The Power of Empowering: An Inclusive and Evidence-Based Intervention for Long-Term Residential Care

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Table of Contents

Table Index

Figure Index

Abstract

Introduction: Care models used in long-term care institutions for the older population have been characterized for their efficiency in meeting basic health and hygienic needs. Notwithstanding, residences that follow such model jeopardize older adult's upper level needs (emotional, self-esteem, self-efficacy) and at the same time lead their professional caregivers down the path of burnout.

Objective: The present thesis proposes an evidence-based intervention on the fundamentals of empowerment and client-engagement for long-term care institutions that care for older adults. The intervention has the purpose of contributing in the transformation of the care culture to a more humanized and dignifying one.

Methods: The Power of Empowering Program (PEP) provides a total of 12 sessions to train older adults and professional caregivers in the essential aspects of empowering care. It will be delivered to a sample of 40 participants, who will be assessed pre- and posttest on empowerment levels, degree of client engagement, quality of life, and burnout syndrome.

Results: At the end of the program it is expected that both groups accomplish a set of goals. On the one hand, it is hypothesized that older adults will increase their feelings of empowerment and client-engagement, as well as the perspective of quality of life. On the other hand, professional it is predicted that professional caregivers will increase client-engagement abilities and reduce burnout symptoms.

Conclusions: The Power of Empowering Program looks forward to filling an essential gap in long-term care for the older population. The program aspires to be widely disseminated and to serve as an example for psychogerontologist and health care professionals interested in contributing to the cultural transformation of caring for the older people by the viewpoint of person-centered care.

Keywords: Empowerment, client-engagement, person-centered care, upper level needs, older adults, professional caregivers.

Resumen

Introducción: Los modelos de cuidado utilizados en las residencias para adultos mayores se han caracterizado por ser altamente eficientes en suplir necesidades básicas de salud e higiene. No obstante, las instituciones que se rigen por estos modelos perjudican necesidades superiores de tipo emocional, autoestima y autoeficacia, entre otras, al tiempo que generan síntomas del síndrome del cuidador quemado en los profesionales.

Objetivo: La presente tesis propone una intervención basada en la evidencia y fundamentada en los conceptos de empoderamiento y compromiso con el cliente para residencias de adultos mayores. El programa tiene como objetivo contribuir a la transformación de la cultura de cuidado a una que se caracterice por ser humanizada y dignificante para el adulto mayor.

Metodología: El programa *El Poder de Empoderar* (PEP; por sus siglas en inglés) consiste en 12 sesiones para entrenar a adultos mayores y cuidadores profesionales en estrategias de empoderamiento. Se aplicará en una muestra de 40 personas, quienes además serán evaluadas con medidas pre y post sobre empoderamiento, compromiso con el cliente, calidad de vida y síndrome del cuidador quemado.

Resultados: Se espera que al finalizar el programa de intervención los participantes logren ciertos objetivos. Por un lado, se predice que los adultos mayores aumentarán su percepción de empoderamiento, de compromiso y de calidad de vida. Por otro lado, se espera que los cuidadores profesionales alcancen habilidades de para empoderar a los residentes y disminuirán síntomas del síndrome del cuidador quemado.

Conclusión: El programa pretende suplir un vacío en el modelo de cuidado de las residencias para adultos mayores. Se aspira que el programa sea utilizado por mucho y que sirva como ejemplo para los psicogerontólogos y profesionales de la salud interesados en contribuir a esta transformación de la cultura de cuidado desde una atención centrada en la persona.

Palabras clave: Empoderamiento, compromiso con el cliente, atención centrada en la persona, necesidades superiores, adultos mayores, cuidadores profesionales.

Introduction

Today's aging revolution has summoned many to creatively transform our culture and environment into a friendlier one for the older population. As the population over 65 years grows exponentially, in numbers as large as 223% by 2025 (World Health Organization, 2002), challenges rise for economic, social, and health systems around the globe. One of the most common solutions to this demographic change has been the institutionalization of older adults in centers for social involvement, day care centers, and long-term care residences. Despite the good intentions behind these ideas, much work lies ahead to make of these places, especially long-term care settings, humanized and empowering spaces for the older population to continue developing (Esteban-Herrera & Rodríguez-Gómez, 2015). The present thesis aims to improve the relationship between long-term care institutions, its professional caregivers, and older people.

Originally thought of as places to foster wellbeing and enhance quality of life, the biomedical care model that governs long-term residences for older adults impairs the mission to promote such gains. Although sharp at providing hygiene, shelter, food, and aid for daily living activities, such settings lack opportunities for personal growth, autonomy, and emotional fulfillment for older adults (Villar, Serrat, Bilfeldt, & Larragy, in press, p. 10). While basic needs are undoubtedly met, upper level needs are unintentionally threatened. Findings reveal that depression, poor social support, loneliness, reduced self-worth, and learned helplessness constitute the downside of long-term care (Cutchin et al., 2005; Karakaya et al., 2009; Zhao et al., 2018). Essentially, long-term care institutions tend to disempower older adults, which in turn leads to client-disengagement and fatal consequences for both residents and professional caregivers (Baur, et al., 2013; Harrad & Sulla, 2018; Kranz, 2011).

Aware of such issues, psychologist, psychogerontologist, and other professionals have put their hands to work and generated theories and models that encourage humanized care. Policies have also been implemented to regulate care and ensure that the majority comply with the protocols of best practice. The person-centered care model (Kitwood, 1997, as cited in Brooker, 2004, p. 218), the Eden Alternative (Thomas, 1996), and the Green House Project (Lum et al., 2008) for residential care are just a few examples of the progress being made. What is more, empirical research has shone light over the path to be taken to accomplish enhanced care for the older

population. One the most crucial findings has been that of the powerful effects of empowerment and client-engagement in long-term care residences (Chang & Park, 2012; Tu, et al., 2006). However, more is needed in this research line since empirical knowledge is somewhat scarce.

This thesis proposes an intervention for long-term care institutions based on empowerment and client-engagement principles. The Power of Empowering Program (PEP) has the purpose of contributing to the transformation of the care culture and looks forward to filling the clinical and empirical gap on this topic. Its integral approach understands the multidimensionality of care and therefore includes two modules, one for residents and another one for professional caregivers. Through its evidence-based courses it provides a total of 12 sessions that will train both groups in essential aspects of empowering care in order to meet upper level needs for the older adults, and at the same time look after the wellbeing of care providers. Follow-up sessions that consider participant feedback are also included in the spirit of continuously improving the program and empowering others every step of the way.

Theoretical Framework

I. The Need for a New Perspective on an Aging Population

The scientific, social and economic development achieved throughout the years have given humanity reasons to take pride in. Accomplishments in equality and human rights, augmented education and job opportunities, improved quality of life and wellbeing, globalization, technological advances, and enhanced healthcare systems with increased access, have all contributed to people living healthier, better, and longer lives than in any other time in history. On the downside of it, these successes have demanded humanity to rise to bigger challenges because as the world becomes older and wiser, so does its people. The inversion of the population pyramid is today a significant social and public health issue that is revolutionizing the world as we know it. An exponential growth of people aged 65 and older has been documented in most countries around the world. The growth rate of the population aged 60 years or more peaked around 2010, and the rate for those aged 80 years or over is expected to summit between 2030 and 2035 (United Nations, 2015). Similarly, prospective studies estimate a growth of 223% of those aged 60 or more by 2025 and predict that 16% of the world's population will belong to this age group in 2050 (World Health Organization, 2002). Moreover, the *oldest-old* (those aged 80 years or more) are increasing their numbers at an accelerated rate and are projected to add 426 million by 2050, which is almost three times more than in 2019 (United Nations, 2019).

This significant change in the world's age structure has a strong impact on economic, social, and health systems around the world. For starters, countries face an increased expenditure of government resources, as well as a reduction in the economic contributions made by this age group. Due to longevity and non-reformed pension systems, the latter are obliged to support people economically for many more years than before and their productive lifespan is interrupted by early retirement age policies. In other words, people are sent home long before they face actual working impediments, and as a result become heavy weight for a country's economy. A report by The Organization for Economic Co-operation and Development (OECD, 2011) explores trends in pension system parameters and highlights a constant increase in the *expected duration of retirement*, concept that refers to the number additional years of life after reaching a pensionable

age. The analysis shows that life expectancy improvements have led to a rise of the years lived without having a job and, therefore, of depending on economic subsidies. Specifically, the data suggest that in the 1960's men lived, on average, 13.4 years after retirement, number that increases to 18.5 years in 2010 and that is predicted to reach 20.3 years in 2050. As for women, on average, they lived 17 years more after retirement in 1960, 23.3 years more in 2010, and the estimate is that by 2050 they will live 24.6 years more.

Questions rise over how pension policies must be modified to belittle the economic aftermath discussed above. More so, since mental health and general wellbeing have also been affected by the increase in nonproductive years lived after retirement. Regarding the first matter, it is a fact that today some countries are extending retirement and pension ages to outweigh the economic impact. For instance, Spain is slowly moving towards rising their pension age from 65 to 67 years, along with other countries such as the United Kingdom (OECD, 2011). On the second matter, psychological research suggests correlations between psychosocial and physical wellbeing. Some studies indicate that 25% of the retirees face negative psychological consequences, including life dissatisfaction and identity loss, and that cardiovascular health worsens for those who had demanding physical jobs (Wang & Shi, 2014). Although these effects are embedded into other variables such as personality and social support, it is a fact that retirement transition factors and postretirement activities play an important role, and therefore so does retirement age. One could suggest that those with high cognitive and functional performance, forced to retire due to their age, and with few postretirement activities will transition into a sedentary and purposeless lifestyle that will challenge their mental health. Results show a six to nine percent decline in mental health, usually because of depression, as well as a preference for later retirement in older adults who perceive longer life expectancy (Dave, et al., 2006; Van Solinge & Henkens, 2010).

This demographic change also impacts the societal level, especially when it comes to family structures. According to census data from the United States, less than 15% of the people aged 65 or more lived with their family by the end of the twentieth century, a small number compared to the 70% of them who lived with their adult children back in the 1850s (Bloom & Luca, 2016). In general, societies are facing more nuclear than multigenerational households but, contrary to what is commonly believed, this shift responds to improved income for today's older adults and not to abandonment or neglect (Connidis & Barnett, 2018). Notwithstanding, this

scenario is only true for older adults who preserve functional capacity and autonomy. In contrast, data reports that 83% of the dependent older adults in Spain are cared for and live with their families (IMSERSO, 2008). Similarly, OECD (2005) findings suggest that most of the adult population receives informal care from family, friends, and neighbors, being spouses and adult children the most frequent source of care (Kalwij et al., 2014; OECD, 2005). These insights confirm that family bonds remain and are an important resource in an aging world.

Although encouraging, having family members as caregivers becomes more difficult as the modern world advances and longevity expands. Previously, many generations ago, family members would care for older adults for short periods of time since many of them did not reach old age. However, increased life expectancy extends their responsibility as caregivers and many times interrupts their own personal development. Studies suggest that caregivers can spend between 8 and 40 hours per week on caregiving activities and it is estimated that 100,000 employees will be forced to retired due to difficulties balancing both duties (Kalwij et al., 2014; MetLife Mature Market Institute, 2011). In addition, research evidences that caregivers bear health issues, psychological affliction, and chronic stress (Grossberg, 2003; Takai & Takahashi, 2013). When these issues arise, or when the older adult presents severe health problems, cognitive, and functional impairment, caregivers question their ability to meet such needs and so consider institutionalization (Buhr et al., 2006; Carretero et al., 2006). This step towards institutionalization has been found to significantly diminish the caregiver burden but has an important impact on the older adult's wellbeing (Garcés et al., 2009; Sánchez-Izquierdo et al., 2017). This topic will be further explained in the next section.

Finally, mental health disorders are also a rising issue for people aged 65 years and older. Mental problems are one of the leading causes of years lived with disability worldwide in the general population (Whiteford et al., 2013). However, longevity has turned older adults into a cluster with increased risk for this type of pathologies. Comorbidity with physical ailments, chronic pain, reduced mobility and functionality, motor, sensory and cognitive alterations, polypharmacy effects, and frequent losses as a result of aging, position older people in a vulnerable place when it comes to mental health afflictions (Avasthi & Grover, 2018; Balsamo et al., 2018; Cabrera & Montorio, 2009; Helsley & Vanin, 2008; Jiménez et al., s.f.). The World Health

Organization (2017a) has stated that around 15% of the adults aged 60 years or more carry the burden of a mental disorder, being depression, anxiety, and dementia the most common.

Despite the difficulties in diagnosing older adults with these conditions due to comorbidities, under-reporting, and overlapping symptoms, epidemiological studies have reached reliable conclusions regarding their prevalence. First, it has been established that depression is the most frequent psychological disorder in the older population, affecting 7.5% of aged women and 5.5% of older men (Helvik et al., 2016; Parkar, 2015; WHO, 2017b). In addition, almost half of those with depression also manifest anxiety disorders, situation that worsen functionality and wellbeing in this subgroup (Alvarado & Modesto-Lowe, 2017). Second, prevalence rates for anxiety disorders are exponentially bigger, reaching a range from 1.2-15% (Andreescu & Varon, 2015), and it is believed that many more cases pass unnoticed. Lastly, reports suggest that 50 million people worldwide are living with dementia, number that is estimated to triple in 2050 as the population continues to age (WHO, 2017a). These conditions related to late life have been associated with negative effects on quality of life, decreased wellbeing, accelerated aging detriment, physical illnesses, emotional suffering, disability, and increased mortality rates. Moreover, they also heighten the use of healthcare resources and expenditure in as much as 50% (Avasthi & Grover, 2018; Blazer, 2003; Cummings, 2002; Unutzer et al., 1997).

To conclude, population aging is one of humanity's greatest successes and at the same time one of its biggest challenges. Economic, societal and health systems have been severely impacted on account of the inversion of the population pyramid. Increased expenditures on health and programs to provide care for the older adults, shifts in family structures that lead to either caregiver burden or the institutionalization of individuals aged 65 or more, and rising mental health conditions are some of the difficulties faced by this demographic turn. As it is, it may seem that older people are a liability for society, nonetheless, one might wonder if this statement should go the other way around instead: the way society conceives aging places a burden on the older population and, as a result, throws to waste a valuable resource. Indeed, a new perspective on aging is desperately needed.

II. Institutionalization and its Effect on the Older Population

The inversion of the age pyramid has called for new ways of life and caregiving methods for older people. Changes in family structures, social policies, and economic systems make it difficult for families to fulfill their traditional role as primary caregivers. In addition, the prevalence of chronic diseases due to longevity increases the physical, emotional, and economic expenses of taking care of an older adult (Greve, 2017). These changes not only demand specialized knowledge and attention, but also extended timeframes and specific settings to deliver quality care. Consequently, and under the premise of favoring healthcare, comfort, and quality of life, care-providing institutions for people aged 65 years or over have been prompted to transform from geriatric asylums for the abandoned or the sick, to day centers or long-term care homes (IMSERSO, s.f.).

The institutionalization of the older population is a common trend that attempts to ameliorate the psychosocial and economic impact of this demographic change. As one of the most aged countries, with 19.4% of its population being over the age of 65, Spain counts with a variety of social services for their older people (INE, 2019). These include: (a) centers for social involvement, dedicated to the promotion of free time activities and the establishment of social relationships (b) day care centers, that offer psychosocial attention for those with functional limitations and (c) long-term residences or care homes, where they live for prolonged periods (Esteban-Herrera & Rodríguez-Gómez, 2015). This last modality of attention is the most concerning and will be the focus of this thesis. Data reports that Spain counts with 6,240 residential centers and 391,475 shares, of which 280,317 are already occupied. Of this total, 70% of the users are women and 82% are aged 80 years or more (IMSERSO, 2019). Additionally, there are 4,2 care homes for every 100 older adults and, on average, 63 people in each residence. Although it may seem that coverage is enough, unequal distributions make this a scarce resource (Abellán-García, et al., 2019).

Despite their original conceptualization as dwellings that foster autonomy and opportunities for personal growth, long-term care institutions lack such qualities. Long-term care institutions are known to adopt a biomedical care model focused on meeting resident's basic needs and health requirements. To begin with, these centers provide hygiene, shelter, food, and aid in the execution of activities of daily living. At a glance, some would state that care homes endorse

general wellbeing and allow older persons to grasp a fulfilling and satisfactory life. Others may question, what more could be asked for when old? However, older people have upper level needs that are unintentionally jeopardized, and even neglected, by the biomedical care model adopted in residences (Villar, Serrat, Bilfeldt, & Larragy, in press, p. 10). Self-identity, social belongingness, emotional and psychological wellbeing, self-esteem, and civic engagement are just a few of these needs.

The standardized care approach of the biomedical model threatens self-identity in this age group. Efficiency and augmented capacity are two important attributes when it comes to delivering high quality health care according to this model. To accomplish this, institutions follow patterns that define how, when, and where things must be done. To state some examples, long-term care residences are known to have tight schedules for cleaning and hygiene duties, predetermined meal hours and menus, along with activity chronograms that are chosen by the professionals, instead of the residents. In this sense, users must wake up, take a bath, and use the bathroom during specific timeframes that fit the professional's availability. They must also eat their meals at indicated hours disregarding if they like what is on the menu or not. Apart from this, residents must participate in leisure activities that are chosen for them and do not always suit their interests or abilities (Golant, 2011; Kane, 2001). Essentially, long-term care institutions tend to adopt a "fit for all" care system that strips away individual differences and personal preferences while expecting people to behave in homogenized ways. Basically, that which makes you *you* become blurred lines.

Long-term care facilities, although full of people, may also become places that nurture loneliness. Loneliness affects all ages; however, it has been identified that older adults are more vulnerable to this feeling. National surveys held in the United States report that approximately 35% of adults aged 45 and older feel lonely (Anderson, 2010). Likewise, research in European countries establish that 45% of the older population experience loneliness (Cohen-Mansfield et al., 2016), being living conditions, type and size of social networks, and social integration determinant variables for its high prevalence (Domènech-Abella et al., 2017; Nyqvist et al., 2019). Furthermore, older adults pay a high toll for having this feeling since it has been associated with increased mortality, illness, disability, cognitive decline, and mental affections, such as anxiety and depression. In other words, loneliness has become a public health issue (Gerst-Emerson & Jayawardhana, 2015).

Although few, studies on this topic have been made in care facilities for the older population. Some indicate that older people living in assisted care homes are twice as like to be lonely compared to those living in community. European researches describe that 50-55% of the older adults who live in this setting tend to feel lonely (Quan et al., 2019). Increased reports of loneliness in long-term care facilities may be since moving into a residence is a stressful event. Facing new environments, new people, and a different lifestyle, at the same time they distance themselves from their usual relationships is not an easy task. It is mistakenly assumed that being surrounded by peers in a safe environment will provide strengthened social connections for older adults. In contrast, losing previous bonds, in addition to the lack of opportunities in these institutions for social cohesion and identity, result in shrunken social networks (Jansson et al, 2019).

Emotional and psychological wellbeing are also at stake for older persons living in long-term care facilities. As mentioned before, the prevalence of depression and anxiety in community dwelling adults aged 65 and older is concerningly high, making it foreseeable that these numbers peak in institutionalized contexts. Zhao and collaborators (2018) assessed depression in 323 residents and found that 26.6% of them suffered depressive symptoms. Similarly, others suggest that more than 32% of the residents in care facilities for older people experience depression (Cummings, 2002), and that the risk of developing this mental health issue is three to four times higher for this group of older adults (Jongenelis et al., 2004). This high risk of depression has been associated with situations that, unfortunately, take place inside a care home, such as perceived lack of freedom, poor social support, and impairment in activities of daily living (Karakaya et al., 2009; Lee et al., 2012; Cummings, 2002). Also, according to a study in Spain, reduced residential satisfaction and sense of belonginess surge feelings of loneliness and, in consequence, represent increased possibility for depression. These authors state that residential satisfaction is composed of social and emotional connections to people inside the facility and symbolic identification with the place (Prieto-Flores et al., 2011).

Psychological wellbeing is not only measured by the absence of mental illness but also by the presence of positive affect. Although several models exist, one of the most accepted is Ryff's (1989) bidimensional model of psychological wellbeing that separates this concept into two branches: *hedonic* and *eudaimonic*. While the first refers to pleasurable experiences, probably

easier to find in a long-term care facility, the second considers opportunities of personal growth and self-realization, which are more difficult to achieve in this setting. Eudaimonic wellbeing occurs when an individual perceives autonomy and coherence between his actions, goals or purpose in life; signifying a contribution to personal growth (Ryff, 2013). Longitudinal studies point out that while hedonic wellbeing is maintained well into aging, eudaimonic wellbeing tends to decline from middle age on (Friedman et al., 2015). In addition, analyses reveal a close relationship between eudaimonic wellbeing, health, and aging, suggesting that diminished eudaimonism is related to higher depression rates, reduced life expectancy, and pathological aging (Curzio et al., 2017; Gu et al., 2016; Kim et al., 2019). Along with this, limited occasions to participate in meaningful and individualized activities also generate feelings of low self-worth (Cutchin et al., 2005). Bearing in mind all the above stated, it possible to say that long-term care institutions are flawed in their attempt to suit emotional and psychological needs for the older population.

What is more, reduced opportunities for civic engagement and participation add to the challenges older adults encounter in long-term care settings. Contrary to what Disengagement Theory establishes -a natural decline in functioning and social withdrawal with age- older adults express a desire of being productive and contributing to others (Hollis-Sawyer & Dykema-Engblade, 2016; Klinedinst & Resnick 2013; Leedahl et al., 2017). Civic engagement becomes an opportunity for the latter and is defined as the participation in community activities that are beneficial for others and individually enriching at the same time. Formal and informal volunteering, voting, working, educating, participating in politics, social groups, and neighborhood activities are some examples of civic engagement (Adler & Goggin, 2005; Cullinane, 2006). Longitudinal researches report many benefits for older people who are actively engaged with their communities. Some examples are, reduced depression, favorable perceptions of health and quality of life, lower mortality, augmented well-being and life satisfaction, strengthened social networks, positive self-identity, and a sense of usefulness (Anderson & Dabelko-Schoeny, 2010; Fiske et al., 2009; Gruenewald et al., 2007; Lum & Lightfoot, 2005; Morrow-Howell et al., 2009). More so, civic engagement has also been found beneficious for older individuals with cognitive decline or physical limitations (Dabelko-Schoeny, Anderson & Spinks, 2010).

Even with all the proven gains, occasions for civic engagement are insufficient in long-term care facilities (Leedahl et al., 2017). The literature identifies that social beliefs and the institutions' ageist framework are the main barriers. First, promoting civic engagement represents a rise on costs for the residence; taking older adults outside translates into needs of transportation, extended working hours, risks of fall, and interruption of the standardized model established by biomedical care structures (Anderson & Dabelko-Schoeny, 2010). Second, institutional architecture transmits a message of segregation and isolates residents from their social surroundings (Villar, Serrat, Bilfeldt, & Larragy, in press, p. 10). Usually, long-care term homes are enclosed, walled, with limited window view access or even far away from urban areas. Third, negative social beliefs about growing old, loosing abilities, along with the power of contributing in society endorse ageist discrimination, which results in the social exclusion of this group (Cutchin et al., 2005). Fourth, such separated spaces for development significantly limit the intergenerational relationships necessary to reduce ageism and supply wellbeing for older adults (Bengtson, 2001). Finally, research on civic engagement in this type of settings is also scarce. A systematic literature review highlights that civic engagement has been reduced to volunteering activities while leaving aside other forms and contextual dimensions, as is the case of long-term care institutions (Serrat et al., 2020).

All in all, care homes fall short in fulfilling upper level necessities for older people. Diminished self-identity due to a standardized model that dehumanizes care, lacking opportunities for the establishment of strong social relationships that end up in feelings of loneliness, reduced chances to exercise autonomy and to reach self-actualization that shrink emotional and psychological wellbeing, and a notorious social exclusion from community life are some of the struggles that older residents bear on a daily basis. Owing to this, disempowerment in institutionalized settings is a common issue that requires for immediate attention since it threatens personal growth and psychosocial wellbeing of the individuals who reside in them. Undeniably, long-term care facilities must transform into places of empowerment that enhance and value the magnificence of aging.

III. Empowerment and Client-Engagement: A Promising Future for Long-term Care

In an ageist revolving world where growing old is synonym of impairment, incapability, frailty and uselessness, empowerment and client-engagement become relevant; particularly for older residents in long-term care facilities. The endorsement and development of these two concepts in care institutions for older people will support the pursuit of an inclusive environment that allows personal growth while aging. Efforts have come together in creating worldwide structured agendas to build a society for all ages. An example is the Madrid International Plan of Action on Ageing (MIPAA; United Nations, 2002), led by the United Nations, that acknowledges the need to empower older adults and support their participation in all aspects of life. Emphasis is made on the promotion of health, economic security and involvement, social, cultural, and political life. Likewise, the MIPAA recognizes the importance of encouraging independence, accessibility, family and community participation, and decision making at all levels. Such efforts have resulted in the creation of empowerment and inclusion programs, like the Elderly Empowerment Project in Lebanon and the Elder Financial Empowerment Project in the United States (United Nations, 2017) into many others.

Empowerment and client-engagement go hand in hand, one might even say that the first is a result of the latter. Several conceptualizations of empowerment have risen throughout the years. While some define empowerment as feelings of control, capacity to meet personal needs and solve problems (Faulkner, 2001), others describe it as a person's skill to assume responsibility over their life (Funnell et al., 1991) or as the process of reducing the powerlessness originated from the experience of discrimination (Kam, 1996). One of the most accepted definitions is the one proposed by Rappaport and Zimmerman, pioneers on psychological empowerment. According to them, empowerment is a process by which individuals, organizations, and communities achieve mastery (over themselves and the environment) through mechanisms of awareness, control and participation (Zimmerman, 2000).

As a multidimensional construct, psychological empowerment considers an intrapersonal component (that refers to an individual's perception of control, mastery and self-efficacy), an interpersonal dimension (that includes social norms, external resources and the possibility to use

them), and a behavioral element (that considers constructive conducts and participation at a community level). In this sense, empowerment not only depends on the individual but also on his/her relationship with the miso-, meso-, and macro-levels highlighting its relational autonomy (Cox, 2001; De Witte & Van Regenmortel, 2019). Furthermore, principles of empowerment have been established in the literature and are even considered as evaluation criteria for empowerment interventions. Some of the principles are strength and connection, positive attitudes, participation opportunities, inclusiveness, collaboration, proactivity or initiative, integrality, structure, and decision making (Anme, 2016; De Witte & Van Regenmortel, 2019). Adding up, empowerment is a broad term that involves the individual and its social relationships, and is attributed to foster autonomy, participation, self-determination, enablement, and the achievement of personal change in relation to others (Castro et al., 2016).

Possibilities for empowerment are limited for those living in care homes. These institutions are troubled by strict procedures, inflexible protocols, tight schedules, an exceeded resident-personnel ratio, and a hierarchical power imbalance (Henderson, 2003; Van Malderen et al., 2017). All these elements place residents as passive receptors of care, situation that summons powerlessness within them. It has been identified that being unable to control their own care experience, being poorly informed, and excluded from decisions are common situations in long-term care homes that create a negative experience for users (Kranz, 2011). Similarly, a study on 17 aged-care centers in Australia reports that empowerment opportunities in these settings are reduced to the individual level (i.e. dressing and eating activities), leaving behind important areas of involvement at a local and organizational level (Petriwskyj, et al., 2018).

On the bright side of it, and every time more, researchers are finding associations between high levels of empowerment and positive outcomes in emotional and psychological wellbeing. For starters, Tu and colleagues (2006) analyzed the relationship between perceived empowerment care and quality of life finding that the institution had a medium level of empowering care, as well as a strong correlation between quality of life and empowered care. Namely, they report that perceived empowering care explained 37.2% of the variance on quality of life. These results imply that care centers can shift away from disempowering systems and, better still, that this transformation increases quality of life and satisfaction for the residents. Likewise, another study completed on a long-term care home of 80 users showed a positive correlation between perceived patient

empowerment and quality of life, in addition to a negative correlation between scores on the Geriatric Depression Scale (GDS) and quality of life; suggesting that empowering residents could indirectly impact mental health (Kranz, 2011). Moreover, psychological empowerment interventions have also proven effective for health behavior modifications and consequently for general wellbeing. For instance, Katula and collaborators (2006) accomplished greater physical activity engagement when using an empowerment-based exercise program that increased older adults' desire and motivation to gain strength.

Furthermore, researchers also underscore the effect of empowerment programs on self-perception and self-esteem (Chang & Park, 2012). A randomized control trial analyzed the effect of an empowerment intervention on self-esteem, interpersonal relationships, and adjustment to the nursing home system in three nursing homes in Korea. While some participated in ten weekly empowerment sessions, the control group received education on health management. According to their results, those who were empowered reported significantly higher levels of self-esteem, interpersonal relationships, and adjustment. Some authors have also created intervention methodologies based on the fundamentals of empowerment, like the Experienced-Based Co-Design in healthcare services, which aims to promote patient participation (Castro et al., 2018). Lastly, others have included empowerment attributes in educational interventions for older adults, obtaining positive and significant outcomes on self-efficacy and self-care behaviors. Key empowered-related components on these programs were motivation and problem-solving strategies, goal setting, stress management, and action plan elaborations (Shearer et al., 2012; Schoberer et al., 2016). On account of all this evidence, there is no doubt that empowerment interventions are needed in the attainment of humanized and dignified institutions for older people.

Apart from that, client-engagement is fundamental when intervening on empowerment in older adults. Some even propose that, if seen as a continuum, the maximum level of client-engagement implies the attainment of power; meaning that empowerment could be measured through this concept. The continuum considers other levels of engagement, such as education, information gathering, discussion, and collaboration, and the theory posits that the broader the scope the closer to becoming fully empowered (Petriwskyj et al., 2018). Explicitly, client-engagement is defined as the interaction and communication that takes place between a service provider and a client, guaranteeing participation and decision-making opportunities (Petriwskyj et

al., 2014). It is a dynamic process that, as well as empowerment, concerns the individual, the organization, and the care-system (Cook & Klein, 2005). For that matter, the shift to empowered models of care based on client-engagement must not only involve the residents but also the staff.

Studies on client-engagement in care homes for older individuals identify a lack of participation and a silenced ambience that neglects user's needs for self-determination and contribution (Baur, et al., 2013). Effortfully, some institutions have looked for ways to engage their clients in their immediate sphere, for example by making decisions on their daily care. However, limits for engagement at an organizational plane persist (Petriwskyj et al., 2018). Barriers have been identified at many levels, including resident and staff characteristics. On the one hand, resident's behaviors and beliefs are thought to influence their ability to engage. For instance, low levels of confidence and sense of ownership, poor alertness to situations, and aversion to cooperate will diminish their client-engagement. On the other hand, staff features such as inflexibility, disrespect for autonomy, negative attitudes towards care and poor knowledge may limit their talent to promote an empowering environment (Petriwskyj et al., 2014). In addition, research suggests that when the system is flawed from the top it is even more difficult for staff to undertake an engagement practice to empower residents (Petriwskyj & Power, 2020).

In the search for a solution, programs to foster partnership and client activation have been implemented. One of the most accepted is the PARTNER approach, that targets empowerment through collective action (Baur et al., 2013). This model consists of five steps: (a) agenda-setting by residents (b) homogeneous groups (c) heterogeneous groups (d) formulating ideas and plans (e) action in practice. Baur and Abma (2011) implemented this model and empowered a group of seven women, who called themselves 'The Taste Buddies', to actively participate in the improvement of the institution's food service. At the end, these women developed feelings of ownership, social identity, purpose, and self-efficacy that improved their wellbeing. Another example is Boelsma and collaborator's (2014) study on how to improve long-term care facilities. In order to do so, they involved older adults who lived at a residence with two main objectives: to fully grasp their perception on the residence's quality and two to generate positive outcomes on the participants after using client-engagement strategies. Other approaches, like shared decision-making methods and resident councils have also shown promising outcomes (Groen-van de Ven et al., 2017; Knight et al., 2010).

In brief, scarce opportunities for engagement and empowerment lead to negative outcomes in older adults living in assisted care homes. There is an impending need to transform the culture of caregiving to enhance quality of life and psychological wellbeing for older adults. This transformation must occur alongside intervention programs that promote a collaborative environment, soften the hierarchical structure of this institutions, and eliminate the biomedical care model that still reigns within many institutions' walls. Spaces for the development of autonomy, self-efficacy, independence, feelings of usefulness, control, personal growth, and meaningful social bonds are required to attend the needs and desires of the world's rapidly ageing population. In this quest, psychological theories and psychogerontologist assume a crucial role.

a. The Influence on Professional Caregivers

Promoting an empowerment ambience fueled by client-engagement also has a positive impact on professional caregivers. Caring for others is one of the most burdensome responsibilities and it is not a surprise that burnout levels skyrocket in geriatric care staff (Harrad & Sulla, 2018), even so actions can be taken to make of this kind duty a more gratifying one. Before anything else, burnout syndrome must be defined. Burnout syndrome refers to the maintained response a person has towards work related stress (Maslach & Jackson, 1981). It is composed of three domains: (1) emotional exhaustion, pertaining the loss of emotional resources to cope with stressful situations (2) depersonalization, which emotionally detaches de individual from others or him/herself leading to lack of compassion and negative attitudes towards others, and (3) decreased personal accomplishments, that deteriorates the perception the person has over their work and competence (Maslach & Jackson, 1981). Having one, or all these symptoms, will have a substantial impact on workers' wellbeing, as well as on the productivity and quality performance of their job.

Long-term care institutions for the older population are home to several precipitators of burnout syndrome. Literature reports point out that geriatric nurses experience more stress than nurses in other health care settings (McHugh et al., 2011), meaning that the elephant in the room must be urgently addressed. In this settings, professional caregivers are assigned hygienic duties (bathing, dressing, toileting), eating, and transferring labors that involve physical tiredness. In addition, time pressured schedules, heavy workloads, and communication difficulties due to severe

cognitive impairment or dementia in some of the residents worsen the scenario. Lastly, high emotional demands because of the frequent encounter with severe illnesses and death are also part of this equation (Westermann et al., 2014; Leiter & Maslach, 2009). In sum, caring for and older person may seem as a substantial challenge if managed inappropriately.

These detrimental effects are not only suffered by the health caregivers but are inevitably generalized to older people. It has been found that caregiver burnout deteriorates professional performance and can even lead to malpractice (Cocco, 2010). Some studies suggest that a high degree of depersonalization is related to decreased resident satisfaction, a lower quality of life perception, and depressive symptomatology; all of these as a result of negative attitudes, lack of compassion, mistreatment, and dehumanization of the older adult (Chao, 2019). Such dehumanization potentiates disempowerment patterns that risk client-engagement and communication, while transmitting a message of learned helplessness among the residents (Faulkner, 2001). In the end, burnout syndrome in care professionals becomes hazardous for all partakers in a long-term care setting.

Fortunately, such unfavorable circumstances may be intervened and improved through strategies that promote empowerment and client-engagement. In order to do so, aspects must be modified at the structural and individual level. For instance, at an organizational level, evidence recommends workload reductions, flexible schedules (Cooper et al., 2016), and goal readjustments (Chao, 2019) to contribute to burnout symptoms reduction. Similarly, individual interventions focused on the patient-centered care model and empowerment have proven effective in treating professional caregiver burnout. Silén and collegues (2019) revealed in their research that working under the premises of person-centered care increased psychological empowerment in the staff and was related with a better working climate and thriving experiences, both negatively correlated to feelings of burnout. In addition, other findings advocate that caregivers who failed to provide empowered care had higher levels of emotional exhaustion and depersonalization, along with decreased feelings of personal accomplishment (Harrad & Sulla, 2018). To conclude, it is important for professional caregivers to learn empowerment strategies that promote a person-centered methodology beneficial for both residents and staff.

IV. Grounding Empowerment in Psychological Theories and Models

There are several psychological theories and perspectives fundamental when approaching the concept of empowerment. These contributions have provided the grounds on which the idea of prioritizing the individual's perception of their own capability and allowing spaces for them to develop and actively participate have been built. Additionally, the empowerment program created presented in this thesis takes from many of these theories. A brief description of the pillars that have aided the journey towards the empowerment of the older adult is presented below.

a. Maslow's Hierarchy of Needs:

Abraham Maslow was a humanistic psychologist who pioneered in the study of motivation. He developed a theory to understand human motivations and actions as more than conditioned behaviors or unconscious longings. According to his theory of human motivation, people's needs can be categorized in five levels that precede one another and are expressed in a model shaped as a pyramid (Maslow, 1943). In the first level, and at the bottom of the pyramid, are the physiological needs, that point to the maintenance of homeostasis in the body. Some examples are the need for food, drink, shelter, sex, and sleep. The second level includes safety needs like protection, stability, order, and absence of fear. The third level recognizes the need for affection, love, and belonginess, which are categorized as social needs. The fourth level refers to self-esteem needs as the desire for achievement, status, dominance, and independence.

Finally, at the top of the pyramid, is the self-actualization need that highlights a constant hunger for growth and fulfillment. Maslow described it as the desire to "become everything that one is capable of becoming" (Maslow, 1943, p.382). These last two levels are closely related to the concept of empowerment since they consider self-esteem, achievement, and growth, which resemble the feelings of mastery and self-efficacy proposed by empowerment principles. The latter not only reassures the importance of continued individual development at all ages, but also allows for the creation of intervention strategies that unfold from psychological motivational theories,

because in order to become empowered motivation to do so must exist. Therefore, the Power of Empowering Program (PEP) includes a motivational module that intends to tackle this point.

b. Bandura's Self-Efficacy Theory

Albert Bandura was a psychologist who focused his research on learning and its interaction with the social environment. He created the Social Learning Theory that emphasizes the role of observation, attitudes, emotion, and behavioral modeling in the process of learning and the expression of human conduct. Within it, he defines the concept of self-efficacy as an individual's perception of his competence to carry out a behavior or deal with a situation (Bandura, 1982). More specifically, the self-efficacy model (Figure 1) includes an efficacy expectation, understood as the judgement a person makes of his abilities, and an outcome expectation, that indicates the belief that such behavior will lead to a desired outcome (Bandura, 1977; Grembowski et al., 1993). Perceived self-efficacy will determine the level of empowerment people feel and how much effort they will thus invest in the face of an obstacle or experience.

Self-efficacy has been studied broadly and found effective when modifying health behaviors, even in older adults (Lee et al., 2008; Miller et al., 2019). However, little is known of its influence on decision making and empowerment despite their strong association. Being self-efficacy one of the components involved in the fulfillment of empowerment, it is given that such ability must be incorporated in an empowerment program. When a person believes that he/she can achieve what they want, and are also motivated to do so, the experience of empowerment is amplified. Such equation is eminently necessary in the fight against ageist prejudices that cripple the older population in today's world.

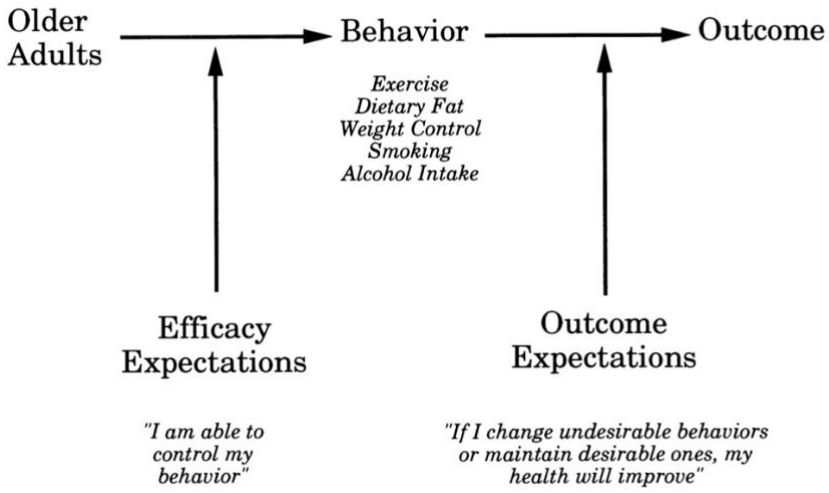

Figure 1. Theoretical Framework for Self-Efficacy (Grembowski et al., 1993)

c. Erikson's Generativity Stage of Human Development

Erik Erikson was a psychologist and psychoanalyst who studied development and personality. One of his most important contributions was the life span model of development that, contrary to other existing models, includes aging as a continued stage of growth in the cycle of life (Villar & Triadó, 2006). Erikson describes eight psychosocial phases that build up an individual's personality, and two of these are specifically directed to late adulthood. One of them is the idea of generativity versus stagnation. In this phase people are motivated to give back to society, to maintain and extend their productivity, and to participate in their community. If these needs are not met, people will reach a state of stagnation, feeling stuck and worthless (Triadó et al., 2019).

It is possible to argue in favor of methods that extend the generativity phase into advanced ages, and empowerment is one of them. As mentioned before, empowerment is transversal to the miso-, meso-, and macro-levels, meaning that the social and community facets of the concept must not be forgotten. This interpersonal dimension of empowerment is directly bonded with the generativity phase spurred by Erikson and is crucial in the pursuit of supporting older people in living meaningful lives. Subsequently, the PEP includes strategies that will teach older adults

means in which they can directly influence their immediate surroundings; hopefully giving back not only to the residence they live in but also to the community where it is located.

d. Person Centered Care Model

The person-centered perspective originated in the 20th century under the influence of Carl Rogers and Humanistic Psychology. This model holds that care must actively foster human growth regardless of age because even at an advanced ages people are capable of learning and pursuing meaning in life (Brownie & Nancarrow, 2012). Numerous attempts have been made to describe the characteristics of a person-centered approach and materialize it as a universal construct, resulting in agreements over the attributes that are essential for this type of care. In this sense, person-centered models of care are required to be holistic, meaning that the person is valued as a whole; individualized, considering the unique needs of everyone; respectful; and empowering. This last attribute looks forward to the establishment of autonomy and self-confidence by encouraging participation and decision making (Morgan & Yoder, 2012).

Throughout the years, patient-centered cared has transformed to become a specific and fundamental pillar in caring for older adults. A pioneer in the concept was Thomas Kitwood who introduced the person-centered care model into the management of dementia, which contributed to improving the quality of care and conceiving patients with dementia as important human beings. Like his antecessors, Kitwood emphasized that when caring for dementia one should meet the person's needs, support their personal growth, and encourage individuality and autonomy. He also stated that accomplishing such duties depended on both the individual and the social environment, establishing the concept *malignant social psychology* to describe unintentional interactions on behalf of the social surroundings that are detrimental for the person's development and result in disempowerment and lack of autonomy (Brooker, 2004).

The dementia person-centered model proposed by Kitwood has been further developed by others. Brooker (2004), for instance, describes four fundamental elements that must be present in person-centered care. Using the acronym VIPS, she denotes that this type of care ought to value people with dementia and their caregivers (V), treat people as individuals (I), look at the world

from the perspective of the person with dementia (P), and promote a positive social environment (S). Besides, this care culture transformation is being generalized in geriatric care for individuals without dementia. Methods of good practice and organizational changes in this train of thought include flexible schedules for clients, adjustment of the activities to their personal interests and preferences, spontaneous activities, family involvement in get-togethers, and shared decision making when it comes to treatments and diets (Martínez-Rodríguez, 2016). Others also propose activities led by the residents, as well as their active participation in decisions over personal issues such as what to wear (Koren, 2010).

Moreover, empirical findings indicate higher levels of psychosocial wellbeing on older people who live in institutions that implement the person-centered model. In addition, reductions in feelings of helplessness, boredom, and depression, as well as increases in quality of life and activity engagement have been reported (Brownie & Nancarrow, 2012; Li & Porock, 2014). Benefits of this care model have also been identified in the professional caregivers who rely on it. Silén and colleagues (2019) point out that staff members who applied the fundamentals of person-centered care experience and augment in their psychological empowerment levels. All told, the person-centered approach is considered an antecedent of the empowerment movement (Castro et al., 2016) making it crucial for the intervention program presented in this thesis.

The Power of Empowering Program

I. Briefing in on the Power of Empowering Program

a. General Description

The Power of Empowering Program (PEP) takes from the fundamentals of psychology to create an intervention that meets the emotional needs of the older adults in long-term residencies and their professional caregivers. Its comprehensive and person-centered design focuses on providing tools that promote empowerment and client-engagement in long-term care users, furthering the call to transform such institutions into places that foster all-inclusive wellbeing and combat ageist prejudices. Accordingly, the program is to be carried out in long-term care residencies for people 65 years and older who have space for improvement in their caregiving services and wish to follow this path of enhancement. All in all, this program looks forward to aiding such long-term care settings and strengthen their transition from a biomedical system to a person-centered care one through an empowerment perspective.

Being a wide concept, one must specify the means by which empowerment will be achieved. In this program, and according to the literature review above, when intervening on empowerment both intrapersonal and interpersonal dimensions must be considered. On one hand, the individual dimension addresses how the person perceives his/herself, including variables like self-efficacy, self-esteem, self-confidence, mastery, and control. On the other hand, the contextual dimension concerns the availability of external resources that allow for a person to engage and, therefore, complete their status of empowerment; it is in this interpersonal facet where client-engagement and empowerment coexist. The PEP adopts this multicomponent approach and, consequently, not only intervenes on residents but also on professional caregivers.

b. Objectives

In account of the intrapersonal and interpersonal features of empowerment, the program evaluates two subsets of objectives: one for residents and one for professional caregivers.

Resident Objectives:

1. To increase intrapersonal feelings of empowerment in older adults who live in long-term care settings.
2. To augment a positive perception of quality of life of the older adults who participate in the program.
3. To upturn participant's perception of client-engagement in the long-term care residential setting.

Professional Caregiver Objectives:

1. To elevate caregiver and client engagement perception.
2. To decrease burnout symptoms on the institution's professional caregivers.

c. Target Population

In agreeance with the program objectives, it is not surprising that it will target two populations. The selection follows specific inclusion and exclusion criteria for each group.

Residential Population:

a. Inclusion Criteria:
   - Live in a long-term care residence for older adults.
   - Voluntarily participate in the Power of Empowering Program.

b. Exclusion Criteria:

- Individuals with known severe cognitive decline or dementia diagnosis, measured by Mini-Mental State Examination (score under 24 points) and the Global Deterioration Scale (score greater than 4).

Professional Population:

It should be noted that, owing to the inclusive character of the program, geriatric caregivers include every healthcare professional that interacts with the residents. In other words, in addition to geriatric nurses, the invitation to participate in the program extends to psychologist, occupational therapist, social workers, physiotherapist, and physicians. There are no exclusion criteria for this group.

a. Inclusion Criteria:

- Geriatric caregivers who work at the long-term residence.
- Voluntarily participate in the Power of Empowering Program.

II. Program Design and Development

The Power of Empowering Program consists of five phases, counting from the design to the final evaluation and conclusion withdrawal (Figure 2). It is predicted that the program will take five months and two weeks to be carried out completely, being the implementation of the intervention the phase that has a longest duration (Figure 3). This timeline is calculated on what it would take to implement the program in one long-term care residence, however, since the first two phases are transversal to the whole program (design and approach), it will only take three months and two weeks to implement it in the residencies that follow.

Figure 2. Program Development Phases and Timeframe

Phase 1: Program Design

This phase belongs exclusively to the psychogerontology professional, who designs and creates the program in its entirety. The design must draw from an evidence-based literature review to ensure its validity and compliance with ethical standards. In addition, the program shall be grounded on empowerment and client-engagement theories in a psychosocial framework, as well as in psychological theories and the person-centered care model. Functions and responsibilities of the psychogerontologist will be specified later.

Phase 2: Advertisement and Approach

In this second phase, the psychogerontologist will offer the program and approach the target population, which in this case is found in long-term care institutions. Several tactics have been devised to fulfill this objective. For starters, residence regulatory entities will be contacted in order include the program as part of the accreditation milestones for residential humanized care. With the help of such institutions it will be possible to disseminate the program widely and positively impact many long-term care residences. Secondly, psychogerontology associations will be contacted, strategy that allows the program to target specific groups that share values and similar interests when it comes to updating their knowledge and enhancing their services. Some examples of such institutions are the Catalan Association of Healthcare Resources (ACRA) and Lares Federation, both located in Spain. Moreover, reaching these groups increases word of mouth marketing. Finally, individual advertisement, either printed or digital, will be sent to long-term care residencies in the neighborhood. Once the contact is established, the psychogerontologist will

meet with the residence director to provide further information (if needed) and elaborate a schedule for the program implementation.

Phase 3: Participant Selection

The participant selection phase will be held together with the long-term care institution representative. The psychogerontologist will take from the cognitive evaluation previously held by the institution in order to exclude those with severe cognitive decline or dementia. If there is any resident missing these evaluations, then psychogerontologist will proceed to complete them. Cognitive performance will be measured using the Mini-Mental State Examination (MMSE) and the Global Deterioration Scale (GDS), which are both internationally used and accepted test for this matter. Cognitive eligibility criteria are justified on the intellectual demands of the program sessions. The program compels an average cognitive function suited for learning and applying knowledge at a minimum level according to age. Therefore, participants who obtain a result less than 24 points on the MMSE, or a GDS score greater than 4 will be excluded, since this suggests a noteworthy alteration of cognitive abilities. Nonetheless, if the current program proves effective there is a possibility to create an adapted version for the remaining, and largest, population that makes part of a long-term care institution.

- *Mini-Mental State Examination (MMSE)* (Folstein, Folstein & McHugh, 1975): Cognitive screening test widely used to identify cognitive impairment, as well as possible symptoms of dementia in older patients. Originally created by Folstein and collaborators (1975) it has been internationally disseminated and translated into numerous languages. Blesa and collaborators (2001) adaptation is recommended in case of requiring a Spanish version of the test.

- *Global Deterioration Scale (GDS)* (Reisberg et al., 1982): Structured interview that evaluates cognitive and functional decline, and later classifies it into seven levels. It establishes that a score of one corresponds the absence of cognitive impairment, while a score of seven refers to severe cognitive deterioration. Lastly, it has been broadly

accepted that a GDS score of four points is equivalent to a moderate level of cognitive impairment and is commonly used as a cut-off point in research.

Phase 4: Intervention Execution and Follow-Up

The intervention execution phase is the longest part of the program, taking a total of two months for its completion. After the participants are selected, they will be divided into two groups according to their role, either as a resident or as a professional. Although they will both receive two hours of intervention per week, the number of the total sessions varies. While residents are involved in seven sessions, professional caregivers will receive five sessions. The reason for this lies in the fact that the main characters in older care and empowerment are the older adults themselves. Finally, a month after the program ends, a follow-up session will be held in order to assess the endurance of learned abilities and improve the intervention, if needed, for future applications. It must be noted that the sessions shall be done by the psychogerontologist.

Phase 5: Evaluation and Conclusions

Lastly, the psychogerontologist will gather posttest evaluations in order to compare them with the measurements initially taken. The results will be analyzed considering the accomplishment, or not, of the stipulated objectives. All input will be accounted for as feedback to improve the program for posterior applications. A structured report with the main findings will be elaborated and presented to the partaker institutions and individuals.

Phase	Months					
	1	2	3	4	5	6
(1) Program Design						
(2) Advertisement and Approach						
(3) Participant Selection						
(4) Intervention Execution /Follow-Up						
(5) Evaluation and Conclusions						

Figure 3. The Power of Empowering Program Monthly Schedule

III. Program Methodology and Activities

a. Program Methodology

The Power of Empowering Program is based on the core values it preaches, meaning that participants will have an active role during the sessions to encourage experiential learning, social interaction, and continued personal growth. As mentioned before, the intervention program has a total of 12 modules unevenly distributed in the two groups. Residents will take part in seven sessions, while professional caregivers will have five encounters. In addition, a follow-up session will be held a month after the program is completed. From the beginning participants will be divided according their role in the residential setting in groups of approximately eight or ten

people. The professional caregiver group will additionally be organized according to labor shifts in order to avoid significant disruptions in the institution's daily routine.

All modules follow the same pattern regardless of the assigned group (Figure 4). To begin with, a brief introduction of the main topic will be made, followed by a summary of relevant information mentioned in previous sessions. Afterwards, an active participation dynamic will take place with the objective of involving all of those present and promoting social interaction. Some examples of these activities are open discussions, workshops in smaller groups, the creation or construction of an object, or individual doings that may be later shared with others. Next, the psychogerontologist will take over to present theoretical information while connecting it to the feelings and results of the activities done before, to finally end with enough time to answer questions and achieve closure. Due to the amount of people and the experiential component of the modules, each will have a total duration of approximately two hours.

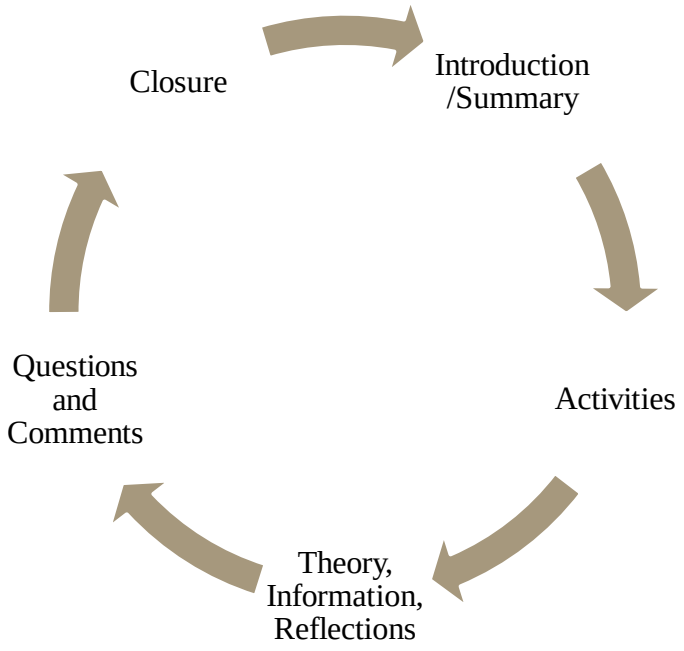

Figure 4. Module Structure

a. Resident Module: Description and Activities

The resident module is designed to increase intrapersonal feelings of empowerment and therefore positively impacting quality of life and client-engagement. It is built on important psychological and therapeutically theories such as Cognitive-Behavioral Therapy, Acceptance and Commitment Therapy, Cognitive Therapy, Self-Efficacy Theory, and Maslow's Hierarchy of Needs, into many others that give scientific bases that will surely potentiate the efficacy of the program. A session to session description of the resident module follows next. For a summary remit to Table 1.

Session 1

The Art of Feeling Empowered

Objectives

This first sessions looks forward to introducing the program, the instructor, and the participants. It will also constitute the starting point for psychometric measures; one of the two hours will be dedicated to completion of the Health Care Empowerment Questionnaire, the Brief Older People's Quality of Life Questionnaire and the Homecare Measure of Engagement-Client/Family Interview.

Activities

1. Getting to know each other. Even though the participants probably know each other from the residence, an introductory dynamic is indispensable to break the ice and for the psychogerontologist to get to know each of them. This activity will be held in a circle and each of the participants will introduce themselves by saying their name and expectations on the program. *[10 minutes]*

2. Measures Completion. Next, psychometric measures will be handed out. The psychogerontologist will be available during this time to aid the participants in any question or doubt about the scales. As some of them begin with the self-applied questionnaires, others will have their turn for the client-engagement structured interview. *[1 hour]*

3. The ABC's of Empowerment. This last segment will finally get to explaining the concept of empowerment, covering all important bases on the what, where, when, how, and who of what it means to become empowered. First, residents will be asked to share out loud what they believe empowerment means and ways to achieve it. Then, they will be separated into three groups and will be each given a puzzle (10 pieces). The three groups will receive different instructions: Group A will be completely ignored during the activity, no questions will be answered, and no guidance will be given during the execution of the dynamic; Group B will receive empowering interventions by the psychogerontologist, who will provide guidance while fostering autonomy, self-efficacy, and sense of mastery; Group C will be invasively directed, not allowing for the participants to play an active role in the activity. With this activity it is expected for the participants to experience firsthand what it feels to be empowered versus disempowered. Comments and reflections will be encouraged as a group afterwards. Finally, theoretical explanations will be given on the topic of empowerment, considering what the participants previously contributed to the discussion. *[1 hour]*

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- Empowerment is a process by which individuals, organizations, and communities achieve mastery (over themselves and the environment) through mechanisms of awareness, control and participation (Zimmerman, 2000).
- Empowerment considers an intrapersonal component (that refers to an individual's perception of control, mastery and self-efficacy), an interpersonal dimension (that includes social norms, external resources and the possibility to use them), and a behavioral element (that considers constructive conducts and participation at a community level) (Cox, 2001; De Witte & Van Regenmortel, 2019).

- Empowerment promotes strength and connection, positive attitudes, participation opportunities, inclusiveness, collaboration, proactivity or initiative, integrality, structure, and decision making (Anme, 2016; De Witte & Van Regenmortel, 2019).
- Feeling empowered is related to having a better quality of life, a higher self-esteem, stronger interpersonal relationships, greater physical activity engagement, and healthy behaviors (Chang & Park, 2012; Katula et al., 2006).

Questions and Comments

Questions and comments will be encouraged throughout the whole session as a way of empowering participants and promoting an active role during the program.

Closure

The session will end with a general conclusion on the topics reviewed and residents will be prompted to bring for the next session two examples of empowering and disempowering situations they experience in the following weeks or have experienced before in the institution.

• • •

Session 2

The Emotional Experience

Objectives

Being aware and properly connecting with the emotional experience is essential for the achievement of empowerment. Relatedly, emotional numbness and learned helplessness, both frequent feelings in long-term care settings, slowly contribute to a generalized emotional blackout. This session is centered around the idea that experiencing emotions is adaptative and will teach participants to connect with their feelings in a healthy way by being mindful.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[20 minutes]*

2. Embracing Emotions. The psychogerontologist will begin with psychoeducation on types of emotions, the emotional cycle, their adaptative and/or non-adaptative functions, and their relation to disempowerment. Information and activities will be taken from the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders, based on Cognitive-Behavioral Therapy (Barlow et al., 2011). *[30 minutes]*

3. Becoming Mindfully Aware. After learning about emotions, participants will be driven to an emotional experience through a mindfulness activity. As a crucial part of the Acceptance and Commitment Therapy, mindfulness provides an ideal setting to experience emotions without judging or changing them. A short 10-minute exercise will be held using one of the disempowering situations identified by the residents as part of their previous homework assignment. After the guided practice, the psychogerontologist will prompt a group deliberation

on the emotions felt. The same exercise will then be repeated with an example of an empowering situation in order to make a comparison and have a broad understanding of such feelings.
[45 minutes]

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- Emotions, both positive and negative ones, are functional and allow us to adapt to life events. It is through the emotional experience that we are informed about what is going on and motivated to act upon such situations. Therefore, it is not beneficial to "turn them off", even when they make us feel uncomfortable (Barlow et al., 2011).
- The emotional experience includes thoughts, feelings or physical sensations, and behaviors, constituting an infinitely ongoing triad that can be modified anytime (Barlow et al., 2011).
- There are five primary emotions that alert us on internal or external events and motivate us to respond. Such emotions are happiness, fear, anger, sadness, and anxiety (Barlow et al., 2011).
- Mindfulness is a practice that fosters the emotional experience as it is, being purposefully aware, in the present moment, and non-judgmental with what we feel (Teasdale et al., 2003).

Questions and Comments

Questions and comments will be encouraged at the end of the session as a way of empowering participants and promoting an active role during the program.

Closure

The session will end with a general conclusion on the topics reviewed. Residents will be encouraged to engage in daily mindful practices in order to improve emotional recognition and tracking abilities.

Session 3

Motivating the Self

Objectives

Conceptions of one's self are central when working on empowerment. Constructs like self-esteem, self-determination, and self-efficacy are found in various definitions of empowerment and are therefore a starting point when trying to strengthen feelings of empowerment. Session three aims to help participants in their understanding of their Self, as well as to build on more favorable conceptions that nurture the experience of being empowered. Parallelly, the session will approach motivational strategies, since the literature points out that a person must not only perceive empowerment but also be motivated to become empowered in order thrive in this journey.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[20 minutes]*

2. "Mirror, Mirror on the Wall". For this activity participants will be given a worksheet with a drawing of a mirror in which they must draw how they see themselves and later write around the picture positive affirmations. The idea of the activity is to reshape self-perception by highlighting those things they value of themselves. After an individual space, the activity will be commented on as a group. *[30 minutes]*

3. The "All or Nothing" and The Magnifying Glass. Relatedly, residents will then be asked to reflect on their capabilities, which is a soft spot for older adults who perceive constant loss of abilities while they age and therefore experience a deterioration in their self-efficacy level. For this assignment two cognitive distortions will be reviewed following Cognitive Therapy

guidelines. On the one hand, the "All or Nothing" trap will be addressed in order to show how, even though there are somethings that cannot be done as before, they are still capable of many things if they work on their cognitive flexibility. On the other hand, the magnification trap will be approached to explain how exaggerating negative situations, usually failures, leads to a reduction of our self-efficacy, self-esteem, and emotional wellbeing. The activity will be held in a group format and each will have a worksheet with examples of both cognitive distortions to identify the ones they relate to and add at least two more. *[30 minutes]*

4. Understanding Self-Esteem, Self-Efficacy and Motivation. The professional in psychology will later give psychoeducation on self-esteem, self-efficacy, and motivation. This theoretical approach will include definitions, tools to increase all concepts, along with strategies to overcome potential detrimental barriers. Lastly, Maslow's Hierarchy of Needs will be used to explain the importance of self-esteem and self-efficacy in the motivation ladder in order to achieve feelings of empowerment; internal and external strategies to maintain motivation will be addressed. *[40 minutes]*

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- Self-esteem refers to the positive evaluation a person makes about his/herself. It is composed of a competence dimension and a worth dimension that speaks to the degree a person feels to be of value (Cast & Burke, 2002). It has been proven that self-esteem can be both an outcome and a determinant for empowerment, reason why increasing self-esteem will reinforce feelings of empowerment (Chang & Park, 2012).
- Moreover, self-efficacy has been defined as an individual's perception of his/her competence to carry out a behavior or deal with a situation (Bandura, 1982). Likewise, the level of self-efficacy is thought to determine how empowered someone feels and how much effort they will invest when facing a challenging event.
- Several cognitive distortions may lead to depleted feelings of self-esteem and self-efficacy. One of them is the "All or Nothing" trap, in which polarized patterns of

thought limit behaviors that may bring emotional satisfaction because we cannot do them exactly as we did them before. Another example is magnified thinking trap through which we exaggerate shortcomings while minimizing positive accomplishments (Beck, 2011).

- In his Hierarchy of Needs, Maslow describes the importance of fulfilling different levels of needs in order to achieve self-actualization, growth, and fulfillment, all concepts related to feeling empowered (Maslow, 1943). The motivational ladder will be explained, emphasizing the importance of working on self-esteem and self-efficacy to get to the higher point of the pyramid.

Questions and Comments

Questions and comments will be encouraged along the session as a way of empowering participants and promoting an active role during the program.

Closure

The session will end with a general conclusion on the topics reviewed. Residents will be encouraged to express at least three in positive affirmations about themselves every day, as well as identify situations in which their cognitive traps limit their personal growth and achievements.

Session 4

Steps Towards Becoming Empowered I

- Values and Communication -

Objectives

Session four dives into specific strategies to become empowered. Although they are initially explained to be applied at a personal and first level of empowerment, such learned abilities will ease the transition into second and third degrees of empowerment at an organizational and community level. It is expected for the participant to learn and apply these tools at an individual level for two weeks and later, in session six, they are expected to generalize their knowledge from an organizational empowerment point of view. This session considers value identification and communication strategies, essential steps to active empowerment.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[10 minutes]*

2. My Value Compass. To work with values a compass analogy will be used, a worksheet with life values ordered in the directions of a compass will be handed out. The psychogerontologist will explain the meaning of values and goals, as well as the importance of their identification to engage in behaviors that allow the grasping of a fulfilling life. Each participant will identify at least four values during the session and sharing will be prompted. *[40 minutes]*

3. Communicating with Others. After recognizing meaningful life areas, it is important to know how to communicate them to others so that they can contribute. Challenges and conflicts may rise when communication is flawed, and it does not take much to make understanding others difficult mission. Information tends to be distorted from the moment one thinks what to say, to

the way it is said, and finally the way it is received and interpreted by the receptor. Consequently, assertive communication is and indispensable skill because it becomes a vehicle through which empowerment is exercised. After an explanation of the components of assertive communication, residents will participate in role playing dynamics to exemplify assertive and non-assertive communications. Both cases will be specific to situations where a resident wants to become involved in valued-directed actions and must communicate such need to a professional caregiver, whether to receive help or to "be allowed" to carry on.

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- Acceptance and Commitment Therapy highlights the importance of identifying life values to behave in such directions and achieve growth and fulfillment. There are ten life domains (family, intimate relations, parenting, friendship, work, education, recreation, spirituality, citizenship, physical self-care) (Wilson & Murrell, 2004).
- Values refer that meaningful pathway that guides our life domain (i.e. Being a loving father/mother) and goals are the concrete activities one can do to follow such value (i.e. Call my children every night) (Wilson & Murrell, 2004).
- Assertive communication is required to maintain healthy interpersonal relationships and pursue empowerment. The following skills will be reviewed and practiced during the role play activity: know what you want, modulate the intensity, making simple requests, formulate *I statements,* using listening skills, saying no, and negotiating (McKay et al., 2007).

Questions and Comments

Questions and comments will be encouraged along the session as a way of empowering participants and promoting an active role during the program.

Closure

The session will end with a general conclusion on the topics reviewed. Residents will be encouraged to finish their Value Compass Worksheet and exert communication skills as an empowerment tool for every day.

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Session 5

Steps Towards Becoming Empowered II
- Problem Solving and Decision Making -

Objectives

Problem-solving and decision-making are the other two specific strategies that will be taught to favor older adult's empowerment in long-term care settings. After learning what their meaningful life domains are and how to communicate their needs and wishes with others, decision making and problem solving are necessary skills to completely exercise empowerment, achieving feelings of control and mastery. This session will review and empirically apply the steps for decision-making and problem-solving.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[10 minutes]*

2. Choosing a Value-Directed Life. Many times, specifically in long-term care residences where dependence and identity loss are frequent, making decisions towards what we value in life is a challenging task. This activity has the purpose of refreshing decision-making strategies that boost empowerment in the older population, since to become empowered one must be able to choose and feel self-efficient when doing so. The decision-making process will be reviewed step by step and practiced with personal daily choices such as what to wear, what to eat, and how to organize the room, into many others. This activity approaches the first and individual level of empowerment. Participants will be presented different pictures of places to go to, food to eat, and clothes to wear, and will be required to choose one, argue in favor of it, and explain why they chose it to their peers. *[40 minutes]*

3. For one problem, a bucket of solutions. Problem-solving gives people control perception. When faced by difficulties, being able to solve a problem victoriously leads to feeling capable and empowered. Hence, learning problem-solving skills is fundamental in the journey to empowerment. Participants will first listen to the psychogerontologist theoretical elucidation on the steps for solving a problem. Afterwards, two cases that expose day to day conflicts in a long-term care setting will be presented and discussed as a group. Residents must go through all the problem-solving steps and come up with possible solutions. *[40 minutes]*

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- Problem-solving and decision-making skills go hand in hand. In fact, deciding is included in the process of solving a problem, since you must choose one of the many alternatives generated in the brainstorming phase (Beck, 2011; Neenan & Dryden, 2002).
- The following are the fundamentals of problem-solving: identify the problem, establish goals and objectives, brainstorm alternative solutions, consider the consequences for each alternative solution, make a decision, implement the solution, evaluate, and repeat if needed (Beck, 2011; Neenan & Dryden, 2002).

Questions and Comments

Questions and comments will be encouraged at the end of the session as a way of empowering participants and promoting an active role during the program.

Closure

The session will end with a general conclusion on the topics reviewed. Residents will be encouraged to complete a Problem-Solving Worksheet with any issue they face in the institution in the following weeks (can be either personal or as an observer).

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Session 6

Sharing the Power of Empowering

- PARTNER -

Objectives

This final intervention session aims to generalize the empowerment skills learned at an individual level to an organizational/community level. Using the PARTNER approach, broadly described in the literature, the session will advance in involving the residents in an organizational meeting to propose a change in a domain of the residence, may it be activity schedules, food menus, visiting policies or any other. This activity looks forward to giving them the experience of empowerment in higher levels of the hierarchy and to serve as an example for future gatherings by themselves once the program is over. It must be said that the PARTNER methodology will be adapted to the needs and possibilities of the institution and the group.

Activities

1. **Summary and Review.** Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[10 minutes]*

2. **PARTNER Activity.** The PARTNER activity will take most part of the session and will be mainly directed by the residents. The psychogerontologist will intervene as needed, always making sure a safe and empowering environment is maintained. The objective is that the participants can make use of all the empowering skills and abilities learned in previous sessions, at the same time they get involved in organizational modifications. First step will be to set and agenda and decide a topic or issue to modify in the residence. Next, deliberation over the topic will be encouraged, making special emphasis in opportunities and possibilities instead of problems. Afterwards, two professionals from the institution (an administrative and a caregiver) will participate in the heterogeneous group where ideas of improvements on the selected topic

will be exchanged until they reach a mutual understanding. Finally, a plan will be formulated to put into action the following month. Ideally the plan must be executed for the follow-up session of the PEP, a month after its completion. *[45-80 minutes]*

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- The PARTNER approach is based on the idea that people are willing to engage in collective action and contribute to the achievement of common goals. Such approach has been extended into residential settings, promoting the involvement of older adults and professionals as partners to ensure community wellbeing (Baur, et al., 2013).
- There are five steps in the PARTNER cycle: agenda-setting by the residents, building homogenous groups, building heterogeneous groups, formulating ideas and plans, and putting the plan into action (Baur et al., 2013).

Questions and Comments

Questions and comments will be encouraged along the session as a way of empowering participants and promoting an active role during the program.

Closure

The session will end with a general conclusion on the topics reviewed and reflections in favor of the collective participation. Residents and professionals will be encouraged to implement the action plan in the following month to improve the selected topic and consequently empower the residents.

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Session 7

A Powerful Farewell

Objectives

This final session looks forward to obtaining quantitative and qualitative feedback from the residents on the program. First, posttest measures will be handed out and then a focal group will be held to obtain the participant's input and appreciations on the program. By doing this, the program aims to empower them by including modifications to the intervention according to their points of view, and additionally it is a space for them to apply all learned tools.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[10 minutes]*

2. Quantitative Measures Handouts. Posttest measures will be taken. All scales will be handed out once again for participant completion. *[40 minutes]*

3. Focal Group. Qualitative feedback will be obtained through a focal group in which residents will be encouraged to assess the program and suggest changes for future versions of it.
[40 minutes]

Theory, Information and Reflections

A brief summary of all theoretical key points reviewed until this point will be made. Refer to previous sessions for more details.

Questions and Comments

Questions and comments will be encouraged along the session as a way of empowering participants and promoting an active role in the program.

Closure

Residents will be thanked for their participation and the one-month follow-up session will be scheduled.

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Table 1. *Resident Module Content and Objective Outline*

Module	Program Objective	Activity
The Art of Feeling Empowered	- Introduce program and participants - Pretest data collection	- Getting to know each other - Measures completion - The ABC's of empowerment
The Emotional Experience	- Being aware of and connecting with the emotional experience	- Summary and review - Embracing Emotions - Becoming Mindfully Aware
Motivating the Self	- Understanding and boosting self-esteem and self-efficacy - Learning motivational strategies to become empowered	- Summary and review - Mirror, mirror on the wall - The "all or nothing" and the magnifying glass - Understanding self-esteem, self-efficacy and motivation
Steps Towards Becoming Empowered I (Values and Communication)	- Identify core values in life domains - Learn assertive communication skills	- Summary and review - My value compass - Communicating with others
Steps Towards Becoming Empowered II (Problem Solving and Decision Making)	- Understand and apply problem-solving and decision-making processes	- Summary and review - Choosing a valued-directed life - For one problem, a bucket of solutions
Sharing the Power of Empowering (PARTNER)	- Learning the PARTNER approach for resident empowerment	- Summary and review - PARTNER activity
A Powerful Farewell	- Collect posttest quantitative measures - Obtain qualitative feedback through a focal group	- Summary and review - Quantitative measures handouts - Focal group

b. Professional Caregiver Module: Description and Activities

The professional caregiver model is complementary to the resident module considering that empowering older adults is a two-way street. In other words, the empowerment of the older population can only be achieved if done in partnership with the professionals who surround them daily and who through actions and verbalizations can promote or deplete an empowering ambiance. Its design considers the Person-Centered Care Model, a fundamental pillar when it comes to long-term care settings for the older population. Next, a session to session description of the professional caregiver module (for a summary remit to Table 2).

Session 1

Introducing Client-Engagement and Empowerment

Objectives

This initial session has two main objectives. First, it intends to give psychoeducation to professional caregivers on the definitions and basic principles of client-engagement and empowerment. Second, it is in this session that pretest data is collected, and a safe sharing environment is established.

Activities

1. Building a safe environment. An introductory activity will be held to create a cohesive group environment. Both participants and the psychogerontologist will present themselves and state their expectations for the course. *[10 minutes]*

2. Measures Completion. Psychometric measures will be handed out for individual completion. The psychogerontologist will be available during this time to aid the participants in any question

or doubt when filling the questionnaires. The two questionnaires to be applied are the Homecare Measure of Engagement-Staff Report, and the Maslach Burnout Inventory. *[45 minutes]*

3. The Basics on Client-Engagement and Empowerment. The first session will follow an academic format in which the psychogerontologist will begin with a presentation and the participants will have a workbook with relevant information, activities to fill in the blank, and matching concepts, as well a space for personal notes. The topics covered on this first encounter will be presented in a funnel methodology, beginning with the Person-Centered Care Model antecedents and foundations, followed by empowerment theories, and ending with detailed information on client-engagement principles.

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- Empowerment is a process by which individuals, organizations, and communities achieve mastery (over themselves and the environment) through mechanisms of awareness, control and participation (Zimmerman, 2000).
- Empowerment considers an intrapersonal component (that refers to an individual's perception of control, mastery and self-efficacy), an interpersonal dimension (that includes social norms, external resources and the possibility to use them), and a behavioral element (that considers constructive conducts and participation at a community level) (Cox, 2001; De Witte & Van Regenmortel, 2019).
- Client-engagement is defined as the interaction and communication that takes place between a service provider and a client, guaranteeing participation and decision-making opportunities (Petriwskyj et al., 2014). It is a dynamic process that, as well as empowerment, concerns the individual, the organizational, and the care-system (Cook & Klein, 2005).
- Person-centered approach is considered an antecedent of the empowerment movement. It emphasizes that when caring one should meet the person's needs, support their personal growth, and encourage individuality and autonomy (Brooker, 2004).

Questions and Comments

Questions and comments will be encouraged throughout the whole session as a way of engaging the attendants in active participation.

Closure

The session will end with a general conclusion on the topics reviewed and homework assignments. Staff caregivers must bring examples of disempowering and empowering actions they have implemented or seen in the institution. A situational record worksheet will be handed to each, it will contain slots for the description of the situation, how they felt about it, and at least one alternative way of achieving client-engagement in future occasions. Although no strategies have yet been learned, the assignment expects to ignite the participant's creativity to solve such issues.

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Session 2

The WE in Empowering

- Benefits and Barriers -

Objectives

The second session will take a step back and lead the participants to reflect on their vocation, motivations, and feelings when doing their job. The objective is to bring the attendants down into an emotional plane, instead of a purely rational one, where they connect with their sensible and humane side. Parallelly, the session looks forward to teaching benefits and barriers for empowerment and client-engagement in residential settings, in addition to highlighting the importance of working as a team.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[10 minutes]*

2. Stop, Breath, and Connect. Getting professional caregivers to stop, breath, and connect with their emotions is the main goal of this activity. In order to understand the importance of empowered treatment they must be able to feel empathy for the older adults they look after. Such connection will be achieved through a mindfulness activity, that will first aim for relaxation and then will describe in detail one of the disempowering situations they recorded for their homework assignment. Critical analysis will be prompted by questions on behalf of the psychogerontologist. *[50 minutes]*

3. Benefits and Barriers of an Empowering Care. The psychogerontologist will then proceed to theoretical information on benefits and barriers of an empowering care model for both

residents and professional caregivers. Once again, professional caregivers will have workbooks with relevant information and short academic activities. *[30 minutes]*

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- Every time more, researchers are finding associations between high levels of empowerment and positive outcomes in emotional and psychological wellbeing. Some have identified increased quality of life, diminished levels of depression, augmented healthy behaviors, and greater physical activity (Kranz, 2011; Tu et al., 2006). Furthermore, researchers also underscore the effect of empowerment programs on self-perception and self-esteem (Chang & Park, 2012).
- Likewise, benefits of empowered care have also been found on the caregiving staff. A study reveals that working under the premises of person-centered care increased psychological empowerment in the staff and was related with a better working climate and thriving experiences, both negatively correlated to feelings of burnout (Silén et al., 2019). Others suggest that caregivers who failed to provide empowered care had higher levels of emotional exhaustion and depersonalization, along with decreased feelings of personal accomplishment (Harrad & Sulla, 2018).
- The literature highlights several barriers for empowered care. For residents, poor attitudes and awareness, low confidence, and aversion to cooperate are the main obstacles. Meanwhile, professional caregivers face inflexible schedules, disrespect for autonomy, negative attitudes towards care, and low knowledge as essential barriers (Petriwskyj et al., 2014).

Questions and Comments

Questions and comments will be encouraged throughout the whole session as a way of engaging the attendants in an active participation methodology.

Closure

The session will end with a general conclusion on the topics reviewed and homework assignments. Staff caregivers will now identify barriers for applying empowering care and client-engagement in the institution. Once again, creativity and critical analysis will be stimulated by asking them to propose solutions for the identified barriers.

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Session 3

Can you feel the heat?

- Professional Burnout in Long-term Care Settings-

Objectives

Session three deepens into the emotional and mental health implications that come along with caring for an older adult in a long-term care setting. This special section is intended to treat burnout symptoms in professional caregivers and make sure they can provide an empowering care. Expressly, by reducing the barriers imposed by the burnout syndrome the possibilities that such professionals participate in client-engaging behaviors and empowered care increases.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[10 minutes]*

2. Understanding the Burnout Syndrome. The psychogerontologist will first present a video on burnout syndrome. The video is a conference given Dr. Christina Maslach, professor of psychology in the University of California and creator of the Maslach Burnout Inventory. In her conference Dr. Maslach approaches ground concepts on the field of burnout, its causes, symptoms, and solutions. After the video the psychogerontologist will open a space for deliberation and debriefing. The objective is twofold, to get professional caregivers to express their emotions and to create a social network they can rely on from this point on. *[1 hour]*

• Video Link: https://www.youtube.com/watch?v=gRPBkCW0R5E

3. Self-Care to Care. Worksheets will be handed out to each participant and the activity will consist of creating an individualized plan to manage burnout. Each caregiver will include in their First-Aid Burnout Kit the strategies they would rather implement when recognizing burnout symptoms. Possibilities will range from physical activities to emotional, cognitive, social, and spiritual. *[50 minutes]*

Theory, Information and Reflections

The following are the key theoretical points that will be discussed in the session:

- Burnout syndrome refers to the maintained response a person has towards work related stress (Maslach & Jackson, 1981).
- There are three dimensions to consider: (1) emotional exhaustion, pertaining the loss of emotional resources to cope with stressful situations (2) depersonalization, which emotionally detaches de individual from other or him/herself leading to lack of compassion and negative attitudes towards others, and (3) decreased personal accomplishments, that deteriorates the perception the person has over their work and competence (Maslach & Jackson, 1981).
- Burnout has negative effects on both the caregiver and older people. Caregivers may experience depression, chronic stress, low perceived quality of life, physical illnesses, and conflicts in their personal relationships. On the other hand, care-receptors may subject to

mistreatment, negative attitudes, and dehumanizing care patterns (Chao, 2019; Cocco, 2010; Westermann et al., 2014).

Questions and Comments

Questions and comments will be encouraged throughout the whole session as a way of engaging the attendants in an active participation methodology.

Closure

Participants will be expected to take home their First-Aid Burnout Kit and implement the strategies when feeling burned out. The worksheet also counts with a space for them to write on their feelings (before and after) they implement the burnout resolution strategy.

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Session 4

Empowerment and Client-Engagement Skills and Strategies

Objectives

After all the psychoeducation and emotional work on themselves, professional caregivers will be guided through the main skills of empowerment and client-engagement. This session has the purpose of training the participants with the use experiential learning strategies.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[10 minutes]*

2. Learning the art of empowerment. While the first session explained the principles and components of empowerment and client-engagement, this session underlines specific skills that must be implemented to effectively empower and older adult. The psychogerontologist will start by giving a lesson on each of the skills and professional caregivers are expected to participate by providing the examples of situations of disempowerment assigned for the homework at the beginning of the program. In this assignment they also had to create an alternative response and this one too shall be compared with the correct way to empower taught by the psychogerontologist. *[45 minutes]*

3. Practice, practice, practice. Attendants will be divided in groups of two and will be given ten minutes to prepare a roleplay. They must use at least three of the strategies mentioned during the session. After the preparation each will get around five to eight minutes to present and at the end a group discussion will be held to review their performance. *[60 minutes]*

Theory, Information and Reflections

The following are some examples of the strategies to be reviewed according to research findings (Chang et al., 2004; McCormack et al., 2010; Schoberer et al., 2016; Tu et al., 2006):

- *Active listening and rapport building*
- *Assessing, identifying, and expressing possible disempowerment factors*
- *Finding common values*
- *Getting know the person's life story*
- *Establishing shared goals and action plans*
- *Using empowering language and positive affirmations*
- *Active observation, paraphrasing, and emotional reflecting*

- *Promote critical thinking*
- *Provide positive feedback*
- *Deliver individualized and tailored care*

Questions and Comments

Questions and comments will be encouraged throughout the whole session as a way of engaging the attendants in an active participation methodology.

Closure

The session will end with a brief summary on the topics reviewed. No assignments will be left for the next encounter.

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Session 5

A Legacy to be Continued

Objectives

This final session has to main objectives, the first being to apply posttest measures and the second to receive feedback on the professional caregiver module. As an inclusive and empowering program, it looks forward to including modifications according to suggestions made by the participants.

Activities

1. Summary and Review. Every session, after the first, will begin with a brief review of the key points of previous meetings in order to ease learning. Homework assignments will also be commented on. *[10 minutes]*

2. Quantitative Measures Handouts. Posttest measures will be taken. All scales will be handed out once again for participant completion. *[40 minutes]*

3. Focal Group. Qualitative feedback will be obtained through a focal group in which professional caregivers will be encouraged to assess the program and suggest changes for future versions of it. *[40 minutes]*

Theory, Information and Reflections

A brief summary of all theoretical key points reviewed until this point will be made. Refer to previous sessions for more details.

Questions and Comments

Questions and comments will be encouraged throughout the whole session as a way of engaging the attendants in an active participation methodology.

Closure

Professional caregivers will be thanked for their participation and the one-month follow-up session will be scheduled.

Table 2. *Professional Caregivers Module Content and Objective Outline*

Module	Program Objective	Activity
Introducing Client-Engagement and Empowerment	- Give psychoeducation on the definitions and basic principles of both concepts - Pretest data collection	- Building a safe environment - Measures Completion - The basics on client-engagement and empowerment
The WE in Empowering (Benefits and Barriers)	- Lead the participants to connect with their human and sensible side - Teaching the benefits and barriers for empowerment and client-engagement in residential settings	- Summary and review - Stop, breath, and connect - Benefits and barriers of an empowering care
Can you feel the heat? (Professional burnout in long-term care settings)	- Explain the burnout syndrome causes, consequences and solutions	- Summary and review - Understanding the burnout syndrome - Self-Care to Care
Empowerment and Client-Engagement Skills and Strategies	- Train caregivers in empowerment and client-engagement skills	- Summary and review - Learning the art of empowerment - Practice, practice, practice
A Legacy to be Continued	- Collect posttest quantitative measures - Obtain qualitative feedback through a focal group	- Summary and review - Quantitative measures handouts - Focal group

IV. Evaluating the Program and its Impact

The Power of Empowering Program will be evaluated in two modalities: one related to the intervention objectives and another that considers the participant's experience and feedback. This twofold evaluation will point out the program's strengths and weaknesses and allow pertinent modifications to be made for future applications. It will also acknowledge qualitative and quantitative methodologies in order to acquire an ample understanding of its impact.

a. Measuring Intervention Objectives

The primary and secondary objectives mentioned above will be assessed individually using questionnaires; constituting the quantitative facet of the evaluation. The psychogerontologist will apply these measures twice, pretest and posttest, in order to weigh program outcomes. The difference between these longitudinal evaluations are key in determining if the intervention had either a positive, negative, or no effect on the participants. Five questionnaires will be applied in total and they will vary according to the participant's assigned group (Table 3). Residents shall receive three surveys and professional caregivers will complete only two. Next, a brief description of the evaluation measures.

- *The Health Care Empowerment Questionnaire (HCEQ)* (Gagnon et al., 2006): A psychometrically sound instrument designed to evaluate individual empowerment related to health care in older adults. It consists of ten items that evaluate three dimensions of empowerment: involvement in decisions, feelings of control, and interaction with healthcare professionals. It was tested in a sample of 873 older persons, with a mean age of 81.1 and 82.4 years, respectively. Includes two four-point Likert scales, one that describes the perception of control and another that assesses motivation for empowerment. Scores may range from 1 to 16 and are calculated by adding the cross-products derived from each item. The higher the score, the more empowered the person feels.

- *Brief Older People's Quality of Life Questionnaire (OPQOL-Brief)* (Bowling et al., 2013): This instrument was specifically developed to measure quality of life in older adults and it stands out for including the perspective of older people in its design. It consists of a preliminary item that evaluates quality of life in general and 13-items selected from the OPQOL-35 complete version. This unidimensional tool is answered through a five-point Likert scale, with a minimum score of 13 and a maximum of 65; high scores suggest a better quality of life.

- *Homecare Measure of Engagement-Client/Family Interview (HoME-CF)* (Baker, Harrison & Low, 2016): This assessment tool consists of a semi-structured interview, that can be applied to clients and/or family members to measure the degree of client-engagement. Through a set of 13 questions, and numeric scales for the frequency (1-5; 'almost none at all' to 'a lot') and the valence of the interaction (1-6; 'extremely positive' to 'extremely negative') a Conversational Engagement Score is calculated. The score ranges from 1-30 and, once again, high scores represent improved client-engagement.

- *Homecare Measure of Engagement-Staff Report (HoME-S)* (Baker, Harrison, & Low, 2016): This six-question report aims to measure all the dimensions of client-engagement (client acceptance, attention, attitude, appropriateness, engagement duration, and passivity). Likert scales are used to evaluate each of the questions and answers are later added to identify the level of engagement. An increased score will translate into a higher level of client-engagement.

- *Maslach Burnout Inventory (MBI)* (Maslach & Jackson, 1981): The MBI is the most recognized and used scale internationally to address burnout syndrome. Through its 22-items it measures emotional exhaustion, depersonalization, and reduced personal accomplishments, which constitute the three components of the burnout syndrome. The tool is self-administered and takes approximately 10-15 minutes to be completed. Responses are registered in a 7-point Likert scale and high scores indicate the severity of the syndrome.

Table 3. *Program Objectives and Assessment Tools Compendium*

Target Population	Objective	Assessment Tool
Residents	To increase intrapersonal feelings of empowerment in older adults who live in long-term care settings.	*The Health Care Empowerment Questionnaire (HCEQ)* (Gagnon et al., 2006)
	To augment a positive perception of quality of life in the older adults who participate in the program.	*Brief Older People's Quality of Life Questionnaire (OPQOL-Brief)* (Bowling et al., 2013)
	To upturn participant's client-engagement perception in the long-term care residential setting.	*Homecare Measure of Engagement-Client/Family Interview (HoME-CF)* (Baker, Harrison, & Low, 2016)
Professional Caregivers	To elevate caregiver and client engagement perception.	*Homecare Measure of Engagement-Staff Report (HoME-S)* (Baker, Harrison, & Low, 2016)
	To decrease burnout symptoms on geriatric institution's professional caregivers.	*Maslach Burnout Inventory (MBI)* (Maslach & Jackson, 1981)

b. Overall Program Evaluation

As stated before, the program will also be assessed from a general scope. This evaluation aims at understanding the participant's experience, listening to their feedback on the intervention and reinforcing their feelings of empowerment by including their opinions in future versions of the program. Such approach requires of qualitative methodology since the object is to highlight their individuality rather than fitting their perceptions into standardized categories. Considering the importance of group cohesion, communication, and activism in empowerment, focal groups where considered the best methodology for this matter. Each assigned population will take part in a focal group led by the psychogerontologist. The activity will have a maximum extension of one hour

and will address feelings, life impact, strengths and weaknesses, satisfaction, and other relevant topics, through a semi-structured interview.

Resources and Program Budget

I. Material Resources

The Power of Empowering Program (PEP) requires a limited amount of material resources. Sessions will be held in a room broad enough to hold up to eleven people, and a video beam shall be used to project slides, videos, and activities. It is expected for the institution to provide these non-fungible goods since the program will be carried out in their facilities. Additionally, the psychogerontologist will supply a variety of fungible goods required to execute the program. These include:

- *Program Workbook:* The workbook contains key information and activities for the participants to take home, review, and complete if desired. It offers a session-to-session guide, as well blank space for the participants to take notes and jot down their ideas. The workbook will symbolize their empowerment and is meant as a program giveaway.
- *Paper Copies:* Paper copies of the screening tests, questionnaires, and semi-structured interview formats will be required. The amount will depend on the total number of participants.
- *Advertisement and Publicity:* Posters, flyers, and/or brochures will be handed out to regulatory entities, associations, and long-term care residences as part of the second phase of the program, concerning advertisement and approach.
- *Writing supplies:* pens and colors.

II. Human Resources

The program requires of only one psychogerontologist to be implemented it in its entirety. The professional must be licensed in psychology and have specific experience with the older population. The intervention will demand half-time availability (Table 4) and the fulfillment of the following functions and responsibilities:

- Create and design the program.
- Design and develop the program workbook for both target populations.
- Advertise the PEP and approach long-term care institutions to be included in the program.
- Apply the screening test, along with the pretest questionnaires in the participant selection phase.
- Implement the sessions, for both target groups, carrying out all the established activities.
- Apply the posttest and focal group pertaining the quantitative and qualitative evaluation components, respectively.
- Analyze the results and elaborate a report that contains the information gathered on the program's impact, as well as recommendations for the long-term care institution, if any.

III. Program Budget

The program has a total length of approximately five months and two weeks, which includes every step from its design to its implementation and evaluation. The following budget (Table 4) is calculated over a base of 20 resident and 20 professional caregivers, for a total of 40 people. This number is assessed considering national statistics on residential care and evidence-based studies. Data points out that in Spain resident occupation varies significantly by communities, however,

there are on average 63 residents per long-term care institution (Esteban-Herrera & Rodríguez-Gómez, 2015). According to the RESYDEM study, one of the broadest researches done in Spain on the topic of dementia and institutionalization, 67.1% of the older people living in long-term care settings are diagnosed with dementia and 14.3% with mild cognitive impairment (López-Mongil et al., 2009). What is more, results from another study in this same country highlight that, out of 209 evaluated residents, 45,5% have severe cognitive impairment (Crespo et al., 2012). Bearing this in mind, and the fact that the eligibility criteria for this program excludes those with severe cognitive impairment or dementia diagnosis, the number of partakers notably narrows down. In sum, after excluding roughly 67% of the average amount of residents, it is estimated that the program will have approximately 20 participants. Lastly, because many of the institutions have double shifts, the budget considers 20 professional caregivers, adding up to a total of 40 people.

Table 4. *Program Budget (calculated over 40 people)*

Category	**Description**	**Units**	**Price per Unit**	**Total Currency: Euros**
Fungible Goods	Resident and caregiver workbooks	40	3 €	120 €
	Paper copies (screening tests + questionnaires + interview format) (15 pages *40 people)	600	0,02 €	12 €
	Advertisement (printed + digital)	20	1,25 €	25 €
	Writing supplies	40	0,2 €	8 €
				Fungible Goods Subtotal: 165 €
Non-Fungible Goods	Workshop room (provided by the institution)	1	0 €	0 €
	Video beam projector (provided by the institution)	1	0 €	0 €
				Non-Fungible Subtotal: 0 €
Human Resources	Psychogerontologist • Phase 1-2: 10h/week * 8 weeks • Phase 3: 1h/person * 20 people • Phase 4: 4h/week * 8 weeks • Phase 5: 10h/week * 4 weeks	172h	40 €	6,880 €
				Human Resource Subtotal: 6,880 €
				Program Total: 7,045 €

Discussion

According to research evidence, empowerment and client-engagement interventions have numerous benefits for older people and professional caregivers equally (Chang & Park, 2012; Tu et al., 2006). Although not yet run through, several hypotheses have been formulated for this program considering the specific variables, participants, and setting that were selected.

First, it is expected for the residents to experience an increase in their feelings of empowerment. The program includes seven sessions that successfully train older adults in individual skills needed to augment their empowerment. Such sessions were created based on the evidence of the components of empowerment, as well as on clinical interventions. Second, it is hypothesized that as empowerment feelings increase, the participant's perspective of quality of life will also escalate. The resident module focuses on aiding the older adults in having a strong self-esteem, self-efficacy, communication skills, problem solving and decision-making abilities, all elements that have proven to increase quality of life and mental health in several research findings (Kranz, 2011; Tu et al., 2006).

Third, the level of client-engagement is predicted to rise as empowerment strengthens and interpersonal relationships with the professionals at the center improve. Regarding professional caregivers who take part in the program, a reduction in their burnout levels is hypothesized. Research findings reveal that caregiver burnout is detrimental for professional performance and wellbeing (Cocco, 2010), while implementing empowered care patterns result in favorable results for this group. Likewise, a better performance and positive attitudes towards the residents, will surely contribute to better client-engagement for all parts.

Limitations must also be pointed out in order to improve future versions of the program. For starters, it is possible that the institution's policies and tight schedules preclude the implementation of the skills learned. Empowering strategies will add to the time it takes for professional caregivers to complete their duties, and although beneficial por residents and staff, it may not be convened by upper levels. Additionally, attendance may be inconsistent due to high workloads by the staff. Although this issue tries to be solved by dividing them into two groups to make up for the shifts, it is possible that other strategies must be put in place to completely solve for this difficulty. Moreover, the time length of the program may represent and inconvenience for

some institutions since it will interrupt activities and usual schedules for an important length of time. Finally, resident inclusion criteria are very limited considering that 67% of the older population in a residence are diagnosed with dementia or severe cognitive impairment. Such percentage represents a significant number of older adults that will be excluded from the program and that probably need the empowerment intervention (López-Mongil et al., 2009). Consequently, future versions of the Power of Empowering Program must be adapted to include residents with varied cognitive performances.

Conclusions and Personal Implications

The Power of Empowering Program (PEP) looks forward to filling an essential gap in long-term care for the older population, both for intervention and empirical research advances. Its empowerment orientation and person-centered care emphasis make it a given that the program will be modified and adapted every time around according to the feedback received by residents and professional caregivers who participate. The program aspires to be widely disseminated and to serve as an example for psychogerontologist and health care professionals interested in contributing to the cultural transformation of caring for the older people in a humanized and dignified way. It is urgent for a transition to be made from a narrowed scope vision that focuses on the ailments of becoming old to an inspirational and uplifting movement that treasures the development cycle in its integrity. Moreover, PEP also reaches out to professional caregivers who willingly dedicate their time, knowledge, and energy to the magnificent adventure of caring for others. This intervention program expects to help them improve their abilities to care for others while caring for themselves. All in all, PEP will surely leave a footprint and offer a refreshing turnover in today's aging revolution. We encourage others to responsibly take from this program to intervene on long-term care residencies for older adults so that more board this life-changing journey.

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