge.

This can appear at any time and in any type of relationship. Indeed, as soon as there is a dependency established between two people, there is a risk of power play. This attitude is opposed to cooperation and does not allow development of independence.

Power plays are the most classic manifestation of explicit or implicit manipulation. They create relationships of domination and dependency. The domination relationship emerges when, in a relationship between people with parity, one of them uses one of their attributes of power to dominate the other.
These attributes of power are conveyed mainly through the body or through words. Claude STEINER thus defines four power play modes, taking the form of three main manoeuvres: **intimidation (physical, verbal), manipulation, and prevention of thought**.

The modes of expression of power plays:

- subtle psychological: I use words to obtain submission, through innuendo, double meanings (ulterior transactions).
  Examples: calling someone by their nickname in an inappropriate situation; using less respectful terms to devalue someone; giving incomplete information; using one's status to put pressure on the other; denigrating; making people wait; shaming; frightening; interrupting the other person, finishing their sentence; pretending not to see someone; devaluing; constantly referring to the other person's mistakes; etc.
- subtle physical: I use my body or a spatial element to obtain submission.
  Examples: standing very close to the other person, invading their personal space; frowning; looking angry; making gestures indicative of strength; etc.
- crude psychological: I show clearly that I can use words to hurt, belittle, cause suffering.
  Examples: humiliation; blackmail; guilt; threats; insults; blatant lies; discrimination; innuendo; intimidation; racism; etc.
- crude physical: I clearly show that I can use force to hurt, to cause suffering, to cause fear…
  Examples: physical harassment; violence, hitting, slapping; terrorising; giving the finger sign; etc.

Lack of professional distance, lack of control over emotions

Professional distance can be defined as *'the moral and psychological limit on expression of personal values in the context of professional activity'*. This is a matter of finding the right balance between involvement and individual 'self-protection'.

A lack of professional distance can lead to excessive involvement of the professional, resulting in a lack of control of their emotions and professional exhaustion, but also in use of attitudes and words that may be harmful to the elderly person. This attitude arises when there is something about the situation of the elderly person that resonates with the experience and personal history of the professional. Also, when in the grip of their emotions, the professional loses objectivity and is no longer able to maintain professional distance.
On the other hand, excessive distance can be just as harmful to the elderly person because it can lead to a misunderstanding of their situation and what they are experiencing.

The professional must know how to identify their own emotions, because recognising them makes it possible to control them, to avoid ending up in an intense relationship. In order to avoid excessive emotion, it is important for the professional to be involved at an appropriate distance.

The right professional distance is one that allows good quality communication with the user and therefore attentive listening to their needs, but also to their distress. In order to establish a good professional distance, the professional must therefore have the 'right intention', i.e., the willingness to find a certain balance between what they want to bring to the other person and what the latter has the right to expect as the person being helped.

Key elements for the right distance:

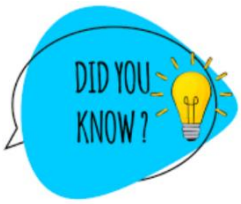
- Person-centred approach (technical intelligence versus sensitive intelligence), right intention
- Emotion is not absent but remains contained without being overwhelming for the professional (control of emotions)
- Identification of defence mechanisms in the relationship for a good balance
- Establishment of limits within the relationship: formalities, vocabulary, maintaining politeness, avoiding intrusion into the other's private life, rules…
- Use of proxemic communication (Edward T. Hall): intimate, personal, social, public space
- Clear framework for the professional: objectives, roles, tasks, boundaries, roles and tasks of other professionals
- Ethical approach (respect for expectations and refusals, consent, meaning of actions…)
- Acknowledgement of own professional limits to hand over if necessary

Judgements

According to Carl ROGERS, judgements do not encourage personality development. Therefore, they cannot be part of the helping relationship. He also raises the point that a positive judgement is as threatening as a disparaging one, since telling someone that they are doing the right thing implies that we also have the right to tell them they are doing the wrong thing. If we manage to maintain a relationship without value judgements, therefore, the person will be better able to realise that 'the place of judgement, the centre of responsibility resides within themselves'.
In the relationship with the elderly person, it is advisable to prohibit this attitude in order to ensure that their civic rights, their self-esteem and their self-determination is appreciated.

Cognitive bias

The theory of cognitive bias was developed in the early 1970s by psychologists Amos TVERSKY and Daniel KAHNEMAN.



A cognitive bias is a misleading thought pattern based on faulty logic. This form of thinking allows the individual to make a judgement or decision quickly. Cognitive biases influence our choices, especially when dealing with large amounts of information or when time is limited. A form of malfunction occurs in our reasoning.
Our brain interprets our environment through simplification, and forms stereotypes, prejudices, beliefs, and categorisations that we use to order the world around us. No one is immune to cognitive biases, which are most often unconscious. They act as a kind of reflex and can be linked to emotions – fear, anger, anxiety – or to thinking habits acquired long ago. They also meet the inherent needs of individuals: the need for security, self-esteem and social belonging.

They can lead to errors in perception, reasoning, evaluation, logical interpretation, judgement, attention, etc., and to inappropriate behaviours or decisions. They act as filters, as the person will only validate what goes in the direction of the filter. It is important for the professional to be able to identify or recognise cognitive biases in the relationship with the elderly person because, under time pressure, these could lead to a trivialisation of everyday situations, to reflex actions and to inappropriate responses in terms of support and care.

B. Identification of other harmful attitudes in the helping relationship to limit aggressive and violent responses

- Prohibitions, deprivations;
- Trivialisation, minimisation;
- Defeat;
- Substitution;
- Guilt;
- Things left unsaid;
- Failure to respect privacy;
- Lack of consideration, etc.

Identify harmful attitudes (by name) in the relationship with the elderly person that may trigger aggression

Scenario 1	*'Mr A., let me do it, you won't be able to button up your jacket'.*
Scenario 2	*'Morning beautiful, did you have a good night?'*
Scenario 3	*'You can't leave your room, or you'll get lost with your Alzheimer's disease.'*
Scenario 4	*'Aren't you in a good mood Mrs. X? It's nothing, it'll be better tomorrow. It's normal, it's old age. Come on … let's get you cleaned up quickly.'*
Scenario 5	*'I saw Mr. Z. come out of your room this morning!!! Supposing your son found out … what would he think?'*
Scenario 6	*'I'll bring you a yoghurt as long as you finish what's on your plate.'*
Scenario 7	*'Are you still watching that TV show? Come on, Mrs. P., you're not the right age for that!'*
Scenario 8	*'Come on, get up quickly Mrs. R. I've got plenty of other things to do, I've got to go and get Mrs. Grumpy washed in 114'.*
Scenario 9	*'Stop crying Mr F.! I'll be crying too because you remind me of my dad. I feel so sorry for you, my heart goes out to you. It's too hard what you're going through.'*
Scenario 10	*'Let it happen. You know you've got no choice, otherwise we'll have to use other means.'*

MANAGING FUNDAMENTAL ATTITUDES CONDUCIVE TO HIGH-QUALITY COMMUNICATION

1. THE BASICS OF COMMUNICATION

A. Concepts in communication

Communication, the expression of a fundamental need

Communication is an inherent part of human life. In order to achieve anything, at every moment of every day, human beings need to communicate. They often communicate through written or spoken words, but just as often with gestures, facial expressions, symbols…
Individuals cannot function without communication, nor can groups. At a basic biological level, communication helps individuals to satisfy their needs for food, shelter and safety. But individuals also need communication in order to fully develop their human potential; through communication, human beings develop and express their identity.

Communication and language: similarities or differences?

The communication system that relies on verbal or non-verbal codes, used to transfer information, is called **language**.
The way that a message or some information is exchanged between two or more people is called **communication**.
A language is a communication tool, whereas communication is the process of transferring messages between them.
Language focuses on signs, symbols and words. Communication focuses on the message.

In summary

LANGUAGE	COMMUNICATION
Communication system based on verbal or non-verbal codes used to transfer information	A way of exchanging a message or information between two or more people
Tool	Process
Signs, words and symbols	Message
Mainly in the ear canals	All sensory channels
Dynamic	Static

Communication and relationship

It is important not to confuse the concepts of relationship and communication: communication is one of the modes of expression as part of the relationship, it is a means through which relationships are built and developed.
No relationship can be strong without communication. Communication structures the relationship, brings development and transforms it in depth: without communication, the

relationship remains vague and implicit, and is therefore vulnerable to all subjective projections; the problems raised by what is unspoken. Communication can clarify or obscure the relationship.

A communicative relationship therefore includes verbal elements and subjective feelings but above all the connection established with the person. We must not forget that communication is a social link that allows the person to maintain their own identity. The individual remains a communicative being, above all, until the end of their life.

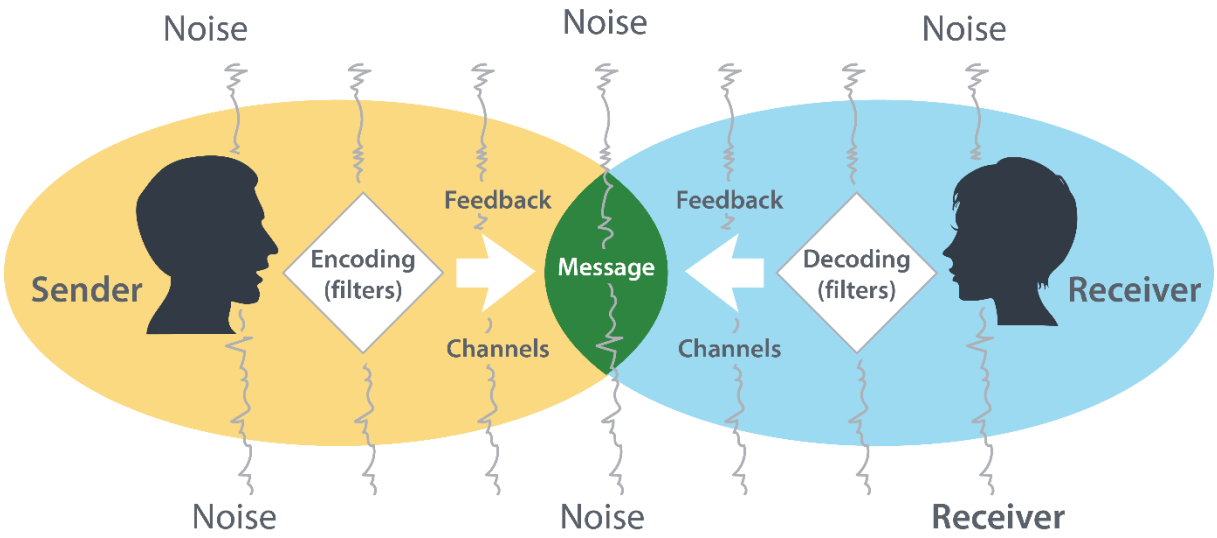
In summary

RELATIONAL	COMMUNICATION
Concerning the relationships between individuals	All the physical and psychological processes that form part of the operation of forming a connection between one or several persons (sender) and one or several persons (receiver), in order to reach certain objectives

B. Communication mechanisms and function

Communication and its mechanisms

The communication system



The sender: this is the one who sends the message, who writes, who speaks, who sends the information.
The receiver: this is the one who receives the message, who reads it, who hears it, etc.
The message: this is the information sent according to a certain form, what is written, what is said.
The referent: this is the subject of the message, what we are talking about.
The channel: this is the means of transmission, by vision or sound, used to establish the connection between the sender and the receiver.

- 5 sensory channels: vision, hearing, touch, smell, taste

- The channels most used in communication: vision and hearing
- The channel may be scrambled

The code: this is the system of signs used for composing the message.
Encoding/decoding: this is the encryption and decryption of the code used, in accordance with shared standards and also its specific filters.
Noise: this is anything that disrupts communication.
Feedback: this is the possibility for the receiver to respond to the sender (a concept derived from the work of Norbert WIENER). The receiver is no longer passive but becomes active, and in turn becomes a sender. Some communications do not allow for feedback. The receiver remains passive. An absence of feedback can sometimes lead to the end of communication.
The context: the setting within which the communication takes place. A distinction is made between spatial context (the place where the communication takes place) and temporal context (the time when the communication takes place).
The situation in which the communication takes place influences the actors.

A message follows a long path. At every step, information can become lost or distorted.

SENDING THE MESSAGE →			**RECEIVING THE MESSAGE**				
Intention	**Expression**		**Sending**	**Perception**	**Under-standing**	**Acceptance**	**Memorisa-tion**
What we mean	What we say	How we say it	What is sent	What is heard	What is understood	What we want to understand	What is retained

Communication and its challenges

According to Alex MUCCHIELLI, professor of information and communication sciences, there are five types of communication issues in particular:

- information issues: communication is an act of information;
- identity positioning issues: communicating means positioning oneself in relation to the other;
- issues of influence: to communicate is to exercise influence on others;
- relational issues: communicating is an act of giving form to human relationships;
- normative issues: communicating entails proposing a set of standards and rules that will support exchanges.

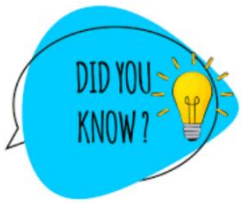
Communication issues for the elderly person:

- Maintaining the social connection
- Supporting a therapeutic action
- Source of self-confidence, respect and consideration
- Prevention of behavioural disorders
- Help with care procedures
- Maintaining one's independence

C. A communication but multiple types of communication

Verbal, paraverbal and non-verbal communication

We communicate through language, but also through non-verbal means. According to Albert MEHRABIAN, verbal communication represents only 7% of the impact of our communication. Paraverbal communication has an impact of 38%, and non-verbal has an impact of 55%.



Types of communication

VERBAL	PARAVERBAL	NON-VERBAL
Vocabulary is essential, choosing the right words is important to give the desired meaning.	Paraverbal communication is the flow of spoken words.	Non-verbal communication is body language.
▪ Choice of words ▪ Vagueness and clarity ▪ Language level ▪ Sentence structure ▪ etc.	▪ Articulation ▪ Diction ▪ Voice volume ▪ Timbre ▪ Speed (slow/fast) ▪ Rhythm (fluid/jerky) ▪ Amplitude (high/low) ▪ Pitch (high/medium/low) ▪ Tone changes ▪ Hesitations ▪ Pauses ▪ Silences ▪ Noise words ▪ etc.	▪ Attitudes, postures ▪ Movements, gestures, micro-movements ▪ Facial expressions: expressions, movement of eyebrows, lips, nostrils, eyes, gaze ▪ Breathing, swallowing ▪ Muscle tone ▪ Perspiration ▪ Appearance (clothes, hairstyle…) ▪ Sign language ▪ etc.

Characteristics of non-verbal communication

Verbal language is conscious whereas non-verbal language may be unconscious.
Indeed, we sometimes communicate non-verbally without being aware of it. There are involuntary gestures such as: blushing, blinking, shrugging, sighing, rubbing one's earlobe, etc.

Non-verbal communication refers to any interaction or discussion that does not use speech or words. In other words, it represents body language. Deciphering an individual's body language calls for subtlety. Our eyes are used to focusing on the obvious. It involves observing the body as a whole as well as certain details such as our gestures.
Although verbal communication is limited to the words and syntax used, there is a very wide variety of non-verbal communication, which makes it extremely complex but also powerful.

In order to decode non-verbal language and to be attuned to the person, it will be necessary to observe the expression of signs sent, because they hold value as language:

- Postures
  - Position of the body, the head, the bust, the way of walking, of standing up, of sitting down, of lying down, etc.
- Gestures
  - Movements of the hands (crossed, open, clenched…), fingers, legs, feet (stamping), the touch of the hand (brisk, tender…)
- Looking
  - Fixed, shifty, blank, absent, anxious, frank, sparkling, encouraging, mocking, etc.
- Facial expressions
  - Frowning, wrinkling of the forehead, grimaces, etc.
- Autonomic manifestations
  - Changes in skin colour (turning pale, going red, etc.), sweating, breathing, swallowing, etc.

Implicit/Explicit communication: what we say and what we mean

All communication has two levels of message:

- The explicit: this is the content of the communication (information sent, advice or orders given, requests made);
- The implicit concerns the communication relationship: all the information (verbal and non-verbal) that says something about the communication relationship itself.

In summary

EXPLICIT	IMPLICIT
▪ What is stated completely and cannot be disputed. ▪ What is expressed completely and clearly without leaving any room for ambiguity.	▪ What is not stated formally but arises naturally from something.

D. Communication conditions

Delays or barriers to communication: better identification of these means we can avoid them more effectively

Communication is a difficult act insofar as there may be, at each stage of the process, a certain number of disruptions – barriers or delays.
It is essential to be aware of these various problems in order to reduce or eliminate them, so that the message thought up by the sender can be understood well by the receiver.

Here we note a few possible delays or barriers linked with:

- people: problems with expression and comprehension, assumptions, interpretations, poor wording or choice of vocabulary, inappropriate relational attitudes, lack of time, etc.;
- the environmental setting: disruptive noises, interference, places, etc.;
- the type of communication used: unsuitable communication type for the person in terms of their capacities for comprehension and expression;
- the situational context: inappropriate communication, poorly chosen for the situational context, etc.

2. COMMUNICATION AND ELDERLY PERSONS

A. Communication and ageing

Communication and normal ageing

Verbal skills are generally retained in the ageing process, but communication may be altered:

- Sensory deficits (vision, hearing) make communication difficult and lead to comprehension disorders;
- Memory and language are dependent on other cognitive functions, for example, attention, which may be impaired in ageing;
- The emotional and relational dimensions are also to be taken into account. For example, a person who is depressed will tend to be isolated and therefore to limit their social and emotional connections.

During ageing, difficulty in finding words and problems with comprehension are directly related to attention issues and to an unfavourable sensory context.

Communication and forms of dementia

Dementia pathologies cause cognitive, psychological and/or behavioural disorders, altering relational life and independence in the actions of the everyday life of the sick person.
Inevitably, memory and language disorders (aphasia of expression and comprehension) have an impact on the communication abilities of the person with Alzheimer's type dementia.

- Memory disorders have a considerable influence on communication because the patient is not in the same chronological time frame as the person they are talking

to; they are spatially present but temporally out of step. Impaired working memory leads to losing the thread of conversation. However, the efficiency of procedural memory allows for verbal and non-verbal reflexes to be produced until a very advanced stage.

- Various cognitive disorders affect communication: attention problems prevent one from following a conversation, especially in a group; judgement and reasoning disorders often make words incoherent; lack of planning weakens communication initiatives.

- Psychobehavioural disorders, including depression and anxiety, are also detrimental to communication. Depression can lead to withdrawal and apathy about communication. Anxiety can cause aggression and verbal stereotypy.

- Gnostic disorders have various consequences. Auditory agnosia leads to difficulties in verbal comprehension and prosopagnosia can create inappropriate attempts at communication.

- Extrinsic factors also influence patients' communication: these concern the contact, the context and the setting.

For people with forms of dementia, verbal deterioration occurs gradually: it usually begins with problems finding words, invention of new words and almost always leads to some form of aphasia. Sometimes they suffer from jargonaphasia, and their speech becomes confused and incoherent with no obvious linking of ideas, losing any value as an understandable message.
Often, while verbal communication has disappeared, non-verbal communication continues. It then plays a significant role in maintaining interaction, in terms of both expression and understanding. Indeed, sometimes, gestures, expressions and looks can reinforce or even replace speech. It has been shown that elderly people with forms of dementia use more non-verbal actions. However, it has also been demonstrated that the progression in dementia induces a significant quantitative reduction in all types of non-verbal acts, with disorders concerning aspects such as speed, intonation and pauses. The absence of intonation, for example, would result from a difficulty in modulating the speech. Concerning the pauses, they often appear in place of a word.

Concerning gestural communication, this appears to be retained relatively well and to remain effective. The eyes seem to play a role until the most advanced stage of the disease. Indeed, studies have demonstrated that elderly persons affected by forms of dementia, in the severe stage, retain a sensitivity to eye contact.

B. Evaluation of expressive and receptive communication is a prerequisite

It is advisable to carry out an assessment of the elderly person's communication skills for expression and reception, in order to adapt and diversify the proposed mode of communication.

This will be carried out by the multidisciplinary team in everyday situations and more formally by a speech therapist.

It will include:

- verbal and non-verbal communication skills;
- language-related functions;
- level of visual integration;
- social interaction skills, etc.

There are various communication assessment tools, including the Communication Ability Assessment Chart (CAAC) for people with Alzheimer's disease or a related disorder.

3. USE OF HELPFUL AND FACILITATIVE COMMUNICATION WITH THE ELDERLY PERSON

A. The principles of active, empathetic listening

Some active listening techniques to use with the elderly person so that they feel understood and heard

Communicating is, first and foremost, knowing how to listen: listening and hearing.
Active listening, developed from the work of Carl Rogers, the American psychologist (precursor of non-directive techniques), consists of listening to the other person attentively and in a non-directive way, establishing trust, respect and empathy with the person you are communicating with so that the latter can express themselves freely, without fear of hasty judgement and without pressure. It is very useful in the helping relationship.

Stepping too far back, being insensitive to the person you are communicating with, or repeating things mechanically does not encourage a proper interaction and understanding.

Some active listening techniques to use with the elderly person so that they feel understood and heard

Active listening will allow elderly persons to feel heard, accompanied and supported. Beyond a simple reformulation, it brings an essential emotional release.

TECHNIQUES FOR USE BY THE PROFESSIONAL	EFFECTS ON THE BEHAVIOUR OF THE ELDERLY PERSON
▪ Adopt physical attitude indicating availability (open face and posture)	This shows the elderly person that the person they are talking with is open and available for discussion
▪ Adopt an attitude of neutrality and kindness ▪ Show empathy	This allows the person to express their feelings freely without filters and prejudices
▪ Allow the person to express themselves without interruption ▪ Practise active silence ▪ Respect their pace	This shows respect and consideration and builds up their esteem. They feel listened to and trusted.
▪ Ask open-ended questions ▪ Encourage the elderly person to clarify their thoughts when they are vague or too general ▪ Give regular visual and verbal signs of interest (nodding, making eye contact, agreement, trampoline/bouncing back sentences, etc.) ▪ Help the conversation along without introducing any ideas of your own (avoid giving any advice or attempting any interpretation)	This opens up the dialogue and encourages the speaker to express themselves by giving more explanations.
▪ Use the elderly person's words in reformulation (repetition of key words)	This shows them that the person they are talking to is paying attention to what they are saying and has understood correctly, avoiding misinterpretations
▪ Paraphrase what the elderly person says in your own words	This allows you to emphasise what they have said, to reflect back to them the meaning of what they have said

B. Use of questioning and reformulation techniques to facilitate the speaker's expression and understanding

Different types of reformulation

Reformulation consists of reflecting back to the speaker what they have just said, with a focus on:

- understanding of the message;
- the perceived emotional content.

This facilitates the elderly person's expression, as they feel heard and understood, and ensures that you have understood them well, by repeating some of their words or certain key words.

There are several types of reformulation:

- *Echo* reformulation

This takes the form of repeating the words of the speaker word for word to use them … like a parrot! Initiators: *'I'm hearing'* / Repetition of key word…	Example: *I've got my osteoarthritis which is giving me pain.* [Reformulation] *I hear that your osteoarthritis is giving you pain.*
This shows that you have listened and are empathetic. It can also be useful to help the conversation along without interfering by using the speaker's own words.	

- *Reflection or mirror* reformulation

This method involves using other words of your own, as a paraphrase, to reformulate those of your speaker to make sure that you have understood what you are hearing. This takes the form of paraphrasing. Initiators: *'If I've understood correctly… / In other words… / According to you… / You meant that…'*	Example: *I refuse to eat lentils. I hate this.* [Reformulation] *If I understand correctly, you refuse to eat lentils because you don't like this dish.*
This is feedback, verifying the information, which allows us to establish whether we have correctly understood our speaker. It also allows them to hear what they've said in a different form, to make changes to it if necessary and it encourages them to speak.	

- *Clarifying or elucidating* reformulation

This technique aims to obtain clarification of what the speaker has said, to remove ambiguity, to move towards concreteness and precision, by getting the speaker to clarify their thoughts. This involves going beyond what has been said, by using what you have understood between the lines or deduced. Initiators: '*In other words, … / So, basically… / So, you think that… / If I understand properly what you're telling me, …'*	Example: *It's hard for me to move around my house and to climb the stairs. It's not right for my situation anymore. I'm looking at possible solutions with my son.* [Reformulation] *So basically, your home is no longer suitable for your abilities. Are you planning to leave it?*
This leads the speaker to respond, to clarify their thoughts, and it offers a new point of view to get them thinking.	

- *Summary* reformulation

This involves identifying the essential elements of a conversation. It is very useful for keeping track and refocusing some of what has been said. It allows you to validate a step or reiterate a point, clarify the discussion and initiate a new starting point for the conversation. Initiators: '*So you want to… / So to sum up… / So basically… / If I've understood you correctly… / In a nutshell…'*	Example: *I can wash myself without help. I'm used to it. I've got a grab bar in my bathroom. I've got a non-slip mat put down in the shower. I get my clothes ready…* [Reformulation] *So basically, you want to do your own hygiene routine, because you've got the physical aids you need and you're well organized. [New starting point] Is it*

	important to you that you manage this by yourself?
This allows you to refocus what the speaker has said on the most important elements of the conversation.	

- *Reverse or deductive* reformulation

This is completely deductive but without interpretation. It reverses the presentation of the subject but without distortion. It is very useful to get your speaker to take a bit of a step back when they are wound up in a feeling that has them trapped. This technique can make them see a different side to what they have just expressed. This reformulation also begins with careful language and is used with a questioning tone.	Example: *I'm sad. My daughter's going down south this weekend.* [Reformulation] *You mean she won't be able to visit you and you're going to be alone this weekend?*
This aims to raise the person's awareness by helping them to express their real feelings, needs and requests.	

The art of asking questions

Asking questions is very important in the helping relationship. It will encourage the elderly person to express themselves; identify their needs; feel valued; optimise cooperation, etc.

- **The open-ended question**: this prompts expansion. For example: '*where would you like to go for a walk?'.* The elderly person is invited to elaborate on their point of view (for those who still have good cognitive abilities).
- **The closed question**: this requires a yes or no answer. For example: *'do you want to go for a walk in the park this afternoon?' YES/NO* (for elderly persons with cognitive impairments).
- **Multiple choice question:** this offers a choice, e.g. *'Do you want to go for a walk in the park or go to the activity room?'.* This is the only type of question where it is necessary for the professional to use their own individual point of view to suggest the initial options, but to which they add '*or something else'*.
- **Reformulation:** the sentence is constructed grammatically in an affirmative way but the non-verbal communication is slightly questioning. The affirmation validates what the speaker has said; the slight questioning gives them the opportunity to refocus their words to improve understanding. Reformulation is a special case of a closed question. This is a major tool in the helping relationship (previous techniques).
- **'Why':** asking why (even without conditions or an obligation to answer) is tricky. This is a question that is even more open than the open question. It asks someone to directly give us the grounds for their thoughts (usually not instantly accessible). This is not recommended for use with people who have communication disorders.

In summary

TYPES OF QUESTIONS	Open	Closed
Neutral	▪ Question requiring a thought process with output of information (explanation) and/or opinions.	▪ Question for clarification and/or with binary type informative answer (yes/no). *Preferred option for use with people suffering from cognitive disorders.*
Induced	▪ The answer is contained in the question.	▪ Misleading question, often a trap.

C. Verbal/non-verbal communication techniques to maintain the communicative connection, to encourage the speaker's expression

Good use of speech to facilitate the understanding of the elderly person

- Vocabulary and choice of words
  - Simple, familiar and suitable for their comprehension skills
  - Positive and active (empowering, encouraging…)
  - Use of the same words for repetition
  - Respectful semantics for the elderly person*: not demeaning or infantilising
  - Expressions to be avoided that could be misunderstood, misinterpreted
  - Technical vocabulary to be avoided

***THE POWER OF WORDS**

If words hold meaning, they also hold intention, responsibility, and even ethics, arising first and foremost from the choices that have been made. Because they act directly on the mind of the person who receives them. They can generate positive behavioural manifestations (motivation, joy…) or negative ones (violence, aggression, withdrawal…). These choices are all the more important with elderly people in vulnerable situations, and with loss of independence. The professional will need to use the right words to avoid any discrediting or discouraging of the elderly person. Examples:

Words to be banned	Words to be preferred
Pad	*Protection*
Patient hoist	*Person Hoist*
Bib	*Adapted serviette*
Washing	*Hygiene*
Giving food	*Helping with meals*
Taking	*Accompany*
Dementia, losing one's mind	*Cognitive disorders*
Granny, my lovely	*Mrs./Miss/Ms.*
We	*I*

- Structuring of speech
  - Short simple sentence without giving too much explanation

- One message at a time
- No double meaning

- Vocal power
  - Ensure that you adapt to a face-to-face context
  - Avoid talking too loudly (feeling of aggression or domination)
  - Risk of damaging the communication relationship

- Tone
  - Avoid using a monotonous tone
  - Modulate your voice to ensure that the person feels that you are asking for their attention, so that they remain attentive

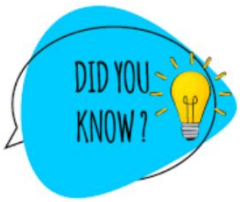
- Speed
  - Speaking at moderate speed, not too slow or exaggerated, not too fast

- Articulation
  - Essential to ensure speech is clear

- Pauses and silences
  - Regular pauses between each sentence to facilitate assimilation of the message
  - Knowing how to accept silences (which allow the person to integrate and assimilate what they have heard and to express themselves in turn if they wish)

Synchronisation techniques to reassure and relate to the elderly person

Synchronisation is a term used in NLP (Neuro Linguistic Programming) and in Ericksonian Hypnosis to designate a set of behaviours, postures, ways of speaking and being, conducive to excellent quality of communication. It involves moving and speaking in the same way as the person in front of you, without falling into the caricature of mime.



Synchronising with each other therefore entails adopting the communication mode of the other person, or at least something close to it. It's a way of getting on the same wavelength as the other person. Synchronisation helps to establish a climate of trust and security in the relationship and to facilitate communication.

In practice, it suffices to mirror the person i.e., to establish a symbiosis with our speaker at the various levels of verbal, paraverbal and non-verbal communication and internal state. The other person will subconsciously spot commonalities.

Synchronisation mode	Synchronisation techniques
Verbal	▪ Identify the main VAKO channel (visual, auditory, kinaesthetic, olfactory). For example: *'I can see what you mean'* (visual channel) ▪ Adapt to the person's level of language ▪ Repeat a few words that come up often
Paraverbal	▪ Adopt the same paraverbal communication modes as the person, in terms of the tone of voice (low, high), the speed of words, the volume, the rhythm, the pauses for breathing
Non-verbal	▪ Copy their body language: body position, movements, gestures, breathing, facial expressions (look, smile), etc.
Internal	▪ Synchronise with their emotions, their mood

This technique of 'mirror synchronisation' is used in Naomi FEIL's Validation® method to allow the professional to enter into the emotional world of the person with cognitive disorders. It is used to build trust with them when they are no longer expressing themselves verbally, in order to prevent them from becoming completely withdrawn. To do this, the professional mainly uses the non-verbal mode, by carefully observing the attitude, eyes, facial expressions, lower lip, general appearance, repetitive movements, etc. of the person with dementia. The professional then tries to match their own attitude, gestures and breathing to those of the other person for validation.

Techniques for enhancing self-worth

- *Positive reinforcement*

Positive reinforcement is a method used to create, maintain and/or induce appropriate behaviours. This is widely used in work with young children and in work with people with disabilities. In the helping relationship, it aims to encourage and enhance the person's sense of their value.
The idea is that the more we communicate positive images to someone, the more this person feels confidence in us and wants to maintain this image. It can therefore only serve to strengthen the relationship. A compliment boosts our self-esteem and encourages us to do more.
I enhance the person's sense of self-worth by using the positive, I put emotion (joy) into validating them, with 'you can be proud of yourself, bravo, …'.
It is important to ensure that reinforcements are authentic and grounded.

This reinforcement may be based on:

- verbal communication (compliments, encouragement, appreciation…);
- non-verbal communication (smiling, nodding, waving…);
- actions or attitudes (rewards, privileges, time spent with the person…);
- aids, such as objects, images…

- *Strokes* or signs of recognition

One of the primary needs for every person is to feel recognised, either physically (by gesture) or verbally (by kind words). To satisfy this need, Eric BERNE, the founder of Transactional Analysis, uses the term *stroke*, to designate a unit of recognition.

Classically, there are two forms of signs of recognition: the conditional sign and the unconditional sign, which may be positive or negative.

TYPES OF STROKES	POSITIVE	NEGATIVE
Conditional These signs relate to actions, behaviours, doing things	*Mr. X, you've made a good choice with this jumper!*	*You haven't buttoned your shirt.*
Unconditional These deal with being, with what the other is	*You're always elegant!*	*You're not good at it!*
Impacts on the person's behaviour Self-confidence Relationship Performance	Gain Encourages Improves	Loss Destroys Reduces

In the helping relationship with the elderly person, it will be important to encourage positive strokes while identifying the negative strokes in their attitudes and behaviours that can obstruct the relationship.

The contribution that non-verbal communication makes to verbal communication in the helping and care relationship

Verbal/Non-Verbal Communication reference sheet

Verbal communication
1. Begin each conversation by naming the person, identifying yourself and explaining the purpose of your visit.
2. Avoid any vague or ambiguous terms.
3. Use simple sentences.
4. State instructions one by one.
5. Avoid using negative wording or the imperative.
6. Accept that you will not always understand everything and observe the non-verbal communication of the person being helped.
7. Rephrase if necessary, to ensure that you are understanding.
8. Do not correct the person if they use inappropriate words.
Non-verbal communication

1. Ensure that you adopt an open attitude.
2. Take account of any hearing or visual impairments.
3. Pay attention to your own non-verbal communication:
    - Tone of voice (empathetic);
    - Capture attention with your eyes;
    - Adapt the gesture to your verbal message.
4. Be sure to communicate with the person in a soothing environment (avoid noise, excessively bright lights, etc.).

Verbal communication	Non-verbal communication
ATTENTIVE LISTENING ▪ Ensure that the person understands that we care about them. ▪ Show authenticity. ▪ Accept silences. ▪ Do not monopolise the conversation, instead try to listen and ask questions alternately. ▪ Use reformulations to make sure you understand each other. ▪ Encourage the expression of feelings. ▪ Show that you understand without judgement.	**OBSERVING** Listen with all senses. During the interactions: ▪ Limit disruptions (noise, light, place not conducive to confidentiality, etc.). ▪ Adopt a complicit attitude. ▪ Use appropriate gestures for the verbal communication. **EMPATHETIC ATTITUDE** ▪ Try to be as close as possible to the person empathetically in order to understand them without identifying with them.

COUNTERTRANSFERENCE ANALYSIS

- Develop attention and vigilance in order to remain objective and not subjective.

4. USE OF ALTERNATIVE COMMUNICATION ADAPTED TO COGNITIVELY IMPAIRED ELDERLY PERSONS

A. Adopting a variety of communication tools

Communication difficulties can be frustrating both for the person trying to get a message across and for the person receiving it. It is therefore not uncommon to see a blatant reduction or total cessation of communication when one or other of the speakers shows little or no indication that they are listening and/or understanding. This is the case, for example, for people with cognitive disorders.

It is essential to maintain communication with these people. A large number of communication tools is definitely needed to ensure that communication with elderly people is maintained. It will be necessary to find the right balance between touch, speech and attitude. This is achieved by sharing moments or activities that stimulate communication. There are different approaches that combine verbal, non-verbal and emotional communication.

B. The approach using looking, talking and touching according to GINESTE-MARESCOTTI's Humanitude® methodology

Premise

Because of their cognitive disorders, the elderly person with dementia will be particularly sensitive to paraverbal elements (the intonation of the voice for example) and non-verbal elements of the relationship (such as the attitude of the professional and the way they use touch). If the professional has an inappropriate attitude, their gestures will be misinterpreted, and the ill person will experience them as an intrusion. This will have the effect of reinforcing their behavioural disorders, including their aggression.

The Humanitude® care methodology was developed by Yves GINESTE and Rosette MARESCOTTI to prevent these behavioural manifestations and to encourage a positive interpretation of care.

Use of looking, speech and touch

The purpose of this method is to allow the person with dementia to interpret care procedures not as an act of aggression, but as an act of kindness. It is organized around specific ways to look at, talk to and touch the person.

- **Looking**

  With dementia, the impossibility of speech does not prevent communication. Indeed, looking is still our first tool of communication. From our earliest days, when speech cannot yet be used, the gaze is a non-discursive form of communication that remains extremely expressive. Where words are not yet possible, or are no longer possible, or are inadequate, looking still allows people to say something. To do this, look steadily and directly at the person's face, hold the look, and do not look or turn away.

  According to the Humanitude® methodology, the gaze must include the following elements to ensure that it is interpreted favourably:

  - *axial gaze (facing the person, not to the side);*
  - *horizontal (at the person's height, not looking down at them);*
  - *long (the gaze is maintained to ensure that it is steady);*
  - *close.*

- **Speech**

  This remains our main means of communication and making contact with others.

  According to the Humanitude® methodology, the professional must announce any actions that are going to be performed in advance and describe them. This prevents the person feeling surprised as they know in advance what is going to happen.

- **Touch**

  Use of touch in this technique allows the caregiver to obtain information about the health status of the person. The comforting touch is more a form of attentiveness, a way of being in contact with the person whilst boosting their esteem.

  According to the Humanitude® methodology, it must be:

- *professional (it is advisable to learn certain less aggressive ways of touching: for example 'gentle cradling' will be preferable and 'tight gripping' should be avoided);*
- *progressive (do not start touching someone in a sensitive or intimate area);*
- *continuous (once the contact has been established, it is maintained);*
- *soothing (a gentle touch that covers large parts of the body).*

This touch is not reduced to a technical and utilitarian gesture, it is offered, not imposed; it then becomes relational touch, 'tender touch'.

Related techniques

- Maintaining *verticality*

This remains essential to our motor functions. It allows good spatial perception and therefore encourages good cognitive function.
According to this methodology, an elderly person receiving support correctly must stand upright. To do this, it is advisable to avoid using bed baths as much as possible and get the elderly person to be upright as much as possible.

- *Sensory feedback*

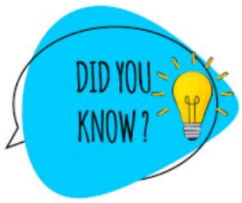
There are several communication channels and several senses that contribute to this: looking, speech and touch. Sensory feedback takes the form of communication using at least two of these senses, ideally all three. The aim is to send a consistently benevolent message with use of several senses at the same time. For example, if I'm saying reassuring words, I should speak in a calm voice and my gestures should be calm. If my gestures are too fast, they are no longer consistent with my speech.

- *Emotional consolidation*

This concerns the ending of the helping and care relationship, where the caregiver explicitly expresses a positive message to reinforce that the care procedure went well. The objective is positive reinforcement of the person's emotional memory in order to better prepare for future care procedures.

C. Emotional Validation® according to Naomi FEIL

Validation® is a method developed by Naomi FEIL, an American psychosociologist, to encourage communication with elderly people who are disoriented or suffering from cognitive disorders. It is based on the idea that there is always a reason behind any behaviour. Understanding why extremely elderly and disoriented people behave as they do, and accepting that this behaviour is theirs, is the key to 'validating' them.



Premise

Naomi FEIL considers the behavioural disorders of the elderly person with dementia both as defence mechanisms and as attempts to resolve old conflicts. She bases her approach on Erik ERIKSON's concept of developmental stages, where each stage of development corresponds to specific tasks to be accomplished. She adds a final stage to this theory: that of resolution,

where there is a concern with putting one's life in order before leaving it, resolving past conflicts.

There are 4 different phases in this stage of Resolution:

- Phase 1: DISORIENTATION
- Phase 2: TEMPORAL CONFUSION
- Phase 3: REPETITIVE MOVEMENTS
- Phase 4: UNRESPONSIVE STATE

The 10 principles of Validation®

- 1- Every person is unique and must be treated as an individual;
- 2- Every person is important, whether or not they are disoriented;
- 3- There is always a reason behind the behaviour of disoriented people;
- 4- The behaviour of extremely elderly people is not only related to anatomical changes in the brain, but reflects all the physical, social and psychological changes that have taken place over the course of their lifetime;
- 5- An extremely elderly person cannot be made to change their behaviour, because they cannot change it unless they want to;
- 6- Extremely elderly persons must be accepted without judgement;
- 7- Every stage of life represents certain tasks. Failure to complete these tasks can lead to psychological problems;
- 8- When recent memory is failing, elderly adults try to rebalance their experiences by going back into their old memories;
- 9- Painful feelings diminish if they are expressed, acknowledged and validated by somebody trusted who is good at listening. If they are ignored or denied, these same painful feelings will increase;
- 10- Empathy builds trust, reduces anxiety and restores dignity.

Empathy and emotions

Validation® relies heavily on empathy and therefore on recognition of the other person's emotions. For Naomi FEIL, not recognising someone's emotions is like denying the individual. The method is therefore based on meeting the person, finding a way to establish a bond of trust and on a certain appreciation of the person as a complete individual in their own right. This is a matter of restoring dignity by driving away the painful feeling of uselessness and loneliness. If there is value and meaning in the present, the person will therefore not have the same need to lock themselves in the past.

How do we validate?

Validation® uses a wide range of verbal and non-verbal techniques to maintain a connection with the person regardless of their level of disorientation. The tools are there to reactivate sensory memories, emotions and feelings and to facilitate their expression.

Through active listening and appropriate communication modes

Verbal interactions are carried out, wherever possible, using various methods:

- Ask closed (yes/no) or open (who, what, where, when, how?) questions to indicate your interest and to allow the person to say more if they are willing and able to do so and if they still have verbal language;
- Reformulate key words used by the person, matching their voice;
- Refer to their past, allowing the person to bring up memories and personal

experiences;

- Practise questioning in the extreme (always, never, often?) or imagining the opposite (what if the opposite happened?), to allow the person to clarify the limits of what happens;
- Identify and use the preferred sense of the person (visual, auditory or kinaesthetic);
- Use ambiguity ('they', 'it' rather than a specific noun) to focus on the meaning of what is being said when you don't understand the words.

Non-verbal techniques become even more important when verbal communication becomes too difficult.

- Use mirror synchronisation based on the person's breathing, facial expressions and movements;
- Adopt a warm and genuine eye contact;
- Practise a respectful and appropriate touch to get the person's attention, respond to a need for presence or awaken old tactile memories;
- Use music, song and dance, adapting them to the needs and emotions perceived.

Communicating with disoriented elderly persons requires us to go in through the right front door:

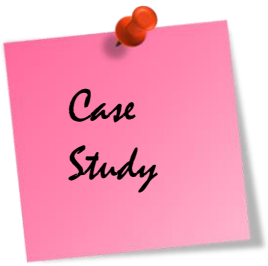
- Use recognition and 'tuning in' to one's emotions whether it be fear, anger, sadness or joy.

Making yourself available

- It is necessary to be prepared. Before approaching the person, the professional takes time to be aware of their own internal state at the time and makes themselves available before entering the other person's world.

Entering into empathy with the person

- By careful observation to try to identify the person's emotional state, the professional aligns their own attitude and posture with those of the person, and similarly modulates the pace, volume and pitch of their own voice to match those of the person.
- The approach is respectful and attentive, at an appropriate distance intentionally to facilitate the relationship and to be comfortable for the person.



Experimenting with the Validation® method

Annie, a caregiver, shows up this morning to help Marguerite D. with her hygiene routine. Marguerite D. has already put her dress on over the top of her nightgown. She is barefoot, dishevelled and greets the caregiver with these words: 'Get the hell out! You're looking for a slap!'.

Mrs. D …

… is cross

Mrs. D. is angry.

- Angry to see a young woman in front of her? (who does she remind her of?)
- Angry at being confronted with her old age, her disabilities?
- Angry about…

Annie is used as a symbol. Mrs. D. does not recognise her as her caregiver.

She is angry at … someone … from her past perhaps or who reminds her of her dependence, when she is so independent!

… has a history

When Mrs. D. was admitted to the service, the team was able to collect some important elements of her life history.

She's 92 years old. The eighth of a family of 11 children, she had to start working from the age of 11. She knows how to clean, how to serve in the dining room and how to cook! After her marriage, she did not work much outside the home and raised her only son, Alphonse. Now a widow, she remained very attached to this son and was unable to have a good relationship with her daughter-in-law. Currently, she lives in a nursing home and does not allow the caregivers anywhere near her. She has met one resident who she sometimes thinks is her husband, and sometimes her son. His name is Alphonse.

… has she gone back into her past?

Perhaps Mrs. D. still has some of her life tasks to resolve? Something in the area of intimacy (the search for a lost love?). Perhaps she's still missing her role as a mother very much? She seems to have difficulty (at times) accepting that this task from her past is no longer appropriate.

… has she lost all her cognitive faculties?

Obviously, Mrs. D. does not understand the situation; she does not acknowledge her need for help; she refuses to be touched in private areas and defends herself against any intrusion.

She has problems with memory and orientation in time and space (she does not recognise the place and the situation), recognition problems (she does not recognise the caregiver) and problems with undertaking actions (she can't wash herself alone without help and guidance), and errors of judgement.

All of these signs are part of the indications of dementia. But if we don't look beyond this view of things, we might miss Mrs. D. completely:

- without identifying the meaning of this refusal and understanding how it fits into her personal history
- without recognising her difficulty in using her gestures and words to express what is important to

her.

Mrs. D. is highly agitated and disoriented. She's approaching the final stage of her life. The caregiver has become the symbol of what she is rejecting.

What should we say to her and how?

- I can try to reason with Mrs. D.: *'Come on, you know me, I'm Annie your caregiver and I'm here to help you. Just let it happen and everything will be fine.'*
  But Mrs. D. can't access her logical thinking… and she may remain deaf to my words.
- I can try to distract her by adding: *'look at that beautiful sun*. *Your son is going to visit soon, you need to look good for him.'*
  But Mrs. D. is not living in the reality of the present time and if her anger is not listened to, it will grow.
- I can join her on an emotional level by mirroring her anger, by recognising the full value of this emotion that's overwhelming her, by helping her to express it: *'I'm going to get a slap if I keep this up! There's a lot to get angry about…'*

This attitude might allow her to express her feeling of resentment, her distress about being dispossessed of her life, her privacy.

How do you validate her as a professional?

- I take a step back and take a deep breath, putting aside my own worries of the moment. Now I'm really available for Mrs. D.
- I observe her: I see her, her face tense, her arms crossed, her breathing fast.
- I adopt the same attitude, same facial expression and same breathing.

I'm then feeling this anger that she is showing, and I check: *'You're very angry right now! What are you so angry about?'*.

—[Mrs. D.'s response]: *'It's you! I don't need you! I'm managing it all on my own!'*

—*'You're managing it all on your own! You're a very independent person!*' (reformulation)

—[Mrs. D.'s response]: *'Of course! I've always worked! I know what I have to do!'*

—'*You've always succeeded in doing everything that needed to be done! Have you ever needed help?*'

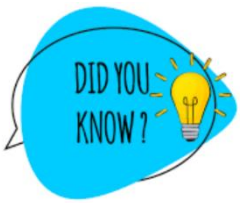
—[Mrs. D.'s response]: *'There wasn't any help in those days! Had to get by…'*

And the conversation can continue: the validated anger gives way to old memories (reminiscence) and important moments that Mrs. D. relives by telling them to the caregiver.

Trust is established and perhaps she will accept help with the hygiene routine…

Source APVAPA, Anick MARTIN, Validation Practitioner

D. Concepts AAC (Augmentative and Alternative Communication) for image-based and gestural communication



Augmentative and Alternative Communication (or AAC) covers all the human support and tools that allow a person with communication difficulties to communicate (i.e., to understand their environment and be understood by the people they are close to) by replacing oral language, if it is absent (alternative), or by improving communication, if it is inadequate (augmentative).

It is a repetitive and regular method that uses symbols as a medium to change to oral communication (actions, photographs, drawings, letters, words, used alone or in combination). The specific feature of this method takes the form of intensive use of specific equipment (electronic or not) to find accessible and comprehensible alternatives to verbal or written communication.

Some AAC tools designed for people with disabilities are suitable for elderly persons with forms of dementia.

Here are a few examples:

The MAKATON program is designed for people with severe language and communication disorders. It helps with development of communication skills by combining speech, signs and pictograms. The strength of this program therefore lies in its multimodal nature. It is based on a vocabulary set that is simple and functional in everyday life. Signs and pictograms are used to support speech to represent concepts and situations in everyday life. Visual illustration is certainly important in giving meaning to the words that are heard or read. This program offers many benefits:

- It reduces the person's frustrations, by allowing them to express their needs or feelings, and to develop their self-confidence;
- it allows the person to interact socially, for example, in the case of a person who cannot speak at all;
- it helps to maintain the remaining language skills by creating positive stimulation.

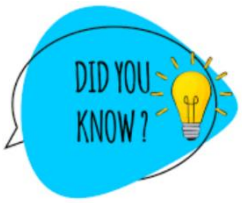
PECS (Picture Exchange Communication Schedule) is a tool based on the exchange of images to communicate. This method can be offered to people if their oral language does not allow them to make themselves understood.

It does not require any particular cognitive level, even for people who show great difficulty in visual comprehension exercises or assessments. The aim of PECS is to allow the elderly person to communicate in order to express a choice, a wish, to ask for help, to make a comment, to ask a question, to accept or refuse an instruction… To do this, they have images (pictograms) available for their use, which they can take and give to the professional. They will be able to make sentences by combining the images. The professional responds to the person's request by means of oral language and gives them what they wanted, answers their question, etc.

ADOPTING CARING PRACTICES IN ORDER TO PROTECT AGAINST SITUATIONS INVOLVING A RISK OF VIOLENCE

1. THE NATIONAL RECOMMENDATIONS (GUIDELINES) FOR GOOD CARING SUPPORT PRACTICES

In France, the Haute Autorité de Santé (National Health Authority) has published a number of recommendations intended to improve quality of life for residents and to provide guidelines for professionals to provide support for an elderly person as part of good care.



A. The national recommendations relating to support for elderly persons as part of good care

These include:

- personalisation of support and the services provided;
- living conditions;
- everyday life and quality of life;
- social life.

Some principles that can be applied to actions of everyday life with elderly persons and/or their friends and family:

Guideline no. 1

Implement freedom of choice in practice

- Work with respect for the rights and choices of the user;
- Personalise admission and support integration of the user into the structure;
- Listen to what the user says and respect their validity;
- Develop opportunities for reciprocal relationships between users and establish an organizational structure that minimises times when users are dependent on professionals;
- Be attentive to refusals and non-compliance, in order to ensure that situations develop appropriately.

Support for independence

- Inform the user;
- Take account of the user's pace of life and all their needs;
- Support the user rather than doing things for them;
- Suggest mediations and supportive actions to maintain independence.

Individual and collective communication

- Offer the user a wide variety of opportunities for expression;
- Create a supportive environment for speech;
- Communicating up to the end of life;

A defined and evaluated admission and support plan

- Set specific objectives within the framework of the user's personalised plan;
- Establish realistic implementation and follow-up procedures that respect the user's abilities and pace;
- Observe the positive and negative effects of the actions implemented for the benefit of the user.

Guideline no. 2

Respect for unique individuality, foundation for the helping relationship

- Support the user and respect their unique individuality in the helping and care relationship;
- Provide an appropriate response for the individual needs of the user.

Vigilance regarding the physical safety and sense of security of users

- Provide protection and ensure physical well-being of the people in care;
- Ensure communication and liaison between professionals;
- Inform users about institutional events and changes in professionals;
- Be responsive to the needs of the user and provide an appropriate response to requests.

A stable institutional setting

- Place value on users' rights;
- Make a reminder for rules, if necessary, without slipping into excessive rigidity;
- Intervene in cases of violence, in order to contain the person who is being violent towards others;
- Investigate how the violent acts occurred.

Guideline no. 3

Work with the user's family and friends and respect the relationship between the user and them

- Create an environment that takes account of family and friends and perceives its own analysis of the user's situation as supplementary to the other analyses;
- Listen to and understand the requests and needs of the family in order to establish long-term care solutions that respect the balance of the family;
- Maintain neutral and non-judgemental professional attitudes with regard to the relationship between the user and their loved ones;
- Help isolated people to create their own social network.

Liaison with external resources

- Open up the organizational structure to external resources and develop partnerships;
- Organize liaison with regular visitors and encourage interactions to create a culture of exchange;
- Establish tools for collecting perspectives from outside the institution;
- Develop the sharing of experiences between different institutions.

Encouragement of expression and exchange of perspectives

- Invite users to express their wishes;
- Set up areas for discussion where professionals, friends or family and users can exchange their opinions;
- Encourage participation by creating clear links between the opinions collected and the changes in how the institution operates;
- Encourage participation in discussion by inviting users regularly and respectfully.

Guideline no. 4

Encouragement of all professionals to have their say

- Promote discussion around close observation;
- Regularly make professionals aware of the purpose of their role;
- Encourage the sharing and development of skills around daily observations;
- Work with professionals to formalise the most appropriate information formats.

Appropriate and personalised professional perspective

- Welcome new professionals and give them the means to understand and adapt to the users they are supporting;
- Support the practices and the professionals by offering regular opportunities to reflect;
- Include these exchanges in a process of continuous improvement of practices;
- In the event of any particularly difficult occasion, set up appropriate temporary support;
- Encourage ethical reflection among professionals.

2. ADOPT APPROPRIATE PROFESSIONAL ATTITUDES AND BEHAVIOURS IN THE RELATIONSHIP IN ORDER TO ENSURE A SUITABLE PROFESSIONAL APPROACH THAT PREVENTS SITUATIONS OF VIOLENCE

A. Reference sheets on professional conduct to be encouraged in the helping and care relationship to prevent violent situations

As part of the MobiQual program (national program to improve the quality of professional practices in health care institutions and at home), the French Society of Geriatrics and Gerontology (SFGG) has set up good practice reference sheets to guide professionals in terms of interpersonal skills and expertise in the practical situations of the helping and care relationship with an elderly person, with or without cognitive disorders.

Preventive professional attitudes and conduct to be encouraged during key times of the day

WAKING UP/BREAKFAST

- Knock on the elderly person's door
- Introduce yourself
- Use polite forms of address
- Pay attention to brightness level
- Wish them a good day
- Respect their pace as much as possible
- Avoid being abrupt and speaking loudly
- Do not generate an 'emergency' atmosphere

HYGIENE AND PERSONAL CARE

- Warn the elderly person that it is going to be time for their hygiene routine
- Choose the type of hygiene routine that suits their abilities
- Carry out the hygiene routine as appropriate to their habits
- Ask for their consent
- Encourage their independence by encouraging them to carry out actions
- Avoid being intrusive
- Allow them to choose their clothes
- Ensure privacy (e.g., closed door, etc.)
- Try to delay the care procedures as much as possible if refused
- Be gentle in your actions and voice
- Explain what will be done as you go along
- Adopt empathetic listening
- Always establish verbal contact
- Start the hygiene routine with neutral areas (hand, arm …)
- Preferably implement approach with looking and touch
- Propose mediation tools that promote care (approaches not based on medication)

VISITORS

- Offer a quiet area for visits
- Encourage communication between professionals and families/friends
- Give advice to visitors
- Inform visitors of the importance of their visit and the possible consequences
- Tell the elderly person that someone is coming (if possible)
- Take over with the elderly person for a few minutes after the visitor leaves

Avoid visits during meals or private times for the resident

MEALS

- Respect the elderly person's choice to eat in a group, alone or in their room (when possible)
- Check the temperature of the food
- Encourage independence or mutual aid among residents by offering support when needed
- Create a calm atmosphere
- Avoid any sudden actions
- Give responsibilities to the elderly person as appropriate for their abilities (enhancing sense of self-worth)
- Respect their pace when eating
- Know their likes and dislikes, respect their food choices
- Sit at the same height when helping them with eating
- Present the menu, the dishes
- Present only one dish at a time
- Do not mix food on the plate
- Adapt food texture to their abilities
- Adapt utensils and cutlery to their abilities (technical aids)
- Allow them to choose who they sit with

BEDTIME

- Create a calm and reassuring atmosphere before bedtime
- Encourage discussion at bedtime
- Respect the person's customary bedtime
- Respect their bedtime routine
- Adjust the quality of protection to minimize the number of protection changes needed during the night
- Respect medication times
- Suggest a non-medication activity conducive to sleep at bedtime

NIGHT

- Reduce the noise level (audio calls, cleaning…)
- Provide temporal orientation
- Reassure, be calming with a soft voice
- Use contact, touch
- Keep the place quiet
- Only use night lights during protection changes
- Respond to the bell and requests
- Do not wake people up systematically
- Provide a nighttime snack if an elderly person wakes up or wanders

During key times of the day (continued)

ACTIVITIES/SOCIAL LIFE
▪ Offer an activity to the elderly person every day, even if they systematically refuse ▪ Adapt the activity to their abilities and wishes ▪ Offer spontaneous activities in response to behavioral disorders ▪ Offer individual and group activities ▪ Encourage self-expression ▪ Encourage active participation in the actions of daily life (cooking, gardening…) ▪ Respect their pace ▪ Provide alternative activities, especially in response to behavioral disorders ▪ Show appreciation for the work done and do not set the elderly person up for failure ▪ Stimulate while allowing maximum independence ▪ Offer a wide variety of activities ▪ Provide time for calming down after the activity ▪ Maintain the person's social connections by offering them appropriate communication aids ▪ Encourage interactions between residents and with family or relatives

MOVEMENT
▪ Warn the elderly person before any movements ▪ Initiate the action without doing it for them ▪ Adapt the technical aid according to their abilities ▪ Reassure the person ▪ Respect their pace ▪ Use a gentle touch, sympathetic handling interaction without suddenness ▪ Facilitate their comfort ▪ Ensure that their position changes to prevent pressure sores ▪ Take account of any painful conditions ▪ Communicate during the movement action ▪ Offer assistance for getting around: assisted walking/guided walking ▪ Secure their environment to avoid the risk of falling

Encourage preventive professional attitudes and behaviours towards elderly people with cognitive disorders

The following <u>communication</u> attitudes are provided as examples and must be adapted to each individual case:

- Avoid various sources of distraction (television, radio, etc.) when communicating with the elderly person;
- Attract their attention: put yourself in front of them, at their height, establish eye contact, attract their attention by gently taking their hand, for example;
- Use short sentences;
- Avoid sending multiple messages at the same time;
- Use gestures and facial expressions to facilitate understanding;
- Repeat the message if you have any doubt remaining about whether it has been understood;
- Ask closed questions, preferably;
- Give them time to express themselves;
- Do not neglect body language: stay relaxed and smile;
- Do not raise your voice;
- Do not hesitate to repeat if needed;
- Include the person in the conversation;
- Avoid being familiar;
- Do not force them to do anything they do not want to do: in this case, change the subject and try again later;
- Do not be distracted by another conversation;
- Ensure that you remain patient.

The following <u>care</u> attitudes are provided as examples and must be adapted to each individual case:

- Avoid doing things for the elderly person that they are still able to do: find out about their remaining abilities and stimulate them;
- Establish a routine, rituals adapted to their lifestyle habits;
- Let them make their own choices (e.g., for food or clothing);
- These abilities decrease as the disease progresses; simplify daily life over time as it develops (e.g., prioritise clothes that are easy to put on, avoid putting too many items on meal trays or tables, etc.);
- Break down the different tasks into several steps (e.g., after choosing the clothes, present them in the order in which they will be put on);
- Do not set the elderly person up for failure;
- Maintain privacy for personal care and hygiene;
- Help with personal care and hygiene, which can be a tense time: make sure the temperature of the bathroom and the water is right, prepare hygiene items in advance (soap, glove, toothbrush, etc.), respect the need for modesty, give the person one instruction at a time, warn them before performing any care procedure such as washing their face;
- Look for alternatives when a care procedure may be causing a behavioural disorder;
- Reassure and comfort the person regularly during a care procedure;
- Let go of behaviours that are not a problem for you, as long as they are not dangerous;
- Propose an activity or alternatives that are relevant as a response to certain disorders: for wandering that is disruptive, suggest another repetitive activity such as folding the laundry; for agitation, propose listening to music or looking at the elderly person's personal photo album, etc.
- If the person does not want to do the requested action, do not insist and do not reason with them;
- If there is verbal or physical aggression triggered by the presence of the professional, let them calm down.

Preventive professional attitudes and behaviours to be encouraged with people with cognitive disorders, according to their behavioural manifestations

- **See Module 3**

Behaviour management for people with dementia.

Behavioural changes: how do they occur and how should we respond?

B. Self-assessment questionnaires for professional practices as part of good care

I. Respect for privacy, dignity and confidentiality	Yes	No
1. I respect the privacy of the elderly person in all situations	☐	☐
2. I respect their dignity in all situations	☐	☐
3. I encourage their self-esteem through their clothing and lifestyle habits	☐	☐
4. I respect the confidentiality of information in all situations	☐	☐
5. During the hygiene routine, I respect their privacy and dignity	☐	☐
II. Pain management		
6. I take account of their pain in all situations	☐	☐
7. I always note the absence of pain	☐	☐
III. The comfort of the elderly person		
8. I avoid noise/light at night	☐	☐
9. I avoid or block any medical discussion between professionals at the elderly person's bedside	☐	☐
IV. End of life		
10. I ensure that living wills are obtained	☐	☐
11. I ensure that the trusted person is identified	☐	☐
12. I accompany the elderly person at the end of life and ensure their comfort	☐	☐
V. Communication		
13. Each day, I identify the needs and abilities of each person (in order to provide an appropriate response)	☐	☐
14. I am attentive to verbal and non-verbal communication	☐	☐
VI. Respect for independence		
15. I encourage the movements and routines of the elderly persons	☐	☐
16. I take account of their tastes, habits and abilities for mealtimes	☐	☐
17. I identify moments of distress	☐	☐
18. I encourage their independence (preference for 'getting them to do it' rather than 'doing it for them')	☐	☐
VII. Respect for the individual		
19. I recognise the impaired person as an adult in their own right, with their own life story	☐	☐
20. I adopt a respectful, non-infantilising attitude	☐	☐
21. I respect their rights, including civic rights	☐	☐
VIII. Organization of services		
22. There are posters and documents on good care in my workplace	☐	☐
23. In my workplace, the staff breaks are organized in rotation	☐	☐
24. In my workplace, the bell response times are evaluated	☐	☐
25. In my workplace, visiting hours are free	☐	☐

Source HAS Self-evaluation – Evaluation of the promotion of good care

Questions to ask yourself to prevent the risk of abuse *A=Always / O=Often / S=Sometimes / R=Rarely / N=Never / N/A=Not applicable*	**A**	**O**	**S**	**R**	**N**	**N/A**
1. I use a familiar form of address to the elderly person without their consent						
2. I don't perform a care procedure due to lack of time						
3. I don't make an effort while performing a care procedure						
4. I don't want to look after the elderly person due to their physical condition or pathology						
5. I use a dry, abrupt tone when addressing the elderly person						
6. I am aggressive when speaking to the elderly person						
7. I use 'we' or 'he', 'she' when talking to the person						
8. I use an intimidating attitude or words towards them						
9. I address insults or slurs to the elderly person						
10. I have an infantilising, humiliating attitude						
11. I make untimely value judgements about the elderly person						
12. I don't knock on a door before entering the elderly person's room						
13. I don't close a door and/or a window during a care procedure						
14. I do things for the elderly person because they're slow						
15. I impose a care procedure on an elderly person without taking account of their pace						
16. I choose not to answer an elderly person's call						
17. I deliberately put the bell out of reach						
18. I adopt an indifferent attitude towards an elderly person and isolate them						
19. I don't ask the elderly person's opinion or give an explanation of the care procedures that I'm performing						
20. I don't take account of one of the disabilities of an elderly person						
21. I use a restraint not prescribed by the doctor						
22. I don't take account of the pain of an elderly person and don't pass on the information						
23. I prefer to put incontinence pads on the elderly person unnecessarily instead of accompanying them to the toilet						
24. I make angry gestures towards an elderly person						
25. I don't put an elderly person back into bed when they ask me to						
26. I don't call on another team member when I'm having trouble						
27. When I'm going through personal problems, I pass them on to the elderly persons						
28. I don't want to work in a team						
29. I don't feel integrated into a team, and this is detrimental to my work with the elderly persons						
30. I'm losing interest in my work						
31. I leave an elderly person completely naked during their bed bath						

Source HAS/CEPPRAL Self-assessment – Managing the risks of abuse in daily practice

3. PROFESSIONAL BEHAVIOURS TO BE ENCOURAGED IN ORDER TO PROMOTE SOCIAL CONNECTIONS AND PREVENT AGGRESSIVE SITUATIONS

Encouraging social connections between residents and with family/loved ones will facilitate communication and understanding between all stakeholders and prevent some inappropriate behaviours that result from frustration and misunderstanding.

A. Professional behaviour to encourage connections between residents and better community cohabitation

Prerequisites

- Definition of collective institutional rules;
- The identification and assimilation of these rules by the residents through communication and materials adapted to the abilities of each of them;
- Analysis of the elements of cohabitation (uniformity and diversity);
- Management of disruptions in collective life.

Everyday life

- Knowledge of each resident (taking account of their positive or negative feelings about each other, previous knowledge, common interests, different personalities and life stories, pathologies…) to encourage appropriate social interactions;
- Assessing the different modes of expression and understanding of each person to facilitate interactions;
- Work on the social environment to facilitate mutual aid between the more independent residents and those who are less so;
- Organization of events that can be used as opportunities for interaction, meeting and expression. If the social climate induces a routine, interactions will not develop (e.g.: sharing habits and customs at parties, linking the past experience to a current event, choosing a new decoration, etc.);
- Collective participation in the preparation of daily life tasks;
- Arranging meeting times during intermediate times between care procedures, meals and organized activities;
- Small breaks in the way daily life is organized can foster new connections (e.g., a new arrangement of living room chairs, etc.);
- Creation of small friendly spaces in the lounges, corridors and gardens to encourage meetings in small groups;
- Provision of items to support social connections in the different living areas, such as newspapers, music, games;
- Resident participation in group projects;
- Organization of group activities and outings;
  etc.

B. Professional conduct to encourage links between the elderly persons and their families or friends

Prerequisites

- The regular collection of information from the elderly person and from their loved ones concerning their respective needs and expectations;
- Identification of respective skills and abilities;
- Consideration of their respective roles and positions;
- Primacy of the words of the elderly person over those of the family;
- Implementation of facilitative communication (active listening, reformulation…) to better understand and hear the requests;
- Respect for privacy and social connections.

Everyday life

- Integration of the family into the personalised support plan;
- Definition of agreed practical arrangements governing the times for interactions between the elderly person and their loved ones: visiting hours, type of shared activities, etc.;
- Implementation of facilitative equipment in terms of arrangements and communication;
- Inviting the family/friends to participate in social activities depending on their wishes and possibilities if the elderly person agrees to it;
- Integration of the family into the helping and care relationship through actions of everyday life: help with meals, walks, etc.
- Inviting the family to help their parent or loved one to arrange their environment (room, home…);
- Participation in the Social Life Council;
- Organization of family outings, etc.

In order to facilitate the social connections, the professional will need to have an appropriate attitude towards the family, endeavouring to meet their needs, which are concerned with the following:

- the quality of the care for the parent, their well-being, comfort (refers to the need for security);
- information concerning their situation, their daily life, possible aids;
- support at difficult times;
- meeting with other families to break the isolation;
- regular communication with professionals to feel reassured, heard and understood;
- feeling that they are still integrated into the life of their parent;
- individual and personalised support.

etc.

Every need is different and evolving, and the professional will have to be attentive to supporting the family/loved ones in order to prevent dissatisfaction, judgements, interpretations, conflicts…

Some rules to follow to facilitate the partnership with the family or loved ones in the helping and care relationship:

Acknowledge the family's suffering, the path taken, the family connections
Support the family in acceptance of the loss of independence, the disease (anticipatory grief), the disorders of their parent/Explain – get them to understand – get them to accept
Reassure the family about the services provided, the situation of their parent
Never judge the family even if they are not present
Treat them with respect and kindness
Do not take the place of the family
Avoid entering into conflict with the family
Adopt a good professional distance
If you need to discuss things with the family: do not do so in the presence of the elderly person (who becomes an object and not a subject) unless they are included in your conversation
Send information regularly (be careful about confidentiality) to foster trust and to keep them informed of your actions
Integrate the family into the support plan and the development of the personalised plan
Discuss the place of the family in a multi-disciplinary team.
If there is a conflict with the family: discuss it again as a team to: ▪ put your emotions and feelings into words for a better way of letting go; ▪ try to make sense of an inappropriate remark; ▪ gain a better understanding of the hidden suffering of the family; ▪ look for a solution together.
Put the elderly person's wishes (not yours or those of the family) back at the centre of support