D2.1 Dementia care and psychobiography care model

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Acronyms and Terms

Term	Explanation
Imprinting	Norms, values and beliefs that people integrated in their lives/mind over the years. (p23)
Key-stimulus	Trigger to people with dementia that stimulates a response the most. (p21)
Levels of Interaction	Different levels of interaction that can be distinguished in the communication with people with dementia in several stages. The deeper someone is in dementia, the more basal the needs and communication. (p33)

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1 Summary

Life of people in dementia can have so much more quality of life when caregivers not only work with, but also really understand what kind of emotional memories, experiences and copings are left in the clients mind, in their limited, but very personal world. For elderly clients in dementia, there is no other reality then their emotional memories, as they were collected until they were grown up. All other things are frighteningly strange to them. The method of Professor Erwin Böhm provides very useful manuals to translate a personal emotional remembered life into a personal daily practice, that leads to stability, satisfaction and the feeling of being useful among the elderly person in dementia. This is a huge improvement in dementia care, that not only helps the client itself, but also formal and informal caregivers in their sometimes very stressful relationship with clients. Actually, up until now, Böhm is the only one who provided these kind of manuals, whereas other equally important specialists do not exceed the stage of practical examples. In German speaking countries, in the Czech Republic and in the Netherlands, the method is quickly gaining ground. In other countries, curiosity is growing and elements of the method are already used, like in Dementia Care Mapping.

There is however, one time-consuming challenge. That is the process of collecting personal emotional memories of clients in a way that caregivers can translate these into a functional daily agenda. It takes more time than averagely can be spent in care. But without the relevant information, it is nearly impossible to reach the client's personal reality. None of the manuals in the Böhm method will work properly without relevant emotional biographical information. Apart from the Böhm method, it is obvious for everyone who tries interaction with people in dementia, that knowledge of that hidden personal world is important to reach the people.

This AAL-consortium in 'MI-Tale' therefore is developing a tool to extract personal emotional information from people with memory challenges and dementia. It will be a device that is attractive to use. Initially we would like to call it a 'game', but that is a risk. One of the most important memories of people refer to times in which 'gaming' meant 'no income, no food'. Playing games may therefore be very stressful for many people in dementia. The content is a huge collection of visuals and soundtracks, that appeal to their memories and challenge them to tell their own stories. These stories will be stored and already somewhat organised, to help family and caregivers in their analyses. At the same time, we think we are creating a wonderful instrument for everyone who is interested in interaction with elderly people, so our device will also be available on the open market.

Although this deliverable was initially indicated as public, we would like to emphasize that we decided with all involved partners that we prefer to keep this confidential / restricted for the purpose as deliverable. In the task of collecting all data, we several times faced the threshold / barrier of the use of material. Owners of that material didn't want us to make this public. However, as in our opinion this particular material was valuable for this document, we decided still to use it – in a restricted document.

2 Introduction

Dementia is one of the greatest societal and healthcare challenges of the future according to the World Alzheimer's Report. Personal emotional history of clients is key information in care for people with dementia, since it is a valuable source of information for the application of a personalised care approach. Collecting information is time-consuming labour. Therefore we will create a device that will help elderly with dementia and their informal carers to recall this personal history and record and organise it.

In this AAL project, our 'MI-TALE' consortium decided to use the dementia care method according to Professor Erwin Böhm. He developed the most elaborated and methodological approach to use personal history as the foundation for a personalised care which is available at this moment. According to this approach, experiences, emotional memories, copings and values that were learned and experienced until the early adult age (0-25 years) are most important. They are regarded as guiding values when people enter into stages of dementia and are therefore reflected in the current behaviour. This information can be of great value in the care for people with dementia.

In line with the Böhm method, MI-Tale aims at the development of a digital and interactive tool that will trigger and record the memories and the personal stories of people with dementia. The resulting collection and interpretation of stories in the form of such a tool has several advantages for both people with dementia and their professional and informal (care) environment.

This document will serve as a background reference for the designers and builders and is a result of our initial design sessions and meeting with professor Böhm and his experts and literature study. The writers of this deliverable, Dolf Becx and Eric Schlangen, are both ENPP-Böhm certified teachers and practiced counsellors in the Böhm methodology. They are part of the Consultancy Zorg Giersbergen organisation, specifically active in Dutch-speaking countries. This is not a scientific document but an attempt to explain the relevant parts of the Böhm method to collecting psychobiographic information and give some reference background to the designers and builders.

In this deliverable, we will elaborate on the Böhm method and the role of collecting, interpreting and utilizing the information in the care process. We will also discuss communication with dementia patients and more in detail the many aspects of collecting biographic information. It is derived from different Böhm publications.

First 3 parts of the method and the manual

The description of the Böhm-care method is written in a large collection of publications, captured in two manuals and a series of other books and publications. For the development of the MI-Tale tool, only the first three sections of the method described in Manual II (see references for more information), part I, are relevant. This report is about these three sections. First section (4.1) is the explanation of the main functionalities of the method, based upon decades of observation, trial and errors. Second section (4.2) is about the psychobiography as a tool and source of information. That is the instrument for which MI-Tale will develop a device. Third section (4.3) is about the very special

issues around communication with people in dementia, profoundly based on knowledge from the psychobiography. This information is very relevant for developing the device in Mi-Tale, because, without this knowledge, there is a risk of too little interaction between client and care.

Although the information is mostly based on Manual II, part I, Prof. Erwin Böhm himself published in 2016 and 2017 his latest updates on the method in the publications 'Tattoos der Alterseele' and 'Soko Demenz' (See references for more information). We used some reviews from his latest publications, to be sure that this report is as actual as possible.

The original manuals from Böhm are all written in German language and situated in the Vienna area. Sometimes we did translate proverbs, places, famous people's names (only in Austria), or we added English or even Dutch and Cypriot examples as these countries are represented in the consortium as well. We encourage you as a reader to look up some of these famous people or typical words in the Internet to get a better feel for their historic influence and importance. Language is extremely important in the Böhm method and the language of emotions is often hard to translate because they are words of the heart and not of the mind...

This report is for internal use by Mi-Tale only and does not pretend to be a scientific study, but a practical guide. That is exactly how Prof. Erwin Böhm himself communicated about his publications.

3 Methods/Procedure

We did collect the input for this deliverable in three ways:

- A meeting with experts, including professor Böhm, the device concept designers and Böhm practitioners and teachers from both Austria and the Netherlands. To avoid the risk of only method-specific input, we also use a Cyprus example, as it is from a different culture and language area, but still in the EU and as Cyprus is also represented in the consortium.
- Literature research using manuals and books written by Erwin Böhm.
- Expert input from dementia care practitioners and future users of the device. Here we use the input of family members from people in dementia (all involved countries), we use day-care facilities, that are also involved in at-home situations (mostly the Netherlands) and we use care centres or nursing homes (mostly in Austria and Cyprus).

4 Results/Solutions

4.1 The Böhm model in short

First of all, Eric Schlangen and Dolf Becx, provide you as a reader with formal information about the Böhm-care model. To be sure that the information is as close as possible to the words of Prof. Erwin Böhm himself, they only used information from the official manuals, in cooperation with the ENPP-Böhm Organisation. For that reason, there are no separate quotes used, apart from some very personal remarks from Prof. Böhm. They are written in italic. Text from the manuals, will sometimes be supplemented by special remarks for the MI-TALE development members.

4.1.1 The Böhm concept

Professor Erwin Böhm, the founder of psychobiographic care theory and the psychobiographic care model, has created a holistic and extremely practical approach to geriatrics, gerontopsychiatry and psychogeriatrics.

With life expectancy increasing, the number of old people suffering from dementia is also constantly on the rise. The everyday care situation in hospitals and at home is becoming increasingly complex for nursing personnel. Professor Böhm's model promotes a deeper understanding of care by means of the intensive study of clients' emotional biography.

In 1965 he began developing a rehabilitative form of care. Instead of the customary approach at that time of reducing care to making sure the client was warm, full and clean, Böhm designed a reactivation model in which residents and other clients were expected to start performing everyday activities themselves again. The model was also influenced by other sciences. For example, he used sections of Freud's depth psychology as well as the individual psychology developed by Alfred Adler. And he also incorporated aspects of behavioural therapy and social therapy.

Professor Erwin Böhm noted that the carers did everything for their patients. No attempt was made to motivate clients to carry out everyday activities by themselves again. This produced an atmosphere akin to a hotel, and had a demotivating impact on clients, who went off "to die", as Böhm put it. He wanted to return these activities to them and to enable them to participate in life. But he also noticed that clients could only be reactivated to performed activities they had already done themselves in the past. Therefore, the important thing was to carry out biographical work in order to ascertain those activities familiar to elderly people from earlier on in their lives and which would provide a motive for them to become active again.

The supreme objectives of Böhm's care philosophy include the psychological revival or reactivation of elderly people, providing the maximum possible support for their resources still remaining, and the acknowledgement of their psychobiographic identity.

Principles of psychobiographical care theory

According to Böhm, peculiar forms of behaviour can only be understood with an awareness of the client's individual (thymopsychic) biography and their 'character' concluded as a result. It is therefore important to know and restore people's psychobiographic normality. Someone who has spent

his/her entire life just washing once a week will find it difficult to understand why a nurse wants him/her to shower every day as his/her normality is simply different. Instead of satisfying the nurse's hygienic expectations, it's crucial to gear the regime to the clients' normality.

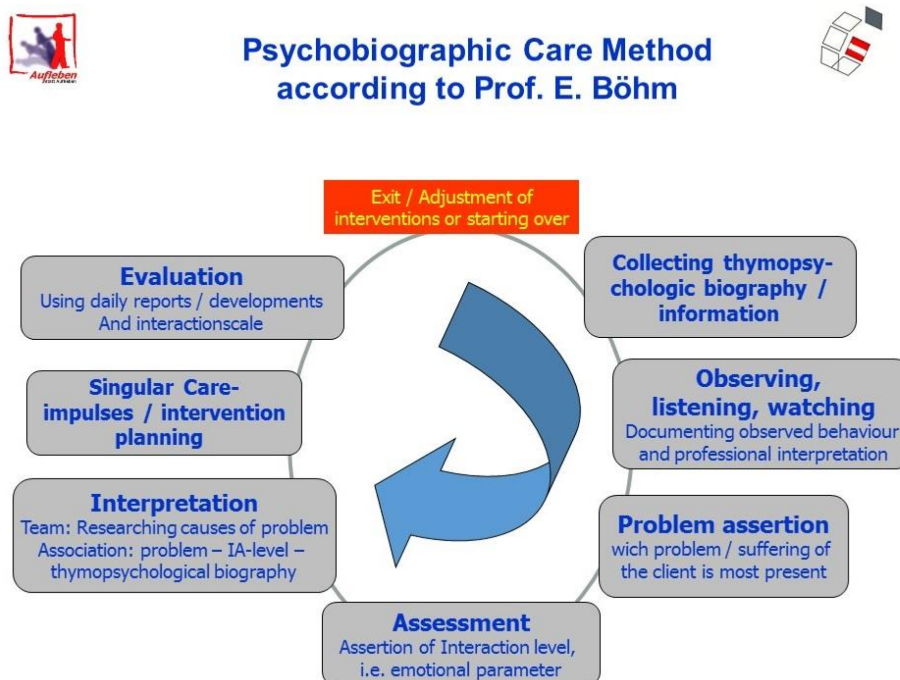
The application of the psychobiographic care model enables reactivation – a substantial improvement in the mental state of people afflicted by dementia – by regarding dementia as a problem to be interpreted psychobiographically rather than an organic condition. People suffering from dementia can still be reached in their feelings, in their thymopsyche. And their vitality can be kindled by means of sign stimuli concluded from their individual and collective biography.

Results
According to series of practical evaluations in individual nursing homes in Austria, Germany, Swiss and Luxemburg, and research by the university of lower-Austria (Landesakademie Niederösterreich) in 2010, the systematic application of the psychobiographic care models at least leads to the following improvements for both the client(s) and nursing team

- Reactivation in clients with a destructive instinct and suffering withdrawal symptoms
- The alleviation of symptoms without the use of psychiatric medication
- An increase in self-esteem among the elderly
- An improvement in nursing quality thanks to 'emotional care'
- A clear increase in job satisfaction
- Reduced sickness

4.1.2 The process circle for psychobiographic care according to Böhm

The Böhm method works according to a specific 7 step process, which is shown below:



At the very beginning of that process, the personal emotional memories should be collected and

organised, together with specific knowledge about the time spirit from where these memories are dated. This is the most time-consuming part of the method. Therefore, the tool to be developed can play such an important role.
The second phase is a well-known practice in dementia care: observation. But in this method, observation is practised with much knowledge of what certain behaviour means, according to the emotional biography. That increases the value of observation enormously.
Third phase is the search for a dominant emotional problem: what blocks a client from feeling good? All this information can be put in some diagrams, that are specifically Böhm-related. These diagrams show the phase of regression, divided in 8 different emotional themes. It also shows the best opportunities to have interaction.
This phase of measuring is followed by creating a detailed care-plan, only based on actions that fit in the personal world of the client.
Last phase is evaluation. When during this evaluation it is clear that stability is not yet optimised, parts of the analyses will be repeated as many times as necessary.

The MI-Tale tool aims to provide extra input in phase 1 (biography) and phase 2 (observation), where personal biographic information is gathered and documented. The focus of our interest is not so much the factual information and dates but rather the emotional aspects of memories. This is what is meant by thymopsychologic information. When dementia sets in we often see a decline of cognitive functioning. This part of the brain is affected first. The emotional brain functions become the "main operating system."

This emotional mind is very focused on a sense of normality. However what is perceived as normal by the patient may very well be completely different from the sense of normality by the general population. So if we want to create an environment that the patient may perceive as normal, we first need to find out what this normality exactly consists of.

Thanks to research in the domain of neuropsychology we now better understand that the memories we are looking for are those that were formed in the first 23 years of the patients life (in average). Most of these memories are hard-coded in the prefrontal cortex of the brain and stay available for a long time in most dementia patients. Memories people store after this age are more often stored by connecting other memorized material. These connections decline in most patients with dementia, causing holes in their memories. What remains are the memories of their childhood and adolescence until it reaches adulthood. Of course there are exceptions. Some traumatic or ecstatic experiences can still be hardcoded in later years. Also some forms of dementia create a different pattern of "damage" to the memories, like vascular dementia, that randomly ravages memories from present to past.

As we stated before, in the psychobiographic care method, we are looking for emotional aspects of memories. So it is interesting, for instance, to know that the patient always had dinner with the whole family present and that mother would dish out the food and that if he was nice he would receive a little extra. This information helps us to create an environment that will help the patient to feel at home at the table and stimulate him to eat. We even know how to make the patient feel special again!

Another important feature is that we need to know this information as saved in the patient's memory. It may, for instance, be different than what close family members remember, although they had that moment together. We all know that our memories change in time. Events may become romanticised, exaggerated, minimised or covered by other memories. For a human being in dementia, these personal memories are the only ones they accept as real life. So, for the purposes of the psychobiographic care method, the memories as the patient presents them, are always true: it are only those, that we should work with. Trying to correct into our sense of reality can confuse the patient even more, so we have no desire to change or correct memories when we hear them.

4.1.3 The goal of the MI-Tale tool from the perspective of Psychobiographic Care

Collecting psychobiographic material takes a lot of time and skills. The ENPP Böhm network teaches their professionals to collect and record these memories unbiased. First of all, many patients do not talk that much anymore, nor do understand a regular way of questioning. For relevant information, caregivers generally depend on when and what they tell. Stimulating life story telling is only possible when the caregiver knows quite exactly what images of a time's spirit someone has in mind. That is something even very good historians can hardly provide, but the saved materials of past times can help. And then there is the difficulty of staying objective, and to be able to really accept what the story teller means. As human beings we are hardly capable of analysing 20 percent of what comes to us in an objective way. Being aware of the "colour of our glasses", the filter of own experience, helps to collect and record the information without twisting it to our own perspective. This MI-Tale device could help us better record biographic information from the patient without the filter of the observer. The information would have less bias as they are literally the words of the patient.

There is another important advantage to be gained from using a device: when people are in a game they are less likely to stick in socially expected behaviour. They quickly slide into an emotional state and will drop their social shields and masks and tell us their personal emotional stories.

Thirdly, this gathering of information takes a lot of time. A device that can be used without the professional carer present may save a lot of time for collecting personal information.

As a last goal we may look at the gathering of information on folklore and local history in a new way. By using this device in a group, we can collect local information on historic events. It is fun for participants to engage in reminiscing about their younger years. Using the device in a group may revive or complete partial memories of local history and folklore. We can use this information to create an environment that is recognized by the patients and gives them a sense of belonging, a sense of home.

4.1.4 Users interacting with the tool

Aim of the MI-Tale project is to develop a device that stimulates elderly, in particular people in early and medium stages of dementia, to share their life stories. We envision this to be a device to make it interesting not only for the elderly dementia patient, but also for the family or (informal) carers around them. It is supposed to be a group effort, that will encourage the elderly to talk, but also creates a pleasant way to interact. Thus it also stimulates communication with family and carers. A welcome side effect is that the family or carer immediately learns about the biography, just from the

experience of the tool. We expect the initiative to use the device will be taken by the family or carer, not so much by the elderly patients themselves.

A special subset of users include the professionals with a Böhm training. The tool to be developed will give them some extra possibilities in interpreting and exporting results (the recorded stories).

Aside from the family and carer in a one-to-one situation (or with a few family members) we envision the device to be an interesting way to talk about local folklore and regional history in a group setting, for example in a day-care setting or as a group activity in a nursing home. Then a health-care professional or activity-coordinator / motivational therapist will guide the group process of talking about local historic events from a certain time period (taking into account the age of our target group, this will be mainly 1945-1960).

As a third application of the device we envision healthy elderly people to use the device as a nostalgic pass-time, amongst themselves, with friends or family.

The requirements from a user's perspective would be those of the elderly persons with dementia, since they will use the device and hopefully benefit from it, but also the ones around them, who will use the device with them and probably will be the ones starting-up the device, adjusting device settings, exporting results, etc. However, although the person with dementia will not operate or programme the device themselves , their input is important, since it provides us as a consortium an overview of how the device would work and how different involved people experience the device.

4.1.5 Suitable aspects of the Böhm method biograph to transfer into the tool.

The Böhm method, described as a process in section b, inspired by philosophers like Epicurus, is aimed at supporting a certain mental state that called "ataraxia" which can be translated as "inner peace" ("Seelenfriede" Böhm, SOKO Demenz, 2017). This mental state can be achieved by promoting a sense of personal happiness and avoiding pain and sorrow. This makes it important for us to know what would sustain such a feeling in a person. In Chapter two we will extensively describe different aspects of the biography work according to Böhm.

To summarise them and boil it down to what we want to use for the tool to be developed, we can say that we are interested in:

- Life stories
- Folklore (local and regional)
- Copings

With an emphasis on the early years of life, where these memories/experiences are stored in the tertiary (long term) memory (Die Tattoos der Altersseele, Böhm, 2015). We are talking about the age 0-25 years.

Biographies can have many forms. Dominant memories can be sorted according to a great variety of principles, resulting in dominant theme's in a person's life. So the biography we are collecting can be the result of an "alloy" of different thematic biographies (Die Tattoos der Altersseele, Böhm, 2015). Some examples of these themes:

- Family biography
- I-identity biography
- Quitting/braking-up biography
- Ownership conflict biography
- Life-ladder (Erikson) biography
- Evolutionary (Choice of life-partners, procreation, maternal care) biography
- And so on…

This makes it interesting for us to look for these thematic tendencies when we are collecting and analysing biographic material.

In an earlier attempt to create a device, shaped like a board-game to collect biographic material, the historian of the ENPP-Böhm network, mr. Dirk Wiedermann, explored which elements of the Böhm theory should be integrated in a device to collect biographic material.

- Collective Memories
- Regional Memories
- Individual Memories
- Communication
- Principle of Normality
- Identifying possible impulses
- Identifying what builds self esteem
- Identifying Coping Strategies
- Life motives

From decades of experience writing psychobiographies, a list was made of themes that seem to be most interesting to elderly people in dementia. To sum it up:

First car, occupations, youth clubs, fragrances, home, food, marriage, upbringing, education, first love, family, anniversaries and celebrations, driving school, flight and banishment/expulsion, siblings, money, pet, handicrafts, wedding, war experiences, idols, illnesses, saving energy, prisoner of war, youth evacuation and , songs, apprenticeship, farming, fashion, politics, religion, travel, butchering, sports, school, black market, gossip, dancing class, daily routine, vacation/holiday, loss, social clubs, ancestors, weather;

Next to these general topics, also some specific themes can be distinguished which are typically referring to National and local experiences. For instance:

Austria: Hard times before WW2; Complex relation with German speaking people, complex relation with Europe after the WW. Pride of rebuilding the country after the world-war, but also long time hard labour and poverty; specific activities in Austria: the way of celebrating, the deep catholic religion, the relation with nature

Germany: BDM time (Bund Deutsche Mädel), HJ time (Hitler Jugend), Kinderlandverschickung, Landjahr, Pflichtjahr, Wirtschaftswunder, WHW (Winterhilfswerk), KdF (Kraft durch Freude),

The Netherlands: kinderuitzending, Radio Oranje/BBC, Bevrijding, distributiebon/bonkaart, NSB, verzet, onderduiken, verduistering, Hongerwinter, smokkelen, Stormvloed, Indonesië, Korea, Wim Sonneveld, nozems.

Cyprus: Fear for intervention from neighbouring countries; losing freedom, the complex relation between the Greek Orthodox Church and Islam, difficult economic times

4.2 Collecting biographic information[1]

The short version described in the previous section is based on the theoretical framework of the psychobiographic care method. With reference to the introduction, here we start with section II (of three sections in total) of the report; the first methodical activity towards clients is the collection of personal emotional memories, for which Böhm uses the term 'psychobiography'. This section of the analyses is the most important part to understand for consortium members in the MI-Tale project. In this paragraph all the elements for collecting relevant psychobiographical information will be explained. As all this literature is only available in German, we will give a translation with some interpretation and addition of examples of the chapter on this theory from Böhm's textbook.

As 'we' as writers of this report use the word 'we'; then we refer to everyone who is interested in dementia care, either as caregiver, family member or, especially for MI-Tale, technical developers.

4.2.1 Collecting psychobiografic information on an emotional level

When collecting psychobiographic information, one should be interested in the categories of information:

- Life stories
- Folklore (local and regional)
- Copings

Although a so-to-say curriculum vitae will often be a starting point, we are interested in much more than that. From the curriculum, the chronologic recital of (important) events we can often easily access life stories, the more personal and emotional account of events.

To explain it a little bit more: a curriculum may give us the information that a patient was born in 1936 in Heerlen, the Netherlands, in a family of 10 children, as a fifth child, father working as an overseer in a coalmine, mother at home.

We are interested in life stories, so a question could be: "*Please tell me a story about your family life as a child*." The person with dementia responds: "*Going to school, every day we had to walk through a neighbourhood where all the coalminers families lived. Since we lived in a neighbourhood where the engineers lived, we were often attacked by the other kids as we walked through 'their' street. So I always had to bring my catapult to fight our way to school and back since I had to protect my little brother.*"

[1] Psychobiographisches Pflegemodell nach Böhm, Band II, 2009

This life story gives us interesting entrances to folklore (social classes were divided in different neighbourhoods, miners were rough people) and copings (he chose to fight rather than run or try to talk his way out) that we are looking for, which we couldn't know only based on the curriculum.

Gathering the information helps to learn about regional and local folklore. Miners were rough but overseers formed a class of their own, living between the engineers who were more educated and the actual miners who had little education. Miners in the Netherlands earned high wages, so there was no poverty in this working class, they ate a lot of rich food because of their hard physical work. There was a lot of comradely since the work was dangerous and people needed to rely on each other's underground.

This short example gives us a better idea of the collection of psychobiographic data. Looking for folklore and copings can help us to create a fitting environment and think of stimuli which we can use to (re)activate the patient.

Loss of copings is often caused by life-events that impact the psychological resilience. That is why we are interested in these type of events, which can be found using questions described in 1927 by the Berlin psychoanalytic Hencke:

- Did the patient lose his work, money or livelihood?
- Did the patient lose a partner or a child?
- Did the patient lose a person who was responsible of keeping an equilibrium in his life?
- Did someone (threat to) outclass/surpass the patient?
- Does the patient need to choose to be hard or soft?
- Does the patient need to decide whether to avenge himself?

Many organisations have started using forms of life-event research. The MI-Tale project aims to add a new instrument to the existing palette of techniques to collect psychobiographic information.

4.2.2 The psychobiographic background of life

Many patterns of reaction that we may observe in patients are not caused by dementia, but rather are the result of genetic predisposition and events and circumstances they have lived through in their lives. These factors have played a role during the entire life of the patient, but become more visible in our practice of dealing with people of age who are coming more in touch with their emotions and who may be losing some layers of social inhibition they developed during their societal career. To analyse and process these backgrounds and events into the psychobiography, psychoanalytic insights are used.

Next will a number of causes of psychosocial phenomena will be described which may be encountered in geriatric practice.

Family of origin

The family people grew up in, has a major influence on the way they shape their further life. What one has experienced in his or her family as a child sets the bar for what is experienced as nice, trustworthy, comforting, tasty or not. Will someone eat moderately or a lot, does someone like or hate potato soup, etcetera. Psychoanalysts like Freud, Jung, Adler or Frankl taught us many insights on the influence of family.

Family is extremely important in personal development of the individual. Therefore it is very important to collect personal family history for all kinds of reasons:

-Family can be a mini-war scene

Both tight relationships and deep rivalry can live together. Think of the Kain and Abel story: the rivalry for the best relationship with the father; the rivalry for being important in the family or getting enough attention. The well-known discussion between children: Who is most loved by mummy?

People who felt supressed in family relations often use words like:

- 'I was the black sheep of the family'
- 'I always felt like the fifth wheel on the carriage'
- 'I had to take care of everything'
- 'I always spoke my mind so no one liked me'

- Partner choice can have deep backgrounds

Starting a relationship or ending a relationship may be the most influencing emotional events in life. It may very well have an impact on later relationships between clients and caregivers. There are several different backgrounds for partner choice:

-Neurotic partner choice: choosing beneath your own level, by a lack of self-esteem (personal identity). A partner could then be the ideal weaker part of one's life. Or: indirect choice for the own father or mother: not really choosing a partner, but a surrogate father or mother.

-emotional backgrounds: Fled from home; protest against parents; sexual fascination, arranged marriages without love.

4.2.3 Rejecting the psychobiographic interview

A specific observation from Prof. Böhm is quoted here:

'*Some colleagues report that they do not know anything about the client. The client does not take them for full, but considers them a simple young girl or boy, to whom the client's secrets probably are of no concern and therefore have no interest in. I may mention that this is normal; It's normal that an old man will not think much of these youngsters ("They do not understand anything, they have not lived their life yet, they have no experience and do not know what life is about.*")

Paula Wessely (a famous Austrian actress) in a radio broadcast 16. 5. 1991:
Editor: "What about the engagements in 1930? It was easy to get a role to play?"
WESSELY: "How old are you, young man?"
Editor: "Year 1953."
WESSELY: "I cannot give you an answer, I would have to talk for years, for you to understand that."

Even Wessely, a cosmopolitan, educated woman, showed a definite defensive attitude to the youthful reporter by her tone alone. I (Prof. Böhm) would like to bring this into consideration, since today more and more young nurses are appearing on the stage of therapeutic conversation and who are, of course,

behaving like adolescents. These modern people with their copings and their linguistic style now want to interview the elderly about their copings. Neither of them, however, wants to give up anything of their personality, neither the old nor the boy. Result: they're just talking. End of Quote.

Of course, the intergenerational exchange of experiences is crucial. In the first place, the experience, knowledge and abilities should pass from the old to the young. On the other hand, at least the only biologically dismantled should also learn from the youngsters, about the main problems existing in the world of today. In Vienna, an association ("Wissensbörse" meaning "Knowledge Exchange") has established itself, to take on this particular task and communicates between young and old, keeping the elderly upstanding when they can pass on their experiences; the young become at least curious. If one does not adjust to the elderly, or if the interest in the historical background is too little, it is not surprising that you may learn nothing.

As already mentioned, the conversation (the survey) and the care for people (whether they are clients, patients or acquaintances) generally take place on two levels:

On the one hand on the professional level (here the discussion partners remain on the rational level; They have good arguments and measures). The client is in an emotional state. The expert radiates through his / her knowledge security to his / her clients and is therefore already soothing and reassuring. This should be the geriatric professional nurse.

On the other hand, we can distinguish the emotional interviewer, often at relative, who might be quite different, as long as he/she is not introduced to the way dementia works in people's mind or did not accept the behavioural change in mind. These persons are emotional themselves, their conversation is on an emotional level. It is largely devoid of a rational, professional basis, even if the interviewer is a professional and his/her own mother is the interviewed client. How else would s/he deal with the confusion and the peculiarities of his/her relatives? S/he himself is emotionally overburdened and forgets his/her expertise. S/he falls from the rational plain into feelings and suddenly becomes a layman. Therefore, he worries and frightens his surroundings because he "does not know what to do." The expectations towards the patient are wrong and inadequate, and phrases such as "Behave yourself, pull yourself together" are his actions. Even nursing staff (if it is emotionally acting) has the wrong attitude and expectation.

Layman	**Professional**
uncertain	confident
emotional	rational
unskilled	skilled
= leads to new erroneous action	= calming influence / placebo

Since the relatives act emotionally to their relatives, they expect us to also act emotionally and thus provide the "best" care for their relative. Based on this motivation, the erroneous view of nursing emerged to care with empathy, acceptance and proximity. In the field of public relations and talking to relatives, it is our duty to intervene here.

We could add in some insight from another famous specialist in dementia care: Naomi Feill. She is founder of the so called 'validation therapy'. Feill has learned, that the intergenerational interaction with a person in dementia involved, can be solved by 'validating' stories and expressions from people in dementia. Do not try to answer with your own set of values, but try to get into the story; take it seriously and pretend to hear it for the first time. Pose questions within the line of the story. If someone is sad because he misses his mother, don't say mother is dead; don't try to get away from that feeling by offering a cup of tea, but ask how sad he feels and why he specifically misses his mother. There is much more chance receiving useful information from a client in this way.

4.2.4 Learning a professional way of interviewing

Although we are focusing on emotional memories rather than on factual history, Having a dialogue at the temporal level of the client requires one to have general-, regional- and singular historical knowledge. Now we will try to introduce some zeitgeist (spirit of the time)-ideas and considerations.

Literature is the memory of humanity.
Whoever writes, remembers, and who reads, takes part in experiences.
Books can be reissued,
After all of books there are archive copies.
But not of people.
(Hans Keilson)

The general opinion is that everyone can have a conversation. I can also talk to my friends about issues of the soul. Is nursing, then, a conversational prostitution paid by health insurance? Transferred to a somatic situation the counter-question would be: Can't a waiter or a friend give a piece of sugar to a diabetic?

Of course, but the waiter will not understand the pathophysiological background.

It is the same with talking. One must have the appropriate knowledge about the disorders and problem possibilities, in order to be able to talk professionally. Thus, professional talking is something different than a bar conversation, even though the patient himself does not care. For him the doctrine is valid: everything that will help, is good.

As already mentioned in this chapter, doing a biographical survey must be learned; One must learn to enter the people's spirit (folklore). In doing so, we can first look into national history or regional history. Only after this exercise we can and should focus on the personal stories rather than the history. The collection of life-history (and not yet of the personal stories that we need) is thus the access or the exploration of the Volksseele (nations spirit).

This Volksseele expresses itself above all in classical and popular poetry. The historical background information of a time-epoch is learned through the study of the respective Zeitgeistes, from plays, but also from the biography of the respective author: Why did someone write something? What historic social aspects form the foundation of this period?

Even nursing models and their founders are subject to a Zeitgeist. For example, F. Nightingale and a Christian-ethical sense were modern in the 1830-1910's. In 1952 H. Peplau, the attempt to introduce "psychologic aspects." From 1960 onwards, some female pioneers of nursing tried to introduce the

Functional Care, and thus - from the Zeitgeist – tried to improve the level of self-awareness among nurses. The women's movement has led to the idea of nursing process theories since 1961. It looked for dynamic relationships and reminds us of the content of M. Balint. In 1963 V. Henderson identified with the, at the time highly modern A. Maslow, who had met the general Zeitgeist in America (Flower power, Addict scene, Vietnam). She rediscovered the 14 basic needs of man already described by an Italian paediatrician. M.E. Levine lived in 1966 in "self-sufficiency", helping people to help themselves became popular all of America.

In 1966 D.E. Orem translated this Zeitgeist with the idea of supporting self-care agency. In 1987 Roper taught socio-therapeutic subjects (12 life-activities), the basic idea comes from V. Frankl. R. Polletti rediscovered in 1989, when another psycho-boom erupted in America, the soul-body-soul-unity. Alternative methods are introduced in nursing; From foot reflexology massage to Bach-flower therapy everything not traditional in care is being tried out. In 1990 a mixture of different ingredients becomes holistic care.

Just like in the art of poetry, nursing model founders have also learned from the psychoanalysis, but have hardly quoted it. After all, the classical psychoanalysts also gained a great deal of their insights from the poetry of the people, and then attempted their analytical interpretation. Why shouldn't nursing also make good use of these patterns of life? This source material (poetry) is, of course, divided into national and regional oriented situations. We will illustrate this using some thoughts on national poetry.

Understanding a nation through its literature
In its content and its statements, world literacy is to be viewed in a completely different way than the regional folk poetry with its manifold expressive possibilities (F: "No need to have a mouth to speak") It is formalistic, intellectual, oriented to language and order. Classical literature in Vienna around the turn of the century remained "much dream and little reality", it hardly ever reached the simple man in the streets. The transformation of the world into an aesthetic totality became a program, but this was never played.

It must be known that with bourgeois clients, higher life drives should be aroused through classical literature: the beauty of thought and feeling, the beauty of freedom. Using the example of Stefan Zweig, I would like to demonstrate that an artist's work is always marked by his biography. Therefore it is not surprising that a man who was already a pacifist before the First World War was scarred by the horrors of the First World War, and mainly wrote pacifist-oriented literature. It is no wonder that he started his first literary walks in neutral Switzerland in Geneva ("Eremias"). He also wrote "The Heart of Europe" for the Swiss Red Cross. After the First World War, he went to Salzburg wanting to continue his "joint European campaigns", which, as is well known, was not achieved due to the new historical situation ("The world of yesterday, memories of a European"). This man lived his biographical impressions by always seeking and finding a unity with his many European friends visiting his villa. This, his own image of how the world should be did not come into existence, and his depression increased steadily (psychologic balancing?).

Many youth memories of famous persons have been written down and are of interest to the study of biographical and emotional references, among others Goethe's "Poetry and Truth" and Dostojewski's "Crime and Punishment".

The poor man, on the other hand, was afraid to enter the high stage of the classics. Thus the worker remained historically and supra-regional with the burlesque, the farce, and the cabaret, of which we can most readily learn through the folk or national poetry (and the souls of the poets themselves). The audience expected more from the burlesque, the farce, and the cabaret than from a beautiful, spiritual language, hoping to escape from everyday reality. No wonder, then, that the National Theater was the ultimate: Hans Wurst, F. Raimund, J. Nestroy and K. Valentin will remain in the nations spirit.

For colleagues in Switzerland Prof. Böhm would recommend as a compulsory reading the works of Simon Gfeller (Peoples literature), Rudolf von Tavel (City of Bern bourgeois) or Jeremias Gotthelf. Jeremias Gotthelf, who became known and loved as a priest of the Emmental region far beyond the borders of this valley, and his works such as "Money and the Spirit", "Cheesery in the village Vehfreude," "The Tenant," or "Ueli the Servant". All are worth a study of the biography by our Swiss colleagues.

Biography and music

Just as the world-literature did not enter the world of the elderly of today, classical music also couldn't conquer the hearts of the Austrian workers. They lacked first in the nursery, and afterwards the actual school education, that is, the key stimulus, to learn something beautiful, aesthetic. Only the obscene street songs found an appeal and still presents a charm to them today (as an impulse).

Quite different in the case of the bourgeois: with them, the world literature as well as the classical music triumphs. As musical impulse for the bourgeois we shouldn't think of the obscene songs of the street, but we should use church music, hiking songs, classical music. The musicians themselves often express their current prevailing emotions and thus their biography. For example with Beethoven, to name only one famous composer, one can recognize his best time, his happiest days, when he wrote Trio Opus 11, the so-called "Gassenhauer".

The people and their healers

While the witches practiced among the ordinary people, the ruling classes engaged their own representatives of secular healing. The medical doctors were actively involved in the elimination of female healing and their lock-out from the universities. Interesting is the fact that this took place long before the persecution of witches. The Church imposed strict restrictions on the medical profession and did not tolerate any development that did not follow the Catholic doctrine.

Medicine was dominated by class and gender struggle for a lifetime; We can learn something from it. The "medical experts" immediately took advantage of the nurses' caring role. Only today, the health movement is set in motion again to shake the establishment, this time in the sense of "self-help groups".

Learning about historic events and tales

The history of events and tales is best learned from the person concerned, the modern historians have recently said, and this is probably because our history was written for centuries by inappropriate people. To see the national history of Austria correctly has become difficult for Austrians because they took part in German history for centuries (Hermann BAHR). It is Austria's curse that it's history has almost always been written by it's enemies. Unfortunately this distorted and discoloured picture of Austria has penetrated countless Austrian heads, so that we have forgotten how to see ourselves with our own eyes and to judge with our own mind (Alfred von Berger).

It seems the oral history, which today is regarded as a modern form of history, has arisen from these considerations. That is to say, the students of history themselves no longer learn from pure sources as evidence, but from the questioning of people on the street or in clubs or colleges of the Adult education centres (Volkshochschule). The proverb, "Dig, where you stand", was created as a continuation of oral history research mostly about the working class. This is seen as a working-up of your own past, as the emerging bottom-up approach towards historical awareness In colleges of the adult education centres, solidarity-communities (trade unions), workers' biography associations. The history of the working class is so interesting, since there was hardly any working-class poetry or literature.

In the process of ascertaining lived history, the patient himself becomes an employee, the "interviewee" becomes a consultant. Suggestions: Collect badges or old books and interpret old historical films.

A people is the society built on a linguistic community and / or blood relations, in contrast to the nation. The people are the embodiment of historical and cultural common development, independent of political limitation and form of state. Early Romanticism created this comprehensive political concept of the people at the same time as these terms for "people's spirit"; Volksseele (Hegel), Volkstum, Volksbewusstsein (Herder). It is thus not surprising that my work of collecting and interpreting biography in nursing diagnostics is predominantly reflected in the investigation of the people's spirit and their actions and reactions as well as in the ability to connect to each individual patient.

What is being noticed in life, also in the sense of historical consciousness, is a result of what one perceives as important in life. Even personal history is experienced as something changeable and is always seen in a new light up until one might reach dementia. In the case of dementia, then, we are probably only conscious of the most essential factors. If one compares the historical events with the life-years, different historical imprints come to surface (What was important to us?). For instance, in the case of younger people the sporting history will be more important than, for example, social history, which perhaps attains much more importance a few years later, as well as the cultural history, the working history, the family history, or the history of leisure. The history for every individual is thus occupied by different values and evaluations of their life.

The pecking order has to be separated between lower, middle and upper class and rural or city population. Theorem: "*It is not necessary to be a bee in order to know how honey tastes, but we must*

have a presentiment of the given history, in order to understand the clients. That way the historical content we can collect today can be used to estimate the interaction-level of the patient".

4.2.5 Learning about imprinting phenomena

When researching imprinting phenomena it is interesting to note that especially German-speaking people have an anal fixation, and therefore, according to S. Freud, have an increased defensive behaviour in the sense of exaggerated cleanliness, love for order, diligence, pedantry, and the desire to organize. The typical folklore words are:

- *"... get it right."*
- *"Order must be."*
- *"We need tables. "*
- *"We are economical."*
- *"Our diligence is admired by foreigners."*

"Ladies and Gentlemen
Aim not for the brim
but in the middle I say
This is the German way. "
(Toilet proverb)

This is also confirmed by the writings of S. Ferenczi, according to which a child is interested in sand, pebbles, mussels and marbles until the concept of reaction formation creates aversion to dirt, disorder and excretion products. In addition there is the distinction between anal restraint (of the hoarding, knotty type) and anal discharge. The word "possession" derives from "being able to sit". Cleaning fanatics can be addressed with proverbs like (translated): "Like the kitchen, so the house, clean inside, clean out!".

If we want to stick to the thesis that in old age and, above all, in cerebral performance disorders, we rely on old stored material, we also have to bear in mind (and we experience this in practice every day) that the mixture of peoples, in the sense of linguistic understanding, brings difficulties. Since elderly clients still appear in Vienna today as "mixtures" (the spurs of the monarchy), we are confronted with the problem that they have spoken German for a lifetime, but now return to their mother tongue in the old age. This will create an unprecedented challenge to the future when we will be confronting many different nationalities and dialects in a diversified society: we must find ways to learn about their language, folklore and personal history.

Problem: mother tongue Hungarian

Diagnosis: As a result of the cerebral decompensation, the patient no longer speaks German but speaks Hungarian.

Impulse: Reception by Hungarian nurses

It is said by German regionalists that although there is a "national character" (see historical biography), this is also to a much greater extent to be found as a regional feature of character. It must be pointed out that there is a difference between Prussia and Bavaria, although both are

Germans, and between people from Basel and Zurich, although both are Swiss. Undoubtedly there are regional ethnic groups, each imprinted with their own feelings of territorial, cultural and often also oral integrity.

The Regional History

The regional history and feelings are even more imprinted in the memory than the historical event in itself. The regional situation predominantly takes place in the actual "ghetto" situation of the locals and is experienced with the heart language - the dialect - but above all internalized.

Example: "When you're a Tyrolean, you're a man – when you're not a Tyrolean, you're an ass."

This exemplary sentence says more than any High German poem. The classics have written complete poems about longing, heart pain, etc., but they do not go as close to the heart as the popular heart language. The imprinting event is therefore very often strictly specific, even "heart-specific".

These homely mother-tongue-words trigger similar reactions as they were derived from the same regional group. There is a big difference, whether one is greeted with the Viennese word "Have the honour", a popular greeting in Austria around 1900, or simply with the word "bye" of today's equal-society.

Regional history becomes very clearly, and for us learnable, through the regional dialect poetry.

Regional dialect

One recognizes the Viennese immediately from their ancient developed ethnic language. With a genuine Viennese one can refresh oneself in the expressiveness and variety of linguistic images. This is no longer a dialect, but already a kind of language which comes from the finest ramifications of heart and mind, and has a hair-striking expression for every sensation.

When comparing Vienna language to Bavarian or Swiss, it becomes obvious that the regional character is as different as its poetry and the jokes, people in a certain region laugh about. What is funny or correct in a particular region can be can be completely wrong or inappropriate in another region. ' The regional language is thus the language of the people we have to look after.

During the monarchy, all the officers in the East of Europe, could speak Yiddish, The Monarchy-Esperanto. Thus, in every city, they could understand each other, because in all garrisons there were at least some Jews present.

In Vienna, and indeed in the sub-proletariat, a sort of crooked, or, more precisely, like-minded language was spoken (called "Griasler" language), which was even rejected and not understood by the working class in Vienna. It was the language of the homeless, a comic mixture of pathetic high German and primitive crooks, of course purely on the emotional level.

Many words of this Griasler dialect have passed into the native Viennese vernacular. The actual content of the word is hardly being understood, that is, many words are used incorrectly. For biography, one needs to understand the language of the heart, in order to become a primus inter pares (first among the equal) as a nurse.

A current occasion, e.g. an anniversary of the Grimm brothers, can become the starting point for a group activity about fairy tales and their impact on children and adults. In particular, we would like to explore memories of their favourite tales, research their effects and feelings. The fact that you learn about their biography by accident is great. Fairy tales are supposed to lead to daydreams and are therefore useful revitalization steps.

Mixing generations has proven to be an emotionally favourable experience for elderly. "What Grandmother Knows" is a way to bring children of the neighbouring kindergarten to the retirement home, and 'grandmother' tells the children fairy tales. As already mentioned, the grandmother who is already in the process of decline and the grandchild in the process of growth, are on the same level, especially on the level of emotion. The parents are largely excluded from the emotional level - they are only educators.

Also the folk music sits deeply. A brief case study by Professor H. Strotzka is intended to illustrate this: A 94-year-old woman is close to her dying moment, she does not take in any more fluids, she no longer recognizes her surroundings and has the characteristic gasping breathing. A visitor from the next generation sits next to her, stroking her hand, which she obviously feels as pleasant. The visitor recognises that a contact is no longer possible. To prevent boredom, she begins to sing quietly (patient is in a single room). The patient seems to become calmer. Her repertoire is slowly coming to an end. At last she sings an old German folk song, "*Kommt ein Vogerl geflogen*," the third stanza does not fall into her mind, and she stops, and then something wonderful happens: the patient sings the third stanza herself, very quietly and hardly understandable. Hours later, she dies.

Example: "Sing to whom singing is given."

Songs from the most famous Viennese singers of their time are a treasure trove of emotions, enabling us to recognize and to feel the Viennese heart. Hearing some of these songs may bring tears to the Viennese listeners eyes. The carer who knows only one or two texts of a Viennese song is already the greatest carer of all times at this station.

The music itself, or because it is played on an old gramophone or a needle-scraping device, is particularly emotionally endowed and can also contribute to the discovery of biographic material. Music therapist Dorothea Mutesius reports of two reactivating cases:

- Lullabies: to middle-class singers, singing lullabies in the evening, is a deeply motivating reminder that there was something else to be done before going to bed: to go to the toilet.
- Our song: Every adult among us knows that a new acquaintance often gets associated with a song which becomes emotionally rooted in it as "our song." Songs and music thus divert attention from the rational plane, embellish situations and awakens emotions.

The song (translated) "If I want to or not, you are my destiny, because everything beautiful ..." often meant: "You have set me a trap, well, now I'll just stay with you forever". The song "I had a comrade" was the code to an old woman's central emotional experience that her husband had fallen years ago. She swore eternal fidelity to him with this song and has kept true to her oath.

Many times I have witnessed that also with music a code stored in the tertiary memory exists, which one can reactivate again in old age. If this is not available, there is simply no entrance by means of music. In the collection of the personal history, we must look to find if such feedback exists now and, above all, ever existed in the past. As far as impulses are concerned, one has to pay attention to the fact that one used to listen to a radio by a so-called detector or demodulator (AM radio) that people sometimes had built themselves. If you do not have old gramophones with needles for reactivation, you have to find one. This provides an adequate sensation of the old sound of radio and music.

As there are writing chroniclers, there are also painters who can bring us closer to the reality of those years. All caricaturists for example painted in the exaggerated style and social denunciations. They show us typical pictures of the "Volksseele" and their burdens. What painters can your patients remember? Let them explain a little about them.

In the book "*Leben auf dem Dorf*" (Life in a village), A. Ilien and U. Jegglee (1978) describe how the economic conditions permeated the interactions of people and were always present. The constant fear of sinking into poverty, perhaps into the great army of beggars, reinforced the obsession for possession. Possession was the only shield against poverty. Hunger and misery defined the village, the size of the houses, the stables, the height of the fences, the relationship between parents and children, between spouses, the generations, the neighbours, and the other villagers. Poverty and fear made people ruthless, hard, suspicious. Despite the assignment to the work process, everyone was always a potential competitor and opponent. The neighbour who helped bringing in the hay from the field during a storm, in order to carry it together faster into the barn, would also think about moving the marker-stones. The folklore saying "Everyone is and was a border offender" is still clearly comprehensible in every Heimat-movie. The learned lesson is that the other is always doing the worst, and most of the time people were right regarding this view of life.

Example: Farmers' Cunning Hypocrites

A farmer had no friends. "The best friend for me is me" was the motto. The imprinting situations were as different as the folklore patterns between urban and rural populations. An elderly woman reports to her husband after her release from a Salzburg state hospital that next to her in the neighbouring bed, there was a lady from the city and that these "city people" "are to be envied, always a theatre nearby, always clean hands, well-kept feet and with many beautiful clothes, unlike them with only one Sunday robe. The Salzburg city lady will surely have explained something similar to her husband. How beautiful the country life would have been, she will have said, every day in nature, the good air, no worries about food. Both of them complain about each other's happiness, about the seemingly missing things that only the other person has.

The two of them are also jealous of what has passed: From Salzburg Radio I learned that the Salzburg woman was very happy about the Holy Mass. In her experience, this was the only hour in the whole week that belonged only to her, where the dog did not bark, the daughter did not scream, the father did not want to eat. From Vienna I learned that the Viennese was looking forward to the childbed, because these were a few days a year, where she experienced peace and quiet. Both have bought peace and quiet, each with a different imprinting.

A bourgeois biography collecting conversation is done like the "small talk" around 1900: The guest politely bows: "I kiss your hand, ma'am," the offered hand holds lightly to his lips and introduces himself as follows: "Madame, I have allowed myself to follow up on your kind invitation and hope not to come at a bad time. "Host:" On the contrary, we have been looking forward to seeing you, please take a seat. " Guest: "Dear Madam, may I inquire about your health?" "Oh, thank you, I feel very well." "Have madam survived the hardships of yesterday's tour?" And so on.

These conversations are imprinted in commoners. You talk about nothing and you don't upset anyone. Talks of this kind are either imprinted or learned from so-called "new rich people" after the Great War. One could buy books about "conversations". It is a very special kind of communication that has nothing to do with today's communication laws! Examples: The shyness in the sense of a pathological subordination need had to be discarded. You needed acting skills for your conversational skills. One always had to praise the energy and prudence of the housewives. Today ambition is no longer about having baked a turban-cake, but about athletic, male-energetic achievements. You can't quarrel with contentious people, and you shouldn't contradict them either. Ask more questions, so that the quarrelsome person has to give his own answer. It is important to empathize, always agree with the other. Every participant in a conversation is looking for attention and wants to stand out. Very poor people are more sensitive than rich, clever people.

Clothing is an essential feature of a conversation: "Perfectly from the crown to the sole." Fingernails, for example, should be polished with deer-leather. For men, care must be taken to draw the left-side hair parting above the left eye. As facial hair only a small moustache is acceptable. Do not put on a false shine! Ties must be made of silk.

Before entering into conversation with someone, you have to abandon unfavourable habits. Rest is elegant. One must always show interest; The best way to do this is to look your partner in the eye and once at their mouth.

A man is as good as his voice, systematic reading exercises are the ultimate. You need a general education in the service of society. You have to take dancing lessons to talk. Non-dancers have something stiff, angular, arrhythmic in their movements, indicating a lack of training.

What to say: "*The pious one can't live in peace, if the evil neighbour does not let him*." That means: avoiding any dispute, agreeing with everyone, not talking about mistakes from others, no hypocritical self-accusation, no double negatives, looking for the favourite subject of the conversation partner, starting conversation about on previously read magazines, a conversational lexicon, flattering everyone with the words, addressing someone only with "you" is prohibited; the title belongs to it, e.g. "Gracious miss".

It is interesting that even the macro-area in which one grew up is of interest for well-being. It makes a big difference whether you were born or imprinted on the North Sea, in the Alps or at sea or in the high mountains. It is not without reason that they speak of mountain peoples, desert tribes or even the landscape-character. The mountain farmer does not give up his terrain, even if his slope is avalanche-prone or his house has collapsed several times. He remains true to his homeland, with which he is rooted in through imprinting phenomena.

The ghetto is probably to be described as a whole as a living environment and is described in this book continuously, so we do not have to describe it separately here. The area where you grew up and the memory in which you lived and still do live is a "zone of well-being" that should not be used without your own purpose. "We can learn a great deal from the elderly themselves, and they should become our co-worker.

This method, which is very much reminiscent of Oral History, has been accomplished for some years by some media companies as a "guideline how to work with life stories" by the Federal Agency for Adult Education in the form of videocassettes., Above all, however, university lecturers Heinz BIaumeiser and Mrs. Mag. Wappelshammer have distinguished themselves with their work "Biography Helps to Help" and "Ottakringer Model" in the elderly work (with ordinary citizens). Here, the elderly man offers himself as a teacher - "I like to remember." This is in the collecting of the biography itself already a form of supporting the lust for life and thus to be seen as an important form of prevention for the normal elderly (I'm important).

Other entry and practice opportunities in which our clients could become our teachers are:

- Founding-festivities (e.g. 100 years of settlers association)
- regional district museum
- 100 years jubilee of a local political party
- Postal Museum visit (with an old post office worker)
- Exhibitions about the working class

Typical time experts in the scene, who could help us through interviews in the study of the elderly, are, for example, caretakers, postmen, waiters, shopkeepers. In addition, the learning of stories takes place through the study of old movies about everyday life (Heimatfilme, like the Hans Moser, Theo Lingen, Hugo Portisch-series), poetry books of the regional homeland, historical data, old testimonials, touring books, textbooks, photos, CVs, diaries, etc.

Where do elderly persons live? That's the first question we should ask ourselves. If you take a look around, you will see that citizens of a certain residential area feel comfortable. The living environment is something chosen with care. Living is something highly private in the consciousness of most people. Your own four walls are something sacred, you pay close attention to who you let past the threshold of your door.

The living environment is the terrain that is close to you and makes social contacts possible (the southerners live more or less on the street). This can also be the railway station. These historical situations in the living environment are all related to mental health. It is impossible to put a working class man from the 16th district of Vienna into a teaching environment without collapsing his soul. The mentality belongs to life like water and bread. Only in the personal living environment can human needs be satisfied.

It is interesting that even a mixture of the sub-proletariat was impossible. It was impossible for a "Griasler" living in the Central Canal district of Vienna to move to the socially higher quarters, such as the “Massenkwartier” neighbourhood, or even be allowed to do so. There was a strict pecking-order of sub-urban camps around 1900. The living environment was sometimes also the “warmth-

room". To slip into another milieu could mean the downfall for some people. "It's funny how it starts," a beggar once said to me. "The change of my regular café was in fact responsible for the fact that I was slipping downwards more and more. You suddenly have to drink your coffee cheaper, go to a cheap pub. There you see the people of a very mixed society, who have a lot of time. They sit there all day, playing or talking about their strange business. At first you are proud. Taste and education arrogance keep you in your place, looking over a newspaper and observing these foreign existences. But one day you will be in the middle of them. It's unbelievable how quickly your lost grasp at the world brings you closer to the subject. "

The living environment of the bourgeois class can be described as the coffeehouse in Vienna. It was the breeding ground from which the commoners drew their secret life-forces. It was about the atmosphere (reactivation) that was emanating here and the meeting with like-minded people.

In one's own milieu, one knows their way around and therefore feels "safe." A bum feels comfortable while bawling, a wanderer wandering, one shares the common language, the common interest, and so one doesn't get scared. We are obliged to penetrate the milieu of our ancestors and to look around in the place of distress, to go through the neighbourhoods of distress and crime and to learn how to accept people as they are.

Why did I study all this material? Why did I tell you all this? Because it is very important for the collection of an emotional biography.

You could say that the theorem is:

Example: Only when the heart is full, the mouth will run over.

Or in other words: Only when we nurses manage to put the client into an emotional state (and this works very well with biographical personal material and/or time-appropriate material), he will tell us something, probably unfiltered by the superego (Über-Ich), about himself.

And that is the material that on the one hand constitutes problems, on the other hand is important for interpretation, and even more important for setting the impulses.

4.3 Communication based on biography

To learn about an individual
is to know how he expresses himself (Quote from manual Prof.Böhm, author unknown)

As mentioned in the introduction, here we enter the third relevant section of the Böhm Manual II. We will give some background information on the relationship between communication and psychobiographic theory of levels of interaction. Functional communication is based on pshychobiographical material, collected in the way above mentioned. For MI-Tale it is important to know that communication with people in dementia requires special skills and is only effective with personal psychobiographical knowledge from the client. Again most of this information is derived from the textbook by Prof. Böhm used in the previous section, with additions from Dutch teachers.

When the word 'you' is used in this section, it is aimed at caregivers and the designers/builders of the Mi-Tale app.

4.3.1 Observing stories

Collecting requires observing. When collecting stories, one needs to be aware, that the collection of life stories of our elderly people is a collection of many shards. Many people had to rebuild their life over five times. Nevertheless, Every time again they did it with the same copings and the same set of emotions. Therefore, it is important to collect the overall emotions instead of dates and figures.

The importance of life stories can be illustrated by the African expression that a dying old man is a 'burning library'. Collecting emotional life stories is finding the entrance of the individual. The best chances you have to find the entrance is to be 'primus inter pares': the first among the equal. As Viktor Frankl noted: 'only someone who lived in a concentration camp can understand someone who lived in a concentration camp'. A labourer understands a labourer and a student understands a student. You than live in the reality of the person.

Someone can grow away from his background, but in dementia he returns.

So, if you really want to enter into the life and life stories of another person, you have to be at least very well introduced in his or her world, or you may never really analyse these life stories well enough.

Collecting life stories also requires to be curious why (or whether) the individual wants to talk about him or herself. There are many reasons why an individual wants to share it's personal life:

- (S)he wants to share what moves him deeply ('elan vital')
- (S)he is a communicative person and therefore communicates
- (S)he is in need of uplifting his personal value and tells you therefore a 'life lie'.
- (S)he is in need of sharing aspects of his personal identity
- (S)he wants to compare his or her own biography with someone else's

Telling your own life stories is always about relieving a burden, or (in a catholic context) a sermon. It may also diminish your deep feeling of fright.

To speak with equal minds feels good. It is communication based on human qualities. Often in dark winter evenings, before the era of smartphones, it was common sense to tell life stories; big or small. This information could compared with the own biography to see whether you had a 'normal' biography. The communicative effect of the story telling is even more important than the content.

Nowadays, the story telling on winter evenings will be less, but in fact, using social media, is much of the same idea. (personal thought of the authors of this report).

Story telling has an effect on your personal wellbeing as well:

- an interesting story, will have a big audience. This makes the story teller feel good and does rise his or her personal value rises
- for the one suffering, it can work as a kind of therapy to talk about it.

What's in a story? Mostly emotions: suffering, fear, hope, concerns. When sharing it, you also share part of the burden. That's maybe why caregivers are focussed on procedures rather than on people: to protect themselves from carrying too much burden. But measuring blood pressure may be less helpful than listening to a story about three deceased children from an older lady.

Listening to stories, will enable the caregiver to discover the personality behind the client.

Please be aware, that you need to listen to what people tell you, to diminish the risk of collecting irrelevant or incorrect information. You should not ask questions before you have established a matching level of interaction. You should also analyse the stories without valuating them. It is not up to you to judge the stories. If you feel the urge to judge; this means that you are simply not on the same level as the story teller and you do not really understand him. Stay away from hidden trauma's. This requires professional assistance.

People who talk about their past see images that the caregiver don't see. This requires, that the caregiver should be open to learn from the elderly.

Useful common openings of a life story can be:

- When I went to School, I..
- I didn't have a happy youth..
- Yes, this happened to me too, but..
- Times have changed; in my days..

Family and friends, from the time a person remembers, can be included in a conversation. But be aware of the fact that they have their own images of the past.

Wrong questions are corrective comments or questions. If these kind of question are asked, the story telling process will be frustrated. For example:

- But, it wasn't that way..
- You can't remember it anymore, can you?
- You were far too small in those days
- What nonsense do you tell now
- That's new for me, what you tell me now

Do not automatically comfort the client if a story is sad. Often people have little positive experience with comfort. You better explain why you want to hear these stories: you want to understand the client.

Elderly people want to share their biography, to prevent themselves from being alone in memories. This invites you to take part in these memories.

Be aware, it is not just you (the interviewer) trying to picture the client; the client is trying to picture you too. But while you, having a healthy memory, are able to use and even create many pictures or references; the elderly person in dementia just has a limited set of pictures. Try to fit into their images therefore. You might be seen as son or daughter. Try to fit in the social environment. Use

the clients name; not just mr. of mrs. By using his name, the client knows you are addressing him or her personally.

It is very well possible that clients don't talk automatically. There are many ways to overcome silence. One of them is checking the intimacy distance (1,5 metre). If a client allows you to come closer, you might be able to have gained enough trust to hear stories.

Another possibility is to use light humour as an opening.

A third solution might be to organise some liveliness and open up a conversation about the situation created.

Try to fit in a stereotype role. If you wear a uniform, you are professional: behave like that. Don't speak too childish. If you are a very young staff member; play the young and unexperienced caregiver. The client is going to help you there. The interaction should be as the client expects it to be.

For MI-Tale this could mean it is important to think carefully about the types of questions to be implemented in the tool. It might be important to have different sets of questions for different types of people who are in lead in the tool. Professional caregivers might need other kind of questions than grandchildren.

Regional expressions as a key-stimulus for interaction

The regional expressions for explaining life are sometimes worldwide similar. They are a treasure for interaction. They have the function of a key-stimulus. As soon as a well-known expression is used, even someone in deeper dementia will react accordingly.

You have to find a collection of expressions in each different culture; this is just as important as collecting pictures of a cultural background.

- Tired like a dog
- He who does not work, neither shall he eat
- The devil visits the rich too — but he visits the poor twice
- A bird in the hand is worth two in the bush
- Money for old rope
- Sleeping like a top
- Eat like a horse

Expressions can be divided into those you need for therapy and those you can use as key-stimulus. Find out, whether an expression is really used by a client, or whether the client is used to a variety of an expression.

There are also many very personal expressions, that are not regionally used, but really do function as key-stimulus for a client.

For MI-Tale, this means, that apart from collecting historical pictures, we should also collect a series of expressions per culture in which we are going to experiment.

4.3.2 Interaction levels

Conversation without arousal is possible with people without many signs of regression. Easy questions are possible to get straight answers: Were you a sports teacher? Did you play with Lego in your youth?

However, if a client is seriously in regression or 'decompensated', then you should be aware of the interaction level s/he is in. We can distinguish as much as 7 levels of interaction (as in Reisberg Global Deterioration Scale, see references). Böhm has described these levels of development from newly born to adult and the reverse process in dementia as the "turnaround phenomenon". The different levels count from adult life back to toddler, starting at the age of 25:

1th Level: Socialisation (18-25 years)
This first level corresponds to the adult level, lifelong learning allows to meet and adapt to the norms in society. If patients can no longer be reached with conversations at this first level, you can try to contact them at the next level.

2th Level: Common sense and cultural values (12-18 years)
This corresponds to the developmental stage of the adolescents. At this stage people speak according to what they learned from their social environment (depending on region and social status) "The bird is known by his note".

3th Level: Psychological and social basic needs (6-12 years)
People at this level have lost many previous skills, abilities and habits. They are in search of security and reassurance of their psychological and social basic needs

4th level: Imprinted characteristics from repetition and examples (3-6 years)
People in this stage behave like they have learned through example and repetition. Rituals provide a feeling of security.

5th level: Personal deep urges and instinct (also 3-6 years)
People in this stage act on impulse. It is a level of learning restraint and promoting self-control, learning to oversee future implications of current behaviour.

6th level: Intuition (1-3 years)
People in this stage act like in the infancy and toddler age; Feelings, fairy tales, superstitions and images play a role.

7th level: Basal communication (0-1 years)
Infancy; the emotional accessibility is given, physical possibilities are limited.

Within every phase it is important, that interest of curiosity should be created by the one that leads the conversation, that leads to interaction. Therefore, key-stimuli belonging to this particular phase are important. Everyone, even in deep dementia, has something to tell. Whether they really do depend on whether they can be spiritually awakened to feel the urge to speak or (in lower levels) to show us non-verbal signs. The deeper they go into dementia, the more important it becomes to make contact in the right interaction level as you only are able to relate to your own level and the levels below it. Also the risk of addressing someone in a level that is lower than the one they are

functioning in, is that it stimulates them to regress to that lower level (or in a best case scenario it makes them angry because they feel treated like an idiot).

The right interaction phase is to be found by analysing the so called interaction scheme, part of the process analysis in the Böhm-method. In this report, we focus on some practical description/examples of interaction in different levels of dementia: how can the interviewer communicate? What kind of questions are relevant in what stage of dementia?

Below we will sum some examples of these key-stimuli to be used in different levels:

Examples of emotional questions for every interaction level

1th Level: Socialisation 18-25 years

- Your life should have been mighty interesting?
- What do you think is really important now?
- What do you still want to achieve?
- What do you still want to do?
- What is the most difficult for you?
- What have you achieved in the past?
- What kind of jobs did you have?
- Did you have a dominant father?

2th Level: Common sense and cultural values (depending on region and social status)

Somewhat 'direct' question, with a slice of humour in it

- How did you make your living
- You did some black market earning, I suppose
- Why did you have so many children
- Home, sweet home

And further:

- Expressions from the pub
- Expressions on tiles from the bathroom
- Deliberate wrong questions'
- Making jokes

3th Level: Psychological and social basic needs

- Your dress is wonderful, it reminds me on Sundays
- Who do you miss most
- Do you like living here
- Who do you like most
- That picture is nice; is it your daughter
- I would like to learn from you
- Knock on wood

Consider the extra value of smoking a cigarette or having a drink and further, let the client:

- Write recipes
- Talk about food
- Talk about sex
- Talk about the bad behaviour of others (gossiping)
- Talk about power

4th level: Imprinted characteristics from memories and examples

- When should you get married
- When should you buy your home
- Lighting candles
- Lighting the fireplace

And further talk together about:

- Change of jobs
- School exams
- Trips abroad
- Holidays
- Religious behaviour

5th level: Personal deep urges and instinct (also 3-6 years)

- You have beautiful eyes
- What do you do to feel well
- What do you like to do mostly
- Does the food taste good
- Where would you like to be instead of here

And further:

- Personal-identity conversations

6th level: Intuition

Where did you witness by seeing of hearing things

- Stories about witches in your region
- Give away a happiness amulet
- Teddy bears for Men
- Dolls for women
- Involve a reverent or priest

7th level: Basal communication

- Associative smells
- Skin contacts
- Signal language

As people in level 5 or deeper are not able anymore to tell stories that we can understand as such, we have to be able to estimate the daily life structure in the framework of their personal regional history. We also have to estimate the signal language they understand. Of course, it would be much better if we would collect all this information earlier from the client, so the estimation is not so uncertain, or accidentally mixed with our own personal images and therefore most probably wrong.

For the MI-Tale project, this means that in line of an interaction analysis, the set of questions around pictures or expressions should be adapted for clients in level 5 or deeper. This could be done by offering suggestions, as mentioned above by Professor. Böhm himself. These suggestions are very important, because we learned in the information above, that failing interaction will not lead to a relation in which the client is sharing emotional life stories with you.

Interaction levels 1 to (max.) 3:

Finding out the normal life structure
Although in dementia people tend to fall back on early memories, a lot of communication aspects of the adult life will be kept in mind, while they are during all those years during a relationship ingested in mind. It is therefore important to collect information of the first interaction levels as well.

E.g.:

- Well, how was your day today?
- 'Night, night!'
- Do I know you from somewhere?
- That's what I thought as well
- Yes, I remember..
- The kind of simple daily humour someone had (like stealing all toilet paper from the ladies room..)
- Often told family stories (also to be heard from family members!)
- Children's drawings or handwriting from the past

Again, it is extremely important to have a good image of the time spirit in which this all is remembered. For MI-Tale this could mean (again) that not only pictures, but also generally used expressions and descriptions of daily habits are just as important to collect for the device.

Interaction level 3

Short expressions (aphorisms) as key-stimulus

Further to the MI-Tale suggestions above, from interaction level 3 onwards, it is even more important to use expressions as key-stimulus for emotional revival (rise of vitality).

Very important is not only to use expressions, but also to pronounce them in recognisable dialect.

With often used expressions, people knew how to tell what really troubled them or how their community should be socially organised, without the need to explain in detail: 'home sweet home'… 'knock and I will open the door..'

Using the right expressions will stimulate the 'at home'-feeling. If you use them, the client will think you are 'one of ours'.

The collection of information for this level is very important, while in practice a majority of the clients we are dealing with, are situated more or less in this level 3. It is the first level of real dementia issues, so the period in which people are searching for help because the problems become most evident. For the MI-Tale tool this means it is important to have different collections per region that will be addressed.

Interesting is, that this could also influence the market potential. Although we might think that we might be able to serve a whole language area, we have to be aware whether we have enough typical information for typical regions within the language area.

Interaction level 4

Away from verbal communication

In this level we will have to try to use vehicles that carry personal emotions from the biography to stimulate interaction. 'You will talk about things from your heart..' Or, you will remember 'good old days'.

- Pictures (marriage, parents, baby photos form the children, favourite holidays, favourite cats or dogs)
- Old books, with personal messages in it
- Old letters from a long kept correspondence
- Postcards

And further:

- Bring favourite food
- Go through the post stamp collection
- Prices the client won by sporting or with their club
- Furniture from home
- Old paintings from home
- Music
- Church symbols

The collection of photos can be extended by family members: ask their collection as well.

Be aware, that everything you choose to show or to bring with you, should fit to the personal memory. It could take many albums before you find a photo that will be recognised.

You should also be aware of the fact, that this collection is either a way to collect life stories or only a starting point for further (re-)activation and not a goal at itself. It is a 'key-stimulus', that had to be followed by further steps.

In the context of MI-Tale it is important to realise, that –when working with images- an ever increasing collection is required, as there are so many different images about recollections and things from the past.

Interaction level 6-7

Bringing out/collecting through by estimating the situation

The interaction will become even more a non-verbal action.

First of all, even more than in the earlier levels, a very good knowledge about the time spirit of the client is necessary. You should try to understand what was accepted or normal in non-verbal communication: do you touch tenderly, or better not? Can you speak by facial expressions or typical gestures? We call it 'signal communication'.

You have to know by the little interaction you get, what the client means or wants, although the client might even not be able to finish the non-verbal communication anymore. Reaching out to a chair next to the bed might mean he wants to be dressed.

Do realise that there is nothing more frustrating for a client then having the idea that he pointed out what he wanted with all his strength and you still don't know what to do!!

Therefore a deep knowledge about his or her biography is so important, but not only the biography of the big events, the most ordinary, daily habits are far more important!

What were the first steps when a client went out of bed in the past? Did he first dress, of did he first go to the bathroom?

For MI-Tale this implies, that the collection of biographies should go through the most elementary daily things in life with examples mentioned above: starting with the first simple actions after waking-up in the morning.

Impulses
To stimulate the client for action or re-activation, we should not take over every movement, but we should support autonomy as much as possible. Don't feed a client too early, but support his hand on its way to the mouth. When a client doesn't understand the world around him anymore; make his world recognisable again.

Do realise, that a client may forget what he/she was intending to do, on his/her way from the sitting room to the kitchen. So, be sure to predict the client's way of doing things and have everything ready for him/her, so it is obvious for him/her what to do, without further thinking. This stimulates the secure feeling of 'home'.

Fear is the most important decompensating factor, that we should avoid for our clients.

Why?
For many issues in dementia it is helpful to ask yourself 'why' it is like that or 'why' something happens. Please, research very well what the right answer is and be aware of the latest research results on things. There is an ongoing research in dementia care (at last) and we have to benefit from that as much as we can.

Problem definition and searching for the cause.
In every situation the first question carers have to ask whether they are dealing with a problem for the client or with their own problem. It is surprising, how many times in the end carers have to admit it was more their problem (or a problem for the group where the client is forced to be a part of, like a department of the nursing home).

Carers tend to 'problem'-searching instead of research towards the real cause. Böhm describes the work of professional carers to be comparable to detective work from special police forces. Trying to find the right clues to solve the mystery (of behaviour).

This pitch fall can be illustrated with the following examples

The man with the fluorescent cap.

Church-community was complaining about the man who came to church in his Sunday suit, but with a fluorescent cap on his head.

While.. The man was a road worker all his life. He only felt secure to walk the streets when he wore a fluorescent cap.

The nun who wouldn't cooperate on reactivation..

She was only praying in the hospital and said to have no time for exercises

While.. She had a bad conscious. She left the convent and her colleagues, just to lay in bed.

Impulse:

A nurse found out, that the nun was used to have a hot water jug at night. When she got it in the hospital, she felt at home and obeyed the staff to do her exercises.

The woman who wandered about all night

Every night she wandered through the hall and cried out lout for her husband.

While.. She missed the feeling of her husband next to her in bed.

Impulse:

The use of a warm cushion with a breathing and light snoring sound in it..

The woman who closed her eyes on the toilet

She always closed her eyes on the toilet and that meant, that sometimes she missed the closet pot.

While: She was raised very strict and closed her eyes on the toilet to avoid seeing ordinary things below.

Impulse:

Here is no impulse needed. The problem is a problem for the staff, not for the client.

Ritual key-stimuli, Religion, Intuition, superstition

This is a difficult part of understanding a certain time spirit. The mix of all for items mentioned in this title makes it even more difficult. Every individual can have a different emotion with rituals or religion. Intuition is even more personal and superstition have a huge variety of backgrounds. The well-known clover-4 is not only an exceptional type of clover, but can also refer to the holy cross. The bad fortune of a broken mirror goes far longer back in history than the invention of a mirror itself. It was the mirror in the water the was meant originally. And so, this kind of superstition is deeply rooted in our systems. The fear for lions or poisoned spiders is maybe the oldest. It refers to humans first natural environment, somewhere in Africa. Specially in the catholic church, there is a thin line between religion and pagan believe of superstition. But be sure you will have no personal meaning! Do not judge! You have to be curious on how a client is emotionally attached to all this.

Helpful questions to collect useful (emotional) biographical information

Level 1
Is a client 'sympathetic' (initiate action) of 'parasympathetic' (waiting)
Did the client dare to take risks in life?
Did he have many insurances?
Did he eat fast of slowly?
Was he member of sporting or cultural clubs?

Level 2
Identification patterns
How important were mother, father, grandparents?
What kind of character did they have?
Who was the most important?
Does the client have a favourite photo?
Who taught him life lessons?

Level 3
Imprinting (23/25 years or younger)
How did the time spirit of the imprinting period looked like?
Did the client have an important role in those days?
What kind of person would the client have been in those days?
And was he?
Did he have an 'alpha-position' somewhere?
Were there emotional problematic situations in those days?
Did he have a nick-name?
Was he eager to learn?

Level 4
Feeling at home
What was very important to the client?

Did he have many friends?
What did he do during life?
What doesn't matter to him?
How did he react when someone got angry on him?

Level 5
Moral and ethical values
With what religion the client was raised?
How was that religion practiced in the time spirit of the client?
Was he sensible to law and regulations?
What would he still like to achieve in life?

Level 6
Emotional basics
What raised emotional excitement (positively/negatively)?
How did 'at home' look like?
Is there something he feels to have missed in life? Was he thrived from lower instincts (food, sex etc.) or higher values (Maslov pyramid)

Level 7
Primary instincts
Where was his homeland?
How did his homeland look like?
What typical expressions does he use?

Helpful questions to find out about ordinary daily structure and 'at home feeling'
Apart from the knowledge about the emotional life history, it is important to know about the ordinary daily life aspects. With this knowledge it is possible to create a stable daily chain of rituals, that a client will recognise and feel happy with. All questions below are meant for the imprinting period.

Bedroom

- What was typical for your bedroom?
- Did you have your own bedroom or did you share it?
- Was it dark in your bedroom?
- Was it cold at night?
- Did you have a small table next to your bed?
- If so, what was on it?
- At what time were you used to go to bed?
- Did you pray before you went to sleep?
- Did you wear socks in bed?

- Did you have a hot water jar in bed during winter?

Getting out of bed

- Wat did you do first when you woke up?
- Did you pray before dressing?
- Did your mother have your clothes ready for wearing?
- What did you do between getting out of bed and breakfast?
- Or didn't you have breakfast?
- What did you have for breakfast?

All day rituals

- School?

Work?

- Household?

Lunch?

Etc..

Copings

Just a collection of possible copings, to know what is meant with this expression:

Pride; fear; courage; abusing illness; humour; singing; sarcasm; deeply religious; diligence.

5 Discussion

First point of discussion may be what knowledge a professional interviewer (carer) should have, to be able to use the MI-Tale tool functionally?

Question is, whether MI-Tale will be able to collect so much material, that without any level of knowledge about the background of the client, the tool would work. I (the author) would suggest, that the interviewer already researches in advance, what social background the client has. This might only be a problem in a professional setting. In family settings, there will be no discussion about a social background.

It will be difficult to program the tool to interpret the detail of the information given by the player and determine if it is detailed enough. In a normal conversation this is the interaction between the professional interviewer (carer) and the client. We could try to encourage the player in the instructions to go into detail by giving an example. We could also try to use the informal carer or family member to perform this task.

Question is also, whether the tool should know in what interaction level of dementia a client is and adapt the questioning/encouragement to tell tales. Professionally in psychobiographic care we use the equivalent of the 7-scale Reisberg Global Deterioration Scale). The better the interviewer knows the interaction level, the better he/she can adapt the questioning and the more result efforts of communication and interaction will have. This remark might only be relevant for organisations that work with the Böhm method or with the RGDS.

Another question is whether there should be different levels of information (e.g. advanced suggestions) for every aspect of the content in the tool?

In the Böhm method, we distinguish different ways or strategies of communication or interaction with clients, depending on the dementia level they suffer from. In that case, it might be interesting for interviewers without much knowledge of the Böhm-method, to assist communication and interaction, by practical information around each level. This is just a suggestion and might be something to bear in mind for later development purposes.

6 Conclusions

Part 1, 4.1

The Böhm-care method for dementia care is based upon the clients very strict personal and emotional recollection of the past. The only recognisable world for a client in dementia, is his own world, existing of his personal memories of the past until his early adult life.

In the Böhm-method, we, as care givers, want to know about and understand this collection of personal, mostly emotional memories.

We will write a so called 'psychobiography', in which we collect and organise all memories in a way, that we can translate them to a daily activity scheme, in which the clients feels safe and content, without fear, aggression or apathy. He will feel a sense of meaningfulness and that, according to Böhm, is very important. It is not only a much improved feeling for the client in dementia, but also a relief for partner, family and care givers. They know better understand the motives behind the actions of their loved one in dementia. Understanding reduces stress in both patient and carer.

The tool should help us with the collection of this information, these memories and tales.

Part 2, 4.2

However, the collection of relevant information to construct a psychobiography can be a very time-consuming activity, especially when a client is not very communicative. This is exactly why the development of a biographical device is requested an for which MI-Tale is acting now. In this paragraph the authors explain the principles of a psychobiography. They also explain the most important aspects MI-Tale needs to know while developing the device. Perhaps the most important suggestion to the device developers is that it should be able to adapt to different regional, social and societal backgrounds. Choosing the right triggers to start the user telling a personal story we should program a variety of scenario's adapting to the user's perceived background. Special challenges are presented by the lingual differences. Many dialects and social situations are very local and this variance may exceed the possibilities of the device.

Part 3, 4.3

Successful collection of psychobiographic materials depend largely on a professional way of communication and interaction with clients in dementia. Professor Böhm developed a whole range of communication- and interaction lessons and tools. The authors restricted themselves to a range of examples. They provide practical information for MI-Tale to succeed in developing a device that should really interact with clients in dementia.

7 References

Erwin Böhm: Pshychobiographisches Pflegemodell nach Böhm, Band I , Vienna 2009
This manual (Part I) is used to explain the elementary details of the Böhm method

Erwin Böhm, Psychobiographisches Pflegemodell nach Böhm, Band II, Vienna 2009
This manual is the main source for the information, provided in this report.

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