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Abuses in dementia, and responses of care

Ottoboni, G., Chirico, I. Chattat, R.

Department of Psychology, University of Bologna, Italy

Intellectual faculties appear to be the capabilities that humans must govern to exercise negative freedom., whose definition posits that people are free to be not interfered in the achievements of their needs and wills. When these assumptions get unmet, people can be subjected to mistreatment and abuse.

A recent literature review has estimated a maltreatment rate that affects between 3,5% to 23,1% of people living with dementia[1]. Analyzing the data collected, the same authors found a basis for the common suspicion that the violences that people suffer are multiple. In fact, it is unlikely that physical abuse does not occur in conjunction with psychological ones . Analyzing the data collected, the same authors found a basis for the common suspicion that the violences that people suffer are multiple. It is unlikely that physical abuse does not occur in conjunction with psychological ones [2]. Furthermore, the analysis revealed that older people with reduced cognitive abilities are those most at risk of dying from abuse[3].

People with dementia can be physically abused by any person sharing time with them, independently of begin professional or family member. Physical abuse involves hitting, slapping, pushing, kicking, misusing drugs, and inflicting inappropriate penalties.

Physical abuse sometimes refers to force-feeding, or rough handling of the person, or body parts (Newsham, 2004). The abuses can be discovered by noticing injuries incompatible with lifestyle, lack of explanations from health professionals and caregivers about the circumstances, absence of written records. Additionally, multiple bruises may emerge on parts of the body otherwise protected by clothing, or weight loss, dehydration, or malnutrition may occur but in the absence of biological causes.

Along with physical abuse, verbal ones occur very often[3]. This type of abuse occurs when people are physically threatened or abandoned or when they are humiliated. The abuse may extend to forms of isolation and the denial of the possibility to choose. The abuses can emerge by observing more significant confusion or disorientation or, conversely, sudden silence when a particular person is with them[4].

Similarly, people with dementia can receive discriminatory abuse: harassment, racism, sexism, or insults based on their physical or mental capacity. They can occur in the event of a lack of understanding of the context that the disease generates, or due to a lack of specific training and education focused on people's needs. Equally, the denial or the neglect of religious, spiritual and cultural differences can occur and the lack of understanding of the importance of fundamental values, the ability to choose and satisfy the person's needs or the respect for his privacy.

Similarly, and with an equal frequency[3], people with dementia can be subjected to "institutional" abuses, that are carried within services hosting the person. Examples are the low levels of assistance, that are evident as pressure damages, or "accident" damages. The high number of deaths can also be attributed to institutional abuse linked to low hygiene levels, malnutrition, low quality of clothing, or low frequency changes.

Less frequently[3], people with dementia may also be subjected to sexual abuse, such as rape, sexual assault, and sexual acts for which the person has not provided consent. Within this category, it must be included inappropriate contacts or inappropriate language. Abuse can become evident in the genital area, where bruising or urinary bleeding or even infections emerge. Otherwise, sleep disturbances, avoidance behaviours towards a particular person occurring when the abuser offers bathing support or when the person with dementia is acknowledged that she will be left with the abuser can indicate sexual abuse.

Furthermore, people with dementia are also subject to financial abuse, which can be perpetrated directly or indirectly. In this type of abuse, we have included theft, fraud, appropriate non-financial transactions, the use of the money by just the person without her consent. Besides, there is the misappropriation of property and assets belonging to the person. This type of abuse can be discovered by analysing financial transactions: sudden movements of money or assets, sudden change of will about money or economic assets, and sudden inability to pay bills, fees or bills for services.

The abuses carried out in the nursing or hosting facilities must be tackled by carefully selecting the support staff. Staff selection must consider both the knowledge and the ability to reflect on the guiding principles of health and social welfare and the reasons that led the staff to choose to work in the health sector.

A three-factor interpretation model has recently been proposed[5,6]. The prevention and intervention model (Abuse Intervention / Prevention Model - AIM) grounds interpersonal, sociological, and sociocultural theories.

The interpersonal theories assume caregiver's stress and the asymmetrical relationship between the abuser and the abused person[7,8] underpin abuses.

The sociocultural ones believe that the core of the problem falls within the negotiation of power relations[9].

The multicomponent ones interpret the various actors of maltreatment as operating in broader and systemic contexts[10,11].

The AIM model argues that abusive behaviour understanding must consider the triad composed of the abused person, the abuser and the context in which the abuse occurs. Specifically, it is necessary to focus, first of all, on the frailties of the abused person. Economic, physical, emotional, cognitive and other difficulties can coexist and impact the person differently to modulate the overall fragility level.

The abuser can be anyone who works, acts or lives, with the abused person. It can be a family member, a formal or informal caregiver, a friend, a financial advisor, a hardened scammer. Many times, the actions of the abuser are not considered to be as such by the abused person[5]: These actions become evident when a break in the routine occurs, an external situation that interrupts the ordinary course of events.

Finally, the context, or interaction between the abuser and the abused person, plays a vital role in mitigating or exacerbating relationships. Specifically, abuses occur when the context is not composed of a network able to meet the person's needs. In that case, the person lives isolated and exposed to the attacks of the abusers.

Furthermore, as for the contextual factors, both the timing and the quality of the relationships must be considered. The relationship often starts before the abuse, but the long-lasting relationship does not

protect against the abuse. If the relationship is disharmonious, the risk of abuse increases. As the Phillips et al. Model (1995) posits the factor that most predicts the quality of care is the level of caregiver fatigue.

The factors that most predict fatigue are the discrepancy between the person's past representation and their current image and the number of adverse events that the caregiver faces[12,13].

On the other hand, Carbonneau, Caron and Desrosiers[14] suggest that both the quality of the relationship and the care meaning can grow by supporting the caregiver' sense of self-efficacy and by teaching how to capitalize the care on the possibilities the context offers.

Unlike the AIM model, in their analysis of the literature, Johannesen and LoGiudice[15] emphasize the increase of cognitive impairments, the rise of challenging behaviours- or concurrent psychiatric disorders- and low-income family relationships are risk factors driving abusive behaviours the most.

Ottoboni and colleagues[16] found that care difficulties are attributed more to behaviour than memory loss. Furthermore, as Kishimoto and his colleagues[17] underline, the lack of a timely diagnosis plays an essential role in generating abusive behaviours. The incapability to refer the behavioural problems to the specificity of the disease drives the caregiver to refer the behaviours to the person's inner will.

Anetzberger and colleagues[18] propose a model of intervention against the abuse of older adults with dementia, aiming to improve collaboration among local health and welfare services. The model suggests screening tools, guidelines, and handbooks support healthcare professionals in identifying risk factors and direct local services towards the contexts where abuses could be frequent.

Finally, although the data collected cannot individuate a typical profile, a few pieces of evidence show no gender distinction between abusers[19,20]. Abuse seems to occur more in family contexts, and that the state of widowhood is a factor increasing the chance of abuse[20].

About the abuses occurring within the family, policies and practices of support families must be improved. Family should receive supportive programs, including educational and emotional and psychological support. In a recent literature review, McCarthy and colleagues[21] have described screening tools based on direct questions advanced to the potential victim and tools to inspect for signs of abuse objectively. In the context of dementia, these investigative approaches may be challenging to use, and this is vein Melchiorre and colleagues[22] suggest using the Caregiver Abuse Screen (CASE).

Selwood and colleagues [20] suggested that to reduce abuse, educational interventions that focus on drugs to control memory disorders are very appreciated by institutional caregivers. Informal and institutional caregivers are favourable to receive material with information concerning the problems and the care modalities. Indeed, abusive behaviours are mostly by-products caused by feelings of inadequacy of caregivers[23].

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