AIMS

◆ to promote opportunities for the exchange of knowledge and expertise between members;
◆ to promote a greater appreciation of psychological factors in ageing;
◆ to advise and participate in matters of teaching and training;
◆ to stimulate research and disseminate research findings;
◆ to act in an advisory capacity on issues relating to the well-being and provision for care for older people;
◆ to foster an exchange of information and ideas with other professional and voluntary groups.

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The delightful photographs scattered throughout this issue, of Cambridgeshire and other scenes of East Anglia, were taken by Jayne Woodcock, Graham Winton, Dave Morris and Dave Bibby.

ISSN: 1360–3671

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PSIGE is the Faculty for Old Age Psychology
(British Psychological Society, Division of Clinical Psychology).
Editorial
Kathryn Sams, Cath Burley & Philippa Blythe

Welcome to the January, 2008, edition of the PSIGE newsletter, from the East Anglia Geographical Group. We meet bi-monthly at the Ida Darwin Hospital in Cambridge, usually on a Thursday, from 10.00 to 12.00. We use this time to catch up on news from around our region, share information from the national PSIGE committee and from the subgroups we attend as part of the local training course, as well as having an emphasis on CPD. We have introduced a regular slot for one of us to present a neuropsychological assessment we have been working on, to encourage discussion, to seek advice from others or to perhaps share something new. We also try to have an outside speaker at each meeting, with a topic that the group is interested in.

Assistant Psychologists based in our services are always welcome at our meetings. We also have strong links with the University of East Anglia in Norwich, where the local Clinical Psychology Doctorate is based. Trainees from the course have core and specialist placements with us and we encourage them to attend our meetings.

We work in three different trusts; Norfolk and Waveney Mental Health Partnership Trust, Cambridgeshire and Peterborough Mental Health Trust, and Suffolk Mental Health Trust. These three trusts cover a very wide and differing geographical area, with diverse populations. Physically, it stretches from the Wash in the north, via the royal estate of Sandringham on the north Norfolk coast via the beautiful National Trust coastlines of Norfolk and Suffolk. It encompasses the timeless seaside towns of Hunstanton, Wells-next-the-Sea, Cromer, Great Yarmouth and Ipswich as far as Roman Colchester in the south. Moving inland, the area incorporates the cathedral cities of Norwich and Peterborough, the classic colleges of Cambridge and the market towns of Newmarket, Bury St. Edmunds, Sudbury, Haverhill, Huntingdon and Royston linked by the Fens to Wisbech and King’s Lynn. The populations are as diverse as the countryside, having developed through waves of new settlers from Boudicca and the tribes to the Romans, war-time Italians and Poles. More recently Asian, Chinese, and Eastern Europeans have merged with the people of the local farming, town and gown, cathedral or railway communities of before.

The articles have been written by some of the psychologists in our geographical group and our thanks go to them for spending the time reflecting on their work and sharing new ideas with us. We begin with a letter from a carer consultant in Norwich, Cressida Hammerton, who shares some of her experiences with us about her husband’s diagnosis of dementia. Her daughter has also kindly agreed that the poster she designed may be used on our front cover. We then hear from Sally Stapleton, Judith Farmer, Siobhan Smyth and Juni West, who tell us more about the Norwich experience of dementia care mapping. Our third article is from Alistair Gaskell, Anna Forrest, Claire Illingworth and Jan Robins, and provides an interesting report of a training project run in care homes in Cambridge. The next article also comes from Cambridge, with reflections on a group for people with dementia, written by Claire Illingworth and Anna Forrest. This is followed by another experience of a group for people with vascular dementia run in Peterborough written by Cath Burley and Yve Griffin. Furthermore, in this section, we have another three interesting articles, the first from Claire Matchwick, an Assistant Psychologist in Peterborough, who shares the development of the sunshine walk garden which was designed to meet the ideas...
brought to the service by users and carers, and the second by Catherine Ford, a trainee on the UEA course, who writes about her doctoral research supervised by Malcolm Adams, on the relationship between beliefs held by stroke patients and post-stroke depression. Finally, Laura Sutton and Ross Chernin describe a tool to introduce trainees to neuropsychological assessment.

The second half of our newsletter sees a set of articles written on the functional side of our work. We have articles on the use of the Identity Map model in a patient with possible Lewy Body Dementia, encephalitis or vascular syndrome, by Rachel Wenman, followed by some interesting reflections by Nick Oliver, on staff training for using a solution-focused approach. We then have some further reflections on a self-esteem group run by Erica Richmond and Lucy Matthews, in Norwich, as well as Julie Clarke's reflections on the use of CAT with older people in Suffolk. Liz Carter then informs us of her reflections on completing the diploma in cognitive analytical therapy at UEA. Finally, we have an article from Clive Sims, the only member of our group to be working in the forensic service, who updates us on his experiences of working in the forensic service and talks of what we may be likely to see in the years to come.

As joint chairs of the group, we are both extremely grateful to Philippa Blythe, Assistant Psychologist, who up until recently was based at St. Clements Hospital in Ipswich, for acting as guest editor. Philippa has not only organised, chased, nagged and encouraged the authors of these articles to adhere to deadlines but has also edited the articles, for which we express immense thanks, as she has taken an enormous work load off both of us. Philippa briefly shares her experiences of working in East Anglia and her work as guest editor below.

Originally from Sussex, I relocated to Ipswich, Suffolk in 2006 to gain further experience as an Assistant Psychologist with Suffolk Mental Health Partnership NHS Trust, before commencing my doctoral level training. I have found the post to be invaluable in continuing my professional development and the psychologists within the region to be nothing but supportive. I would definitely recommend to others looking for similar experiences to apply for assistant posts within this region. I originally volunteered to act as guest editor at the beginning of my post in November of last year. At the time, it was thought that the job would be most suited to an Assistant Psychologist who was likely to still be working in the area the following year. Given that I was the only Assistant Psychologist who would be in this position, the task naturally fell on to me! Despite this twist of my arm, metaphorically speaking, the experience has generally been a good one and a useful addition to my CV. Though as the deadlines have crept up, juggling the editing work with the end of my employment has been stressful at times. I would also like to express my thanks to the psychologists who have spent time writing the articles for this edition at adhering to the deadlines set and tolerating my endless reminder e-mails!

We hope that this newsletter highlights the broad range of research and projects that have been carried out throughout the East Anglia region. It was thought that it would also be interesting to draw attention to some further projects that will be happening within East Anglia in the near future.

Kathryn Sams, Cath Burley & Philippa Blythe.
Special Interest Group – CAT in Later Life

In ACAT (Association for Cognitive Analytic Therapy) we have had a special interest group for CAT in Later Life. This group was put ‘on hold’ whilst Jason Hepple and Laura Sutton were preparing the book *Cognitive Analytic Therapy in Later Life*. Meanwhile, we’ve been exploring issues of ‘neglect’ in later life – which was presented at the recent PSIGE conference in Nottingham (in preparation – hopefully for co-publishing in the PSIGE and ACAT newsletters).

Now we’re aiming to start up the ACAT special interest group again – so far we have two ACAT members who would like to give us a hand. If you would be interested in developing this group with us or joining it, then please get in touch with one of us. We are anticipating mainly an electronic network at first and then getting back to offering workshops at ACAT and PSIGE conferences, etc.

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Experiences of using an identity map model

A group is being piloted in Peterborough for older people with mixed anxiety, depression and emotional dis regulation with the aim of improving their ability to tolerate emotions. The group is largely informed by dialectical behaviour therapy and mindfulness approaches and aims to incorporate experiential work in addition to information provision and group discussion.

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A belated happy new year to everyone. Since my last letter the National Committee has held its three-day strategy meeting and also met in November. We have four strategic objectives for this year:

1. Influencing policy and practice;
2. Providing professional guidance to members;
3. Developing infrastructure to support our vision, aims and objectives;
4. Our developing relationship with the DCP.

Objective (1) is in danger of running away with itself. There were 16 items for discussion at our November meeting. This perhaps reflects the growing activity around older people’s mental health. It is impossible for the committee to become involved in all issues that are flagged up. Key areas that we are focussing on include Increased Access to Psychological Therapies (IAPT); the National Dementia Strategy; and standards for in-patient care. We are also keeping an eye on the issue of merger of MHSOP and AMH services. There is the possibility that PSIGE may participate in a national conference in May and I have been invited to join a CSIP sponsored reference group looking at issues around anxiety/depression and end of life.

Under (2) we were disappointed to learn that the DCP had refused to financially support the distance-learning proposal that Catherine Dooley has worked so hard on. Catherine is currently looking into alternative options. A major piece of work by Don Brechin, Sarah Dexter-Smith and Nicky Bradbury will come to fruition soon – the development of a depression care pathway.

The website continues to develop as a key component in our infrastructure. Patrick McGuinness is continually updating it so please keep checking for new information.

Our relationship with the DCP continues to develop. Steve Boddington is exploring the issue of the transfer of our membership database and Alice Campbell Reay is tentatively commencing discussions regarding the thorny issue of financial control. As a committee we are trying to ensure that the needs of older people are represented at various DCP groups and meetings.

Finally a big thank you to two PSIGE members for trying to represent PSIGE interests on external bodies: Rachel Demone and Alice Campbell Reay. Rachel stood for the post of committee member on the DoN and Alice went for the post of DCP treasurer. Both were up against stiff opposition and sadly neither was successful. Thanks for having the guts to have a go.
WHEN MY HUSBAND first showed signs of dementia I was not prepared for its consequences and was totally uneducated as to its causes and effects. Hitherto, our life together had been much like the majority of couples with careers and children and I could not have predicted the roller-coaster of events that were to shake up our lives.

It was not for some years that Peter was finally diagnosed as suffering from vascular dementia and by that time I had become inured to a life of the inexplicable and unexpected as Peter’s behaviour was totally unpredictable and sometimes even dangerous, especially to himself. I do understand that early diagnosis can be difficult. At one time Peter was diagnosed as having a brain tumour but the resulting biopsy at Addenbrookes proved inconclusive and there were other symptoms that diverted us from the true nature of his illness such as cellulitis, bad circulation, etc. It was my doctor, finally, who spotted that Peter was walking in a rather lopsided manner. I was able to explain our problems to her and she immediately referred him to the Julian Hospital. From then on, regarding help, our lives took an upward turn and it was through the staff at the Julian that I was given information as to the nature of vascular dementia.

I was referred to a charity called Pabulum (unique in this area) where a woman and a man came to see me. One of them befriended Peter, and he was not a person who made friends easily, and the other gave me support.

Later, I took part in their training sessions and eventually became a trustee. It proved to be a turning point in my life. It was through Judith Farmer at the Julian that I was introduced to the work of Tom Kitwood and the latest research done at Bradford University and finally to the study of dementia and practice of Dementia Care Mapping (DCM). When I first heard of DCM I almost shouted for joy – here at last was a science based on minute observations of the interaction between the person with dementia and whoever was looking after them. Mapping is an excellent word for describing one’s exact location and thereby revealing both what is lacking and what is positive in dementia care.

All this was to come later but in earlier days of Peter’s dementia I struggled, not only to come to terms with his illness, because I was partly in denial, but also to try and make sense of what was happening to him. This I discovered was a fruitless journey though it did lead me into wondering what the difference was between mind and brain! The tools of logic and clock-time had to be discarded along with questions and decision making. Friends eventually were disinclined to visit as they were out of their depth. Night times became nightmares from which I only gained relief when I had to call out an emergency doctor who left some liquid tranquiliser for Peter. It may sound a small thing but psychologically it worked wonders for me. I knew that if things got really unbearable, rescue was at hand. I kept that bottle for emergency only and hardly ever used it. Knowing it was there was enough to calm me down! Which reminds me, partners when they bring their loved in to the surgery may appear distracted and confused themselves, thereby clouding the issue. Maybe this illness is catching, maybe I’m going cuckoo myself! I went through so many phases I had come to acceptance and living in the day. Also I needed to practice person-centred care on myself!

A person with dementia is not a demented person and that is easier to understand when you have had experience of the
person behind the dementia, when you have the broader picture and can tune into the essential person you have known for a long time. Peter died in 2003 in a home at night time with only a night carer I had never met. I have my regrets, my guilt at abandoning him to the mercy of strangers but he has left me a legacy I could never have expected. I now work with the Trust as a ‘carer consultant’ and I am privileged to be a facilitator in training sessions for professionals. Most importantly, I am one of a team of Dementia Care Mappers that meet regularly at the Julian Hospital. All those years with Peter, when I muddled along to the best of my ability and without much hope, have brought out the pioneer in me. I feel we are on the edge of exploration into new techniques and fresh understanding of dementia and I have Peter to thank for that.

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Happisburgh Lighthouse – marooned in Norfolk!
From one… to over 100 mappers

THE YEAR 1997 was a year that was to change the face of services for people with dementia here in Norfolk, for it was in this year that I (Judith) began the journey to become a trainer in Dementia Care Mapping (DCM) with Bradford Dementia Group. As the ward manager of a recently-closed continuing care ward, I brought the inspiration gained from the DCM course to a newly-created day hospital. Little did we know at that time, but it was this day hospital, alongside one of our continuing care wards, that was to form one of the pilot sites for the development of DCM 8 (2005).

DCM and person-centred care have been written about extensively (e.g. Brooker, 2007; Kitwood, 1997) but in brief, the process of regular DCM evaluations helps care teams to continually re-focus on the experience of the person with dementia to enable teams to plan and improve the care for that person. In our opinion, this provides the optimum conditions for person-centred care approaches to flourish.

Whilst, it has not always been a smooth ride, training in person-centred care and the process of DCM evaluations have enabled our services to make huge changes in the philosophy and quality of care that we offer to people with dementia and their families. Our Trust now has over 100 dementia care mappers across a wide range of disciplines, including both registered and unregistered staff. For me (Sally), as a psychologist, the most striking consequence of this is to be able to share a common language about both the psychological needs of people with dementia and psychologically-based approaches to working with people with dementia. I have been particularly amazed by the change in the understanding and value placed on psychologically based approaches and skills within the service since the introduction of ‘personal enhancers’ within the eighth edition of DCM. Personal enhancers are the name given to approaches used by staff that enhance psychological well-being, and any psychologist will see their roots in psychological therapies, e.g. ‘warmth’, ‘genuineness’, ‘collaboration’, ‘validation’, to name but a few.

Lessons learnt along the way

Not all of our experiences with DCM have been positive ones, particularly in the early days and, as a result, there are now more support mechanisms, supervision and training to assist dementia care mappers within our organisation. A dementia care mappers forum, primarily aimed at supporting the practice of DCM, but open to anyone with an interest in person-centred care and DCM, was set up in 1999 and has just celebrated its eighth anniversary.

In the last three years, we have set up a training pathway in person-centred care to give an introduction prior to the DCM course (see Figure 1). Part of the reason for this was to challenge the idea that only staff working in a care facility need to know about person-centred care and DCM. It is our view that all staff should have skills in person centred care whether they work with people in a care facility or within their own homes. The training pathway includes a one-day introduction to person-centred care entitled ‘Shining the spotlight’, a three-day course on

Happy 10th Birthday! Celebrating our 10-year journey with person-centred care and dementia care mapping in Norfolk

Sally Stapleton, Judith Farmer, Siobhan Smyth & Juni West
the therapeutic value of activities called ‘not them and us, just us’ and a three-day course in understanding psychological needs and using positive communication skills entitled ‘Communication and personal enhancers’. These courses are facilitated by dementia care mappers with professional backgrounds in nursing, occupational therapy and clinical psychology in addition to our carer consultant, who provides us the link between the knowledge of DCM and person-centred care with her own invaluable personal experiences of caring.

We have also set up a training pathway to support the continued professional development of dementia care mappers (see Figure 2). This includes practice mapping in a clinical area with an experienced mapper, including a supported briefing and feedback session, a day on briefing and feedback skills, an extending empathy workshop, with a focus on experiential learning through, for example role play, and finally the advance level DCM course.
Figure 2: Advanced specialist dementia care training pathway.

In his final book, Dementia Reconsidered, Tom Kihlwood described DCM as:

"A serious attempt to take the standpoint of the person with dementia, using a combination of empathy and observational skill.”

For mappers to be able to use this tool and process with success they will need continuing person-centred support and education.
The art and science of dementia care
Training in person-centred care and DCM has inspired a number of projects within our organisation.

The science bit…
From 2005–2006, I (Siobhan) inspired by my clinical work during my clinical training, conducted my doctoral research within the service. My research used DCM to evaluate the use of life review books and reminiscence therapy on the well being of individuals with dementia within our specialist dementia wards. The research is currently being written up for publication, but the main results were that using life review books and reminiscence significantly enhanced levels of well being. In a comparison of life review books and reminiscence, life review was found to be most beneficial for the majority of individuals. This has led to the making of life review books for other individuals within the specialist dementia wards (Smyth, Stapleton & Adams, 2007).

The art bit…
Following her own personal experiences of her father’s diagnosis of dementia and subsequent care, Sophie Hammerton, a local artist, was inspired to paint her own interpretation of the five psychological needs of dementia (Kitwood, 1997), which now can be admired at the entrance to one of our specialist dementia care wards. Sophie has kindly given her permission for this painting to appear on the front cover of this newsletter.

2007 – a NICE year for person-centred care and dementia care mapping
Our positive experiences with DCM and person-centred care have been validated by the recognition of DCM and person centred care within the National Institute for Clinical Excellence guidance for supporting people with dementia and their carers in health and social care (NICE, 2007). In addition, the Commission for Social Care Inspection (CSCI) are due to train their Inspectors in a new tool called SOFI, which stands for Short Observation Framework for Inspection. This tool has been developed in conjunction with the Bradford Dementia Group and is grounded in the overarching principles of person-centred care and DCM. SOFI is designed, for example, to provide first-hand experience of sitting alongside people in a communal area of a care home and give insights into residents general mood state, level of engagement in activities and the quality of staff interactions with residents (Brooker et al., 2007). In our opinion, this is highly supportive of the use of person-centred care approaches.

The future
We now hope to have our second DCM trainer following my (Juni) completion of the training apprenticeship with the Bradford Dementia Group. Our next task is to ensure that DCM and person-centred care is fully recognised within all relevant strategic plans within the organisation. The release of the NICE (2007) guidelines and CSCI’s plans to use SOFI has been extremely supportive developments. Our vision for the future is that every single member of staff who works with people with dementia will have training in person-centred care to ensure that we always have PEOPLE with dementia at the very centre of our work (Kitwood, 1997).
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References


Aldeburgh beach.
The need for mental health services to work in partnership with residential care providers in order to raise the standard of care of older residents is one that has long been recognised. Current policy guidance such as Everybody’s Business (CSIP, 2005) and NICE guidelines on dementia (NICE, 2006) recognise the role that secondary mental health services should have in promoting mental health care, in particular person-centred care, within care homes. There are also many examples in the research literature of the way in which psychosocial interventions such as training can have a beneficial effect (for example, Lyne et al., 2006; Fossey et al., 2006; Teri et al., 2007). The provision of support to residential homes from mental health services, however, is sporadic to say the least. In Cambridge and the surrounding area, we have been working over the past two years to try to develop a more substantial partnership between the care home sector and local mental health services. Whilst the service is still a developing one, we feel that it might be of interest to describe the process of development, the dilemmas we are facing and the emerging evidence of the effectiveness of the service.

Origins of the service
The service developed out of a working group set up within the Trust during 2005, of people interested in working with care homes. We looked at examples of services developed elsewhere, including services in Camberwell, Cumbria and Bridgend, as well as at our own experiences. The members of the working group shared an interesting mixture of enthusiasm for offering training and working with care home staff and cynicism about whether it would be possible to create real and lasting change.

We were concerned about such things as the commercial (i.e. cost cutting) ethos of some of the provider organisations; the high turn over of staff; and apparently low levels of skills (including language skills) among the care staff. I think that we had a sense that managers and staff would be jaded and ‘difficult’ to work with. From a psychologist’s perspective we also knew that there was a literature dating back at least to Georgiades and Phillimore’s 1975 paper, The myth of the hero-innovator; addressing the dangers of assuming that it is possible to change organisations simply by training staff (‘hero-innovators’) and sending them into conflict with organisations in the way that knights of old were sent to slay dragons. They warn that powerful organisations (as in a psychological sense care homes certainly are) are well capable of eating hero-innovators for breakfast.

The upshot of this was that if we were to do anything we needed to do it with residential homes rather than to residential homes. If we were to do this we needed to start talking to them.

We therefore started with a process of consultation and engagement with care homes beginning with a postal survey. We then organised a consultation event, at which Jane Fossey kindly agreed to speak, and went on to form a working group comprising mental health staff, representatives from the Alzheimer’s Society, Primary
Care Trust’s (PCT) and the County Council and managers of a number of local care homes. Our enthusiasm grew as the process proceeded and we agreed to put together a package of training and post-training support and to pilot it on two clusters of homes.

**Pilot projects**

In the model we adopted, training was offered on-site to small clusters of homes. On-site training was a clear request from the homes and we hoped that training groups of staff together would assist in bridging the gap between training and practice. Five half-day sessions on dementia/depression, person-centred care, challenging behaviour, activities and communication were provided by a small group of Trust staff from different disciplines. The training sessions were delivered weekly for three hours over five weeks. It was made explicit from the start that staff should aim to attend all sessions. To provide continuity between sessions, two of us (Anna and Alistair) attended all of the sessions at a particular site. We also maintained contact with the homes through small supervision/discussion groups that aimed to consolidate training and maintain knowledge and skills in the homes. We were aware of the limited nature of our input, but felt that this represented the best compromise between the needs of the homes and the limited time at our disposal.

The aim of the sessions was to promote knowledge and to encourage people to think about their own experiences, rather than for trainers to provide teaching using didactic methods. The teaching included interactive exercises, group based discussion, role-play and case discussion. The ethos of the training was person-centred care. Materials were adapted from the excellent resource pack *Improving Dementia Care* (Loveday et al., 1998).

The pilot projects took place between April and June, 2006. Five residential homes were involved, two with specialist dementia units. The other homes had a number of residents who have dementia or significant cognitive impairment. In total, 28 members of staff took part in the pilot training project, and comprised mainly carers and senior carers. We asked home managers to nominate participants, stressing the need for informal as well as formal leaders to be part of the training in order to facilitate the process of cultural change.

Evaluation of the pilot projects was by feedback questionnaires given at the end of each session; together with the Approaches to Dementia scale (Lintern, unpublished) and some brief unstandardised questionnaires given pre- and post-training. Feedback was very positive (68 per cent rating sessions as ‘very helpful’ and 71 per cent as ‘very relevant’) and responses to the brief questionnaires showed increases in perceived knowledge of working with older people and confidence in managing difficult situations. The Approaches to Dementia questionnaire showed positive movement on both subscales of the questionnaire (‘Hope’ and ‘Personhood’) for both projects although data were somewhat incomplete.

Follow-up meetings were offered to staff from both clusters of homes, initially for a period of six months. For one of these clusters the meetings were well attended and used whilst for the other the meetings were cancelled by the host home after a couple of sessions. The main reason for this seemed to be a crisis in the home unrelated to the subject matter of the training.

**Extension of the project after the pilot phase**

During the pilot phase we were able to gain agreement from the local PCTs for some of the money saved from a ward closure to be reinvested in a training post, to continue and extend the project. This represented a considerable commitment from them at a time of deep cuts in local services.

The postholder (Jan) is an experienced Community Mental Health Nurse who had previously managed a large nursing home in the area. She was appointed under a dual
management arrangement whereby one of us (Alistair) was responsible for clinical supervision and management, with a service manager as her operational manager.

With her appointment the project gradually began to expand. Jan undertook the role of ‘host trainer’ at each of the new projects, attending each session and leading some of them. She also led the follow-up meetings. Jan has continued to co-facilitate training together with us or other members of staff from the Trust.

The structure of training has changed little from the pilot projects, with the addition of a sixth session chosen by participants. Interestingly, they have often opted for this session to be about managing their own stress. Both quantitative and qualitative feedback has continued to be overwhelmingly positive and at times has taken unusual forms. For example, at the end of one course, one of the participants presented us with an enormous (and very tasty) ‘thank you’ cake. We have been surprised by the strength of the feedback, as we have few pretensions to be expert trainers, and see it as a reflection of how little support or time to reflect on their work that care staff routinely receive.

To date (August, 2007) a further 10 programmes of training have been delivered covering 14 further homes, including nursing as well as residential homes, both with and without specialist dementia units. Most of the training has followed a fairly standard format although occasionally we have adapted it for homes with clearly different needs, such as a supported living unit for people with long-term functional mental health problems.

The expansion of the project has thrown up a number of challenges. One is that during the pilot phase, the training group from the Trust and the managers of the homes was fairly small which facilitated group cohesion. Since the appointment of the trainer, she has shouldered a much larger proportion of the work and has had to build relationships with a much wider group of care homes. Equally staff who had been able to take time away from their ‘day jobs’ during the pilot phase, found it more difficult to make the case to their managers for continued involvement. There has been a danger of the trainer becoming isolated and of losing the collaborative feel of the project, which to this point has been one of its strengths.

We have aimed to combat this by trying to keep home managers involved, through the project steering group, through a further consultation meeting and most recently through a specific two-day training for managers focusing, amongst other things, on supporting staff in the process of change. This was enthusiastically received and we plan regular support/education meetings for a managers group. Another suggestion from the most recent consultation meeting is for us to develop further, more in-depth training for ‘facilitators’ who would have a role in follow-up meetings and possibly in delivering further programmes of training. We are hoping to develop this idea in 2008. We are also currently instituting a review of the training programme, so trying to involve as many of the trainers as possible in the project and maintain the feeling of participation.

Evaluation
As the project has developed the need to evaluate it more formally has become clearer. As the aim has been to improve the quality of psychological care given to residents the selection of suitable evaluation criteria has not been straightforward. What both the Mental Health Trust and the PCTs would like us to be able to show is that the service reduces mental health admissions to hospital. Although we have anecdotal evidence that this might have happened on one occasion, the base rate of mental health admissions from care homes is now so low that it is very difficult to gather good evidence on this point. We have also faced constraints of time in gathering adequate evaluation data.
The solution we have taken is to continue to gather routine evaluation data, whilst gathering fuller data on a small subset of projects.

Consequently, we have selected one residential home with a dementia unit on which to conduct an in depth evaluation. We are measuring: overall quality of care using Dementia Care Mapping; the effect on residents in terms of depression measured on the Cornell scale (Alexopolous et al., 1988); and challenging behaviour (using the Challenging Behaviour Scale, Moniz-Cook et al., 2003). We have also measured staff job satisfaction using the Measure of Job Satisfaction (Chou et al., 2002). At the time of writing we only have post-training data from Dementia Care Mapping, but this shows a significant increase in individual and group ratings of well-being and a reduction in the use of interpersonal detractors.

Current and future developments

The fast-changing climate of health and social care brings with it both opportunities and threats to the project. On the positive side, there has been support for the project from Trust management which in principle could see it expand to cover the whole geographical area of the Trust, although it is not clear from where money would be found for the extra posts needed. Also positive are changes in inspection practices in care homes, particularly the introduction by the Commission for Social Care Inspection of the Short Observational Framework for Inspection, which seeks to look at the service provided through observation and an attempt to empathise with the feelings of residents. Although it is not clear at the time of writing whether or how this kind of measure of quality of care will affect star ratings of care homes, it does bring the issues of psychological quality of care more centrally to the attention of care home providers. It must be said, however, that care home managers seem to view the changes with a lot more uncertainty.

The threats come more from the move towards Foundation Trusts and the potential for these Trusts to take a more commercial approach. There has already been some discussion within our Trust of the idea that private care homes could be seen as competitors in the future health care economy. In this context, the future of a project with a collaborative ethos, which has offered training largely for free, would seem uncertain.

The wider picture

Overall, it feels as though the fruits of the project have been well worth the time and effort put in by many staff from the Trust and from care homes. It has been a rewarding and enlightening experience, which has strengthened both internal and external relationships, and aside from the evaluation evidence, we do get a sense of learning being put into action. Having just completed a two-day workshop for 17 very enthusiastic managers and deputies, we realise that at least some of our initial doubts were misplaced. Yet other doubts do remain. Ours is a small project trying to address a big problem.

The recent report of the Joint Parliamentary Committee on Human Rights highlights the extent of problems of abuse, neglect and inadequate care in hospitals and care homes (Joint Parliamentary Committee on Human Rights, 2007). From our own experience, we know that many carers are starting from quite a low level of skills and experience. Rates of pay are low and as our sessions on stress management for staff have taught us, many carers are simultaneously coping with a demanding job and significant personal stressors. Although we have sometimes been humbled by the dedication of carers from overseas, there is a real problem if they do not speak adequate English.

This kind of project can only be part of the solution to raising standards of psychological care within care homes, alongside better regulation, increased inspection and improvements in levels of funding. Yet it seems to us that projects like ours, which
offer partnership and support to care homes to build on their strengths, are a vital part of any process of change.

Acknowledgements
The authors wish to thank their colleagues from Nursing, Occupational Therapy and the staff from the residential homes for all of their support and contributions to developing this project. In particular, we would like to thank Dee Wall and Lisa Myson, Occupational Therapists, and Caroline Lindsay, Assistant Psychologist.

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References


Development of the group

This group was developed for people with mild memory problems and targeted those in the early stages of dementia or with a diagnosis of Mild Cognitive Impairment (MCI). The aim was to educate clients and carers about different types of memory and about various memory strategies to enable them to manage their difficulties more effectively. The group took a cognitive rehabilitation approach, which aimed to facilitate optimal well-being and functioning across a range of domains. This is based on the understanding that despite difficulties with memory, people with dementia still have the ability to learn new associations and information, and adjust their behaviour and responses (Clare, 2007).

The purpose of the group was to identify ways of dealing with the problems that arise as a result of cognitive changes, so as to enable the person to participate in interactions and engage in desired activities as best they can, within their own personal and social context. Cognitive rehabilitation interventions draw on a range of principles, methods and techniques, all with demonstrated efficacy for people with dementia (for example, Moore et al., 2001; De Vreese et al., 2001) and with many suggesting that significant improvement can be made in targeted areas.

The role of the facilitators was to assist group members in developing individualised memory rehabilitation strategies to help them come to terms with their difficulties and to encourage them to maximise and maintain their independence. The purpose of this article is to briefly discuss the content of the group, to summarise the outcomes and to discuss recommendations for future provision for people with mild memory problems and those who care for them.

Referral to the group

Information on the group, together with group criteria was sent to all Consultant Psychiatrists, Community Mental Health Teams (CMHTs) and the Day Hospital in Cambridge and South Cambridgeshire. This stipulated that referrals to the group should be for people with mild memory problems, either with a diagnosis of dementia or MCI. It was also advised that: the person being referred should have some level of acceptance of a memory problem that is related to dementia and is more than the usual effects of old age; be keen to participate in a group and to share ideas with other group members; be willing to commit to attending six weekly sessions; be physically able to attend; be able to provide transport; and, ideally, be able to attend with a carer.

In total, seven people were referred. All were visited at home to assess their suitability for the group. All seven were assessed as appropriate and five of them agreed to attend.

Group members

Of the five group members, there were four males, who all attended with their wives, and one female, who attended with her brother-in-law. The mean age was 78-years-old (range 74- to 83-years-old). Of these, two had a diagnosis of Alzheimer’s disease. The others were diagnosed with MCI.
Group format
The group was run in one of the communal rooms at a local sheltered accommodation complex. Two qualified clinical psychologists facilitated all sessions.

The group ran over six weeks. Each session was 90 minutes long with the first 60 minutes focusing on the week’s topic and the remainder of time for informal support and coffee. The following topics were discussed:

- **Week One**: Introduction to the group, types of memory and how memory works.
- **Week Two**: Problem solving.
- **Week Three**: Adapting the environment.
- **Week Four**: Memory aids.
- **Week Five**: Adopting a healthy lifestyle.
- **Week Six**: Review/signposting/Assistive Technology rep to talk.

Handouts were given of the notes from each session as a memory aid.

Participants were encouraged to think about their own experiences and at the beginning of each session to review and reflect on strategies they had tried. Although thinking about the emotional adjustment to memory problems was not the main objective of the group, the facilitators were mindful of allowing people the space to discuss this if they wanted to.

Evaluation of the group
Prior to the group, clients completed the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1994). This comprises seven statements about symptoms of depression and seven about anxiety and is scored on a four-point scale (0–3). Lower scores equate to lower levels of anxiety and depression. The Memory Aid Checklist (MAC; Harrison, 2003) is a measure devised in the Newcastle Memory Clinic and consists of 19 statements describing strategies used to manage memory problems. Higher scores on the MAC equate to greater use of strategies. Both measures were repeated at the end of the group.

Both clients and carers were also asked to complete a self-report questionnaire about how they perceived their memory difficulties and how much they felt affected by this. This questionnaire was again repeated at the final session with some additional questions about the venue and the group process. Client and carer questionnaires were separated out to account for their differing needs, which might need to be addressed in the future.

All participants also completed feedback questionnaires at the end of each session asking how helpful and relevant they had found the week’s topic.

Outcome
At the start of the group the mean HADS score for anxiety was 10.25 (range 6–14) and the mean score for depression was 6.75 (range 6–8). At the end of the group the mean anxiety score had fallen to 7 (range 4–9) and the mean depression score was down to 3.8 (range 0–7). Post-group scores indicated that all clients’ anxiety and depression self-report ratings were within mild to normal limits and were a slight improvement on pre-group scores.

The MAC was also administered pre- and post-group. The mean pre-group rating were 37 (range 29–46) and post-group was 43 (range 35–51). This suggests that clients were reporting using more memory aids by the end of the group than they were at the beginning of the group.

According to the feedback forms completed at the last session, both clients and carers participants felt that they knew more about memory problems and seemed to feel they were coping better. All participants rated the group as very helpful and useful. Ratings showed that participants felt they could say what they wanted to, felt listened to and understood. Suggestions for improving the group included, having more information on medication and diet, meetings taken place over a longer period and with more follow-up.
Discussion

Feedback

Overall, the feedback from the group was extremely positive. All group members felt that they had learnt strategies from the group that they had implemented in their day-to-day life. They felt that the opportunity to share their experiences, their frustrations and their ways of coping was invaluable. Whilst the role of the group was not to address the emotional impact of having dementia, the process of sharing, developing acceptance and learning from others certainly was effective in helping group members to address some of the issues around identity and adjustment.

At times, the issue of having people in the group with different diagnoses was difficult to manage given that some group members perceived their memory problems and future prognosis as markedly different from others. Nonetheless, the group members dealt with this well and, in fact, it in turn raised more questions about coping than it did anxieties.

Demand

Although the participants were appreciative of the group and appeared to find it helpful, under normal circumstances this group of clients do not meet criteria for access to secondary mental health services in this locality. With the new NICE guidelines, people with mild cognitive problems due to Alzheimer’s disease are no longer eligible for the dementia drugs and as the majority of this group experience no behavioural or emotional difficulties, they would not require support from the community mental health teams. Whilst the Alzheimer’s Society locally offer support groups and the local day hospital offers groups for carers, little is directly offered to the clients and few groups offer the same structure, containment and means of evaluation. There is clearly a demand for ongoing support of this group of people both in terms of cognitive rehabilitation for the client and in terms of focusing more on the emotional impact for both the client and their carer.

Future recommendations

This article has described how a memory group was developed for people in the early stages of dementia who were previously receiving none or very little input from the local mental health services. The benefit of this type of group is clear from the feedback and questionnaires, which indicated an increase in knowledge about memory problems, improvements in ways of coping and an overall decrease in levels of anxiety and depression.

Given the different diagnoses of the group members, the facilitators felt it might be useful for future groups to carry out a more detailed assessment of cognitive functioning (e.g. Addenbrookes Cognitive Examination – Revised; ACE-R; Mioshi et al., 2006) to determine the level of impairment and to identify specific areas of difficulty that could be beneficial in running the group. Another option would be to aim to run groups for people with the similar diagnoses.

Given that most people with this degree of cognitive impairment are managed in primary care, another consideration is whether we should be looking to primary care to make referrals. This could, however, potentially result in high numbers of referrals and it may be difficult to meet this demand unless other staff are trained in running these types of groups.

As part of the feedback, group members said they were keen to continue meeting and that the group should be run for longer. Both facilitators encouraged group members to meet outside the sessions and after the group had finished but unfortunately all felt that without the facilitators present, they would deem little benefit. This highlights the need for long-term support for people in the early stages of dementia and their carers. It indicates the need for services to work together if we are to provide consistency and continuity of care.
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References

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The Sunshine Garden – is an external environment beneficial for people with dementia?
Claire Matchwick & Cath Burley

This article reviews the literature on external sensory environments in dementia care. It describes the development of a sensory garden in a day hospital for older people with dementia and functional conditions. Dementia Care Mapping was used to map clients attending the day hospital before, during and after the creation of the garden. Carers and staff were interviewed before and after to elicit their opinions.

Benefits of nature

THE IDEA THAT the natural environment can be beneficial in a health care setting is well over 200 years old (Ulrich & Parsons, 1992). In Europe in the 18th and 19th century hospitals for the mentally ill were built with gardens for patients to use (Pachana et al., 2003). In the US, Benjamin Rush, the so-called ‘Father of American Psychiatry, is quoted as saying ‘digging in the soil has a curative effect on the mentally ill’ (Tereshkovich, 1973). However, the early 20th century saw a shift in emphasis in psychiatric hospitals to hygiene, cleanliness and reducing the risk of infection. Ulrich (1991) proposed that this change led to hospitals becoming stark and stressful institutions, which were not designed to meet the emotional needs of clients, families or staff.

The effect of the environment in health care settings on clients, their families and staff is increasingly being investigated. Ulrich (1984) looked at the records of clients who had a cholecystectomy in a hospital in Pennsylvanian, between 1972 and 1982. He matched participants and compared those who had a view of a natural scene with those who had a view of a brick wall. The former spent a shorter amount of time in hospital, took fewer and more moderate forms of pain medication and had more positive comments written about them by nursing staff. In further studies Ulrich et al. (1991) found that natural scenes helped recovery from stress. In one study, participants were provoked into a state of stress by being shown a film, which depicted serious injuries and mutilation. They were then shown imagery of natural scenes or an urban scene. The natural scene group showed faster levels of physiological recovery in comparison to the urban scene group.

There are specific benefits attributed to viewing a natural environment. It provides an opportunity for escape and a sense of control in respect to stress (Cooper-Marcus & Barnes, 1995). A view of a natural scene can heighten satisfaction with the health care provider and the overall perception of the quality of care received (Cooper-Marcus & Barnes 1995; Whitehouse et al., 2001). Benefits are gained from not only viewing a natural environment but from being able to be in it and use it. These benefits include improved attention (breast cancer patients: James, 1985; Cimprich, 1990); stress reduction (undergraduates: Simson & Strauss, 1998; Ulrich et al., 1991); Pearling et al., 1981; Selye, 1946; Cimprich, 1990) and improved mood (gall bladder surgery patients aged between 20–69: Ulrich, 1984; college-aged students: Parsons et al., 1998). In a case study of a stroke patient undergoing a rehabilitation programme, Deitweiler and Warf (2005) examined the impact of a ‘dementia wander garden’ during a period when the patient was becoming resistant to treatment. Following
the introduction of the garden to his programme, the patient looked forward to his treatment sessions and achieved his overall treatment goal (Deitweiler & Warf, 2005).

One proposed explanation for the benefits of nature in health care setting is Stress Response Theory (Lazarus, & Folkman, 1984). Suffering from illness, being in pain and staying away from home in an unfamiliar setting are all stress inducing situations. Viewing nature or being in a natural environment is proposed to reduce the negative physiological effects of stress (Ulrich et al., 1991; Parsons et al., 1998; Pearling et al., 1981; Selye, 1946) through cognitive appraisal. ‘Cognitive appraisal is the process in categorising an encounter and its various facets with regard to its significance to well being’, (Lazarus & Folkman, 1984; p.31). Additionally, arousal theories suggest recovery from stress will occur more quickly in places which provoke lower levels of arousal as they are less complex and engaging (Ulrich et al., 1991). This reduces the overload on the system for dealing with detailed and overburdening information. Appraising a situation as non-threatening or calming may help to reduce information overload, and, therefore, reduce the physiological arousal generated by real or perceived stressors.

Dementia
Dementia is an umbrella term, used to describe a number of different disorders where ‘there is a loss of brain function that is usually progressive and eventually severe’ (Medico, 2006). Classic symptoms of dementia include cognitive deficits, particularly memory loss, plus changes in behaviour. These changes can include behaviour that caregivers find difficult to deal with such as shouting, repetitive talking, agitation, and even physical attacks on others (Andrews, 2006). Behavioural problems are reported more frequently for clients with severe dementia (Teri & Logsdon, 1990).

There is a small body of research investigating the potential benefits of gardens for people with dementia, primarily on the development of what are often referred to as ‘wander gardens’. There is a general consensus in the literature about the requirements of such a garden to make it appropriate for the people with dementia. These include: a safe and secure environment; a path in a circle or figure of eight formation to help orientation; raised beds and pots; non-poisonous fragrant textured plants; and seating areas for socialising (Sulavik, 2004; Cohen-Mansfield & Werner, 1999). The benefits for people with dementia of both passive and active interaction with a garden have been examined (Pachana et al., 2003). Passive interaction includes looking at plants, wandering through gardens and simply participating in discussion groups about gardening. Active interaction is physically and actively taking part in gardening.

Nazami and Johnson (1992) observed the behaviour of residents of a nursing home with a garden at times when the door to the garden was locked and unlocked. They found that simply giving the residents a choice of whether to go out into the garden or not by having the door open was calming in itself regardless of whether they actually went into the garden or not. Another study examined the impact of passive interaction with a garden on the occurrence of disruptive behaviour in people with Alzheimer’s disease (AD) (Mather et al., 1997) but found no significant differences between pre- and post-measures. However, in this study the garden was not being optimally used and when Mather et al. (1997) looked just at the residents who had used the garden they found a reduction in disruptive behaviour. Additionally, in the winter they found that residents spent more time looking out of the window and trying the handle of the door to the garden.

There is also evidence for the positive effects of active interaction with a natural environment on clients with dementia.
The specific benefits relate to reducing the risk of falls, behavioural and psychological symptoms, cognitive function and improving nutritional status (Rolland et al., 2000). Additionally, a study of older residents in long-term care reported increasing autonomy through horticulture therapy (Catlin et al., 1992). The natural environment can be used as a mode of expression and provider of mental, visual, auditory and olfactory stimulation. Furthermore, it can provide a means of interaction requiring minimum verbal skills. This is important given that some people with dementia may no longer have the ability to fully express themselves through speech (Burgess, 1990).

**Current study**

The present study investigated the effects of positive environmental change on clients, staff and carers who attended Grebe Day Hospital. The plan was to develop a sensory garden that could be safely accessed through an open door. Prior to the development, clients looked out onto a barren piece of land and were unable to go outside for safety reasons. Clients, carers and staff were consulted about their ideal garden and were involved in every part of the garden’s development.

**Method**

**Participants:**

**Clients**

Seven clients participated in the research (six males), six of whom had a diagnosis of dementia and one had a diagnosis of depression. Their average age was 74 years, range 62–85 years (see Table 1). One participant dropped out of the study due to deterioration in their condition.

**Carers**

Eight carers (six females) participated in the study. All had a spouse who regularly attended the day hospital at the time of the study. The average length of time they had been a carer was 4.6 years, range 0–9 years.

**Staff**

Eight female staff participated in the study. The mean length of time staff had been working at the day hospital was 9.1 years, range 0-24 years.

**Measures:**

**Mood and cognition assessments**

The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983) and the Addenbrookes Cognitive Examination Revised Scale (ACE-R) (Mioshi et al., 2006) were completed with each participant pre- and post-development of the garden to assess mood and cognition (Table 1).

**Dementia Care Mapping (DCM)**

DCM is an observational technique developed from Kitwood’s psychosocial theories of dementia (Kitwood, 1989, 1990, 1997). It promotes best care practice, from the point of view and experience of someone with dementia (Fossey et al., 2002). It encourages the provision of person-centred care in formal care settings. Fossey et al. (2002) found DCM to be a valid tool for the longitudinal evaluation of the quality of life in people with dementia in formal care settings.

DCM was used to monitor the participant’s behaviour pre- and post-development of the garden. Three types of data were collected: mood and engagement; behaviour category codes; and any other observations the mapper felt important to feedback (Appendix 1). Pre- and post- Well-being-Ill-being scores were calculated for all participants (Table 1).

**Semi-structured interviews**

Semi-structured interviews were conducted with staff and carers which consisted of a number of prompt questions relating to the project and the garden.

**Consent:**

As the study included older adults suffering from dementia who might lack insight there were considerations to make regarding...
informed consent. The staff at the day hospital were asked to decide which clients were able to provide informed consent and which were not, due to their in depth knowledge and experience of working with the clients. If clients were unable to provide informed consent their next of kin were asked to provide consent for them.

**Procedure:**

**Mood and cognition assessments**

The ACE-R and HADS were completed in a quiet room at the day hospital. Clients were informed that the assessment could be stopped at any point should they wish.

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### Table 1: Details of the participants and their scores on pre- and post-group measures.

<table>
<thead>
<tr>
<th></th>
<th>Terry</th>
<th>Monty</th>
<th>Larry</th>
<th>Magnus</th>
<th>Albert</th>
<th>Nellie</th>
<th>Jack</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>62</td>
<td>73</td>
<td>72</td>
<td>85</td>
<td>76</td>
<td>84</td>
<td>68</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>AD</td>
<td>AD/Mixed dementia</td>
<td>Mixed/Vascular</td>
<td>Lewy body</td>
<td>Dementia in Parkinson's Disease</td>
<td>Probable mixed dementia</td>
<td>Depression</td>
</tr>
<tr>
<td><strong>Pre- ACE-R</strong></td>
<td>4/100</td>
<td>12/100</td>
<td>4/21</td>
<td>34/65</td>
<td>71/100</td>
<td>61/100</td>
<td>72/100</td>
</tr>
<tr>
<td><strong>Pre- MMSE</strong></td>
<td>3/30</td>
<td>3/30</td>
<td>4/21</td>
<td>14/25</td>
<td>25/30</td>
<td>19/30</td>
<td>25/30</td>
</tr>
<tr>
<td><strong>Pre- HADS</strong></td>
<td>Not complete</td>
<td>Not complete</td>
<td>Not attempted</td>
<td>A = 6 (mild)</td>
<td>A = 8 (mild)</td>
<td>A = 6 (normal)</td>
<td>A = 10 (mild)</td>
</tr>
<tr>
<td><strong>Pre-WIB score</strong></td>
<td>+1.8</td>
<td>+2.7</td>
<td>-0.7</td>
<td>+4.3</td>
<td>+3.2</td>
<td>+4.8</td>
<td>+2.6</td>
</tr>
<tr>
<td><strong>Post ACE-R</strong></td>
<td>Unable to complete</td>
<td>15/100</td>
<td>19/71</td>
<td>32/65</td>
<td>66/100</td>
<td>63/100</td>
<td>71.5/100</td>
</tr>
<tr>
<td><strong>Post MMSE</strong></td>
<td>Unable to complete</td>
<td>4/30</td>
<td>10/29</td>
<td>17/25</td>
<td>20/30</td>
<td>23/30</td>
<td>25/30</td>
</tr>
<tr>
<td><strong>Post HADS</strong></td>
<td>Unable to complete</td>
<td>A = 2 (mild)</td>
<td>Not attempted</td>
<td>A = 11 (moderate)</td>
<td>A = 10 (mild)</td>
<td>A = 6 (normal)</td>
<td>A = 10 (mild)</td>
</tr>
<tr>
<td><strong>Post WIB scores</strong></td>
<td>Unable to complete</td>
<td>+2.2</td>
<td>+2.6</td>
<td>+1.7</td>
<td>+5</td>
<td>+4.7</td>
<td>+4.6</td>
</tr>
</tbody>
</table>

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**Dementia Care Mapping (DCM)**

An RMN/RGN working for the Trust trained both in basic mapping (editions 7 and 8) and as an advanced mapper completed all the mappings of the groups.

On each occasion of DCM, clients were observed taking part in groups with other clients and staff as they would do on a normal day-to-day basis. The groups were observed in both passive interaction (Group 1) and active interaction (Group 2).

Group 1 were mapped taking part in a group activity which was not specifically focused on the garden or gardening. However, they were able to look out the
window at the development of the garden in the ‘pre’-condition or wander into the garden in the ‘post’-conditions whenever they wished. Group 2 were taking part in groups focused on the garden. In the ‘pre’-condition they had a group discussion about gardens and made posters about gardens. In the ‘post’-condition the group planted bulbs into pots whilst out in the garden.

**Semi-structured interviews**
The interviews with carers and staff were completed at their home or in a quiet room at the day hospital. The researcher asked prompt questions and allowed staff and carers a chance to respond. The interview typically lasted between 30 and 45 minutes.

**Results**
**Mood and cognition assessments**
Full details of the participants and their pre- and post-activity scores can be found in Table 1. Three clients showed improvement on the ACE-R; three clients scores declined and one client was unable to complete the ‘post’ assessment. Participants with severe dementia struggled to comprehend the HADS so results are only reported from five of the participants. Three of the participant’s scores on the HADS increased in the post assessment indicating higher levels of anxiety and depression. One of the participant’s scores decreased. Jack’s depression score decreased from 14 to 12.

**Dementia Care Mapping (DCM)**
Six clients participated in the pre- and post-maps. The WIB scores of two participants (Monty & Nellie) decreased slightly but were still within ‘well-being’ (Table 1). The individual WIB scores of the other four clients positively increased with the development of the garden. Group WIB scores were also calculated. In both groups there was a positive increase from the pre- to the post-condition.

**Discussion**
This study attempted to see whether a new sensory garden would have an effect on clients, staff and carers involved in a day hospital for older people. The DCM showed positive increases in the group WIB scores and the majority of the individual WIB scores after participating in the project. The semi-structured interviews with carers and staff at the pre-project stage contained positive clear themes of what they hoped the garden would achieve and at the post-project stage of what they thought had been accomplished. In their post-interviews, the staff highlighted the benefit of the garden, particularly in alleviating client agitation. This is consistent with previous studies with other client groups indicating that gardens help to calm clients when they are stressed or anxious (Parsons et al., 1998; Pearling et al., 1981; Ulrich et al., 1991); this is in accordance with the proposal of SRT that the natural environment reduces the negative physiological effects of stress.
The findings add to previous research that has found gardens to have a positive impact on older adults and adults with dementia (Dvorak & Poehlman, 1998; Rolland et al., 2000). Mather et al. (1997) focused specifically on disruptive behaviour and did not find any significant group changes in the pre- and post-measures, although this may have reflected underutilisation of the garden. In the present study much use was made of the garden as the staff at the day hospital were extremely good at involving clients in the garden. The garden was used both formally and informally. Informally clients were allowed to access the garden whenever they wished as the doors to the garden were open at all times. They could follow the wander path around the garden, sit on the benches and observe plants. A feature of the garden was a smaller gate within it that clients could open and close, to try to give the sense of going into another room. More formally staff would go out with the clients and point out plants to them, particularly on the raised sensory bed, or sit in the seating areas with them, or plant bulbs/bedding plants in the relevant season.

Prior to the garden being developed clients had been involved with discussion about it by looking at gardening magazines and collages and visiting garden centres to identify which plants they would like to include in it. There was definite change in the behaviour of the clients once they had used the garden indicated by their WIB scores and observations from staff. Additionally, the clients appeared to gain benefit from simply having the choice of whether to go outside or not, as reported previously (Nazami & Johnson, 1992). Both family carers and staff commented on this in the post-project interviews along with a sense of freedom provided by the garden.

Previous research has investigated either passive (Nazami & Johnson, 1992) or active (Dvorak & Poehlman, 1998) interaction with a garden. In this study we looked at both types of interaction. The participants in Group 1 were observed in day-to-day activities which were not solely focused on the garden. They were able to look out at the garden or wander outside. Group 2 were involved in active interaction in the garden taking part in a gardening group. In line with the previous studies, whether clients were having passive (Nazami & Johnson, 1992) or active (Dvorak & Poehlman, 1998) interactions with the garden, it seemed to have a positive effect on them, indicated by the positive increase in WIB scores for both groups.

Limitations of the study
The study has a number of limitations but attempts to add to the literature in this field. The entire project and the development of the garden had to be completed within a six-month period. Ideally there would have been a greater time span between pre- and post-conditions to allow clients more access to the garden. It was not possible to have two DCM mappers as originally planned, which would have enabled inter-rater reliability checks. The number of participants was small, due to small group sizes at the day hospital and deterioration in clients’ conditions. However, the drop-out was low once people were engaged in the project.

It is difficult to tell whether the garden development was responsible for the positive changes found. This is due to the complexity of dementia, the progressive decline people experience and the interplay of physical illness, family factors and social interaction. Nevertheless, clients, staff and carers were all positive about the development of the garden.

Conclusion
The aim of this pilot study was to investigate the effect of environmental change on clients, carers and staff in a day hospital setting through the development of a sensory garden. Previous research indicated that access to nature benefits patients in health care settings and the present study aimed to investigate this with clients with dementia. This study found the sensory garden to have a positive impact on all those involved at the day hospital.
Acknowledgements
The authors would like to thank:
Clients, carers and staff of Grebe Day Hospital for their positive encouragement and engagement in the process.
The members of the project group:
Neera Appadu (Occupational Therapist) for submitting the original bid, Jim Bird (Project lead), Department of Health Estates Department for information and support, Suzanne Cunningham (Day Services Manager) for Mapping, Natercia Godhino (Trust lead for user and carer research), Joan Jinks (Occupational therapy technician), Sue Julian (Staff nurse), Sue Lewis-Pilarski (Day hospital deputy team leader), Annette Lumb (Professional Lead for OT), Professor Geoff Shepherd (Director of Partnerships), Tracey Shepherd (Management accountant) and Simon Wiggins (Landscape gardener, Excel Landscaping Ltd).

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References


Punting on the River Cam.
Appendix 1: Behaviour Category Codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Memory cue</th>
<th>General description of category</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Articulation</td>
<td>Interacting with others verbally or otherwise</td>
</tr>
<tr>
<td>B</td>
<td>Borderline</td>
<td>Being engaged but passively (watching)</td>
</tr>
<tr>
<td>C</td>
<td>Cool</td>
<td>Being disengaged, withdrawn</td>
</tr>
<tr>
<td>D</td>
<td>Doing for self</td>
<td>Self-care</td>
</tr>
<tr>
<td>E</td>
<td>Expressive</td>
<td>Expressive or creative activities</td>
</tr>
<tr>
<td>F</td>
<td>Food</td>
<td>Eating or drinking</td>
</tr>
<tr>
<td>G</td>
<td>Going back</td>
<td>Reminiscence and life review</td>
</tr>
<tr>
<td>I</td>
<td>Intellectual</td>
<td>Prioritising the use of intellectual abilities</td>
</tr>
<tr>
<td>J</td>
<td>Joints</td>
<td>Exercise or physical sport</td>
</tr>
<tr>
<td>K</td>
<td>Kum and Go</td>
<td>Walking, standing or moving independently</td>
</tr>
<tr>
<td>L</td>
<td>Leisure</td>
<td>Leisure, fun and recreational activities</td>
</tr>
<tr>
<td>N</td>
<td>Nod Land of</td>
<td>Sleeping, dozing</td>
</tr>
<tr>
<td>O</td>
<td>Objects</td>
<td>Displaying attachment to or relating to inanimate objects</td>
</tr>
<tr>
<td>P</td>
<td>Physical</td>
<td>Receiving practical, physical or personal care</td>
</tr>
<tr>
<td>R</td>
<td>Religion</td>
<td>Engaging in a religious activity</td>
</tr>
<tr>
<td>S</td>
<td>Sexual expression</td>
<td>Sexual expression</td>
</tr>
<tr>
<td>T</td>
<td>Timalation</td>
<td>Direct engagement of the senses</td>
</tr>
<tr>
<td>U</td>
<td>Unresponded to</td>
<td>Attempting to communicate without receiving a response</td>
</tr>
<tr>
<td>V</td>
<td>Vocational</td>
<td>Work or work-like activity</td>
</tr>
<tr>
<td>W</td>
<td>Withstanding</td>
<td>Repetitive self-stimulation of a sustained nature (not of other or outside of self)</td>
</tr>
<tr>
<td>X</td>
<td>Excretion</td>
<td>Episodes related to excretion</td>
</tr>
<tr>
<td>Y</td>
<td>Yourself</td>
<td>Interaction in the absence of any observable other</td>
</tr>
<tr>
<td>Z</td>
<td>Zero option</td>
<td>Fits none of existing categories</td>
</tr>
</tbody>
</table>

Appendix 2: Staff and carers most common answers in response to semi-structured interview questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Carers Pre-Answer</th>
<th>Carers Post-Answer</th>
<th>Staff Pre-Answer</th>
<th>Staff Post-Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Do clients/your spouse ever talk about what they might do at the day hospital?</td>
<td>They do not talk about this or there is limited sharing of information as they do not remember.</td>
<td>They do not talk about specific activities.</td>
<td>This occasionally happens but it depends on the client group.</td>
<td>It depends on the client group. Some are confused and unsure why they are at the day hospital.</td>
</tr>
<tr>
<td>6. What kinds of things do they mention?</td>
<td>They do not talk about specific activities.</td>
<td>They do not talk about the groups that they have been in.</td>
<td>They need prompting to talk about the groups that they have been in.</td>
<td>Some clients do not remember why they are at the day hospital. Some clients may mention bingo or doing a quiz.</td>
</tr>
<tr>
<td>7. Do they talk about what groups they have been in?</td>
<td>They had not mentioned the garden. However they may do when it becomes more noticeable.</td>
<td>They had not mentioned the garden but this may be because they do not remember when they get home.</td>
<td>Some clients have mentioned the garden but this is dependent on the client group.</td>
<td>Functional client are more likely to do this than other client groups.</td>
</tr>
<tr>
<td>8. Have they noticed any changes in the person/people you care for over recent weeks? In particular?</td>
<td>Yes they have deteriorated. In particular their memory has worsened and they have lost skills.</td>
<td>Their condition has deteriorated.</td>
<td>There has been no change in the clients except there had been more interest in the garden.</td>
<td>Clients do mention the garden.</td>
</tr>
<tr>
<td>9. Have you noticed any changes in the person/people you care for over recent weeks? In particular?</td>
<td>They are happy to go to the day hospital.</td>
<td>They are generally happy to go to the day hospital.</td>
<td>It is dependent on the client group. Some of them are happy and relaxed on arrival, others can be anxious and agitated.</td>
<td>A change is that if clients become agitated or anxious they can now go out in the garden to calm down.</td>
</tr>
<tr>
<td>10. How are they when they are getting ready to go to the day hospital/arrive for the day?</td>
<td>They are happy and relaxed on their return from the day hospital.</td>
<td>They are happy and relaxed but due to memory problems unable to remember much about their day.</td>
<td>They can be anxious and agitated when getting ready to go but it depends on the client group.</td>
<td>Clients are usually settled and relaxed but it does depend on the client group.</td>
</tr>
<tr>
<td>11. How are they when they return home/get ready to go home?</td>
<td>They are happy and relaxed on their return from the day hospital.</td>
<td>They are happy and relaxed but due to memory problems unable to remember much about their day.</td>
<td>It is positive for their spouse. Gardens are calming and this can have a calming effect on people.</td>
<td>The garden was a brilliant and wonderful idea which had now turned into a reality.</td>
</tr>
<tr>
<td>12. I wonder whether you have any comments on the project or the garden itself?</td>
<td>It is a good idea.</td>
<td>The garden will be relaxing and peaceful for all parties concerned.</td>
<td>It is a good idea which would be beneficial to clients once finished and they are able to use it.</td>
<td>It has had a positive impact on everyone and is a relaxing and tranquil place for people to use.</td>
</tr>
<tr>
<td>13. What do you feel the impact of having the garden will be/has been for the clients, staff and yourself?</td>
<td>The garden was a brilliant and wonderful idea which had now turned into a reality.</td>
<td>It has had a positive impact on everyone and is a relaxing and tranquil place for people to use.</td>
<td>It would be beneficial for clients and give them a sense of freedom. Staff themselves would be able to use it on their breaks.</td>
<td>It has had a beneficial and positive impact on every one at the day hospital.</td>
</tr>
</tbody>
</table>
Vascular Dementia: An unsupported journey?
Yve Griffin & Cath Burley

In 2006 the Alzheimer’s Society ran a series of national workshops about Vascular Dementia (VaD) as part of the Hearts and Brains project. Termed ‘Hearts and Minds’ seminars, they took place in Cardiff, Newcastle, Penrith, Doncaster and Peterborough. The presentations from these workshops are available on the Alzheimer’s Society website.

I (Cath) was invited to present at the Peterborough workshop on psychological services. The local workshop also included inputs from: a psychiatrist on diagnosis and medication; a geriatrician on stroke services and scans; a Community Psychiatric Nurse on the work of the memory clinic; and a very eloquent carer on the long and lonely journey she had experienced during the process of obtaining a diagnosis and support for her husband. Liz Tebbutt’s story was not unusual and it made me reconsider the service offered to this group of people.

We have a very active memory clinic, which works hard to assess, diagnose, provide medication for and support people in our locality. Given the numbers of people referred, however, there is sometimes little time for follow-up and support, particularly for those who are not eligible for medication. From time to time we are able to run groups such as ‘Managing your memory problems’ or ‘Developing memory skills’. Sometimes these groups are run in conjunction with day hospital services or with the local branch of the Alzheimer’s Society. They are often information-based groups for clients and carers with a number of visiting speakers.

Following the seminar, I wondered whether it might be helpful to run a group which offered clients and carers the opportunity to talk about their recently-acquired diagnosis of VaD and the impact it had had on their lives. In addition, the group would provide people with information about VaD.

**Vascular Dementia**

VaD is linked to any condition, generally cerebrovascular disease that inhibits the blood supply to the brain reducing the oxygen supply to brain cells causing them to die. It is the second most common cause of dementia, accounting for almost 20 per cent of cases (a further 20 per cent have mixed dementia). Onset is most common in 60- to 75-year-olds and affects slightly more males than females. A vascular history of Transient Ischaemic Attack (TIA), diabetes or stroke is a common precursor to VaD. Heart valve infection (endocarditis) or amyloid angiopathy, and the build-up of amyloid protein in the brain’s blood vessels, which may cause haemorrhagic or bleeding strokes, are contributory factors to VaD. The experience of developing VaD, in adults of working age, is often mistaken for the development of depression or having a mid-life crisis.

The person with vascular dementia may develop a gradual awareness that they are losing ability in some way and may retreat from work, relationships or activities. This may lead to early redundancy, retirement or the break up of marital, family and social relationships. The silent stepwise progression of small infarcts in the brain can cause changes, which may be almost imperceptible at first and may make the person feel that they are ‘going mad’. There is often a reluctance to talk about these changes and spousal or family perceptions that people are good at tasks at some times and struggle with them at others, may lead to a feeling that...
there is nothing really wrong, and that they are attention seeking or putting it on. This variability in both emotional and behavioural states may mean that people are reluctant to contact their GPs in the first instance, and when they do, the condition may be missed, because the presenting symptoms – memory loss, lack of concentration, poor sleep, weight loss, lack of self care, poor communication and disinterest – may mirror many other presentations.

The National Institute of Clinical Excellence (NICE, November, 2006) guidelines for anti-dementia drugs did not initially recommend medication for VaD. The findings were variable about the benefits in Alzheimer’s disease, as the studies focused on the impact of the drugs on memory function. Clinically, people tend to report the Acetylcholinesterase inhibitors (ACHEIs) improved social functioning and awareness and might reduce behavioural problems. Some prescribing outside the protocol has suggested the drugs (particularly Galantamine) may also be useful in early VaD or mixed dementia but until now the lack of license has tended to mean that few drug treatments are available for VaD.

In specific VaD conditions, for example, Binswanger’s disease, medication can help to control high or low blood pressure, depression and heart arrhythmias. Medication to control high blood pressure, cholesterol, diabetes and heart disease can significantly slow or halt the disease process. Aspirin or Warfarin may be prescribed to prevent small clots forming and blocking small blood vessels. Lowering homocystein reduces risk of further infarct by 4.9 times. Where high blood pressure is treated in people over 60, studies report a 55 per cent lower risk of subsequent dementia. Exercise stimulates the production of growth factors to help neurons survive and adapt and reduces risk of atherosclerosis. Education is productive in causing the development of robust cell networks. Reducing brain inflammation and the use of NSAIDs (non-steroidal anti inflammatory drugs) may bind amyloid plaques and/or dissolve them and prevent the formation of new ones. Sometimes surgery can clear arteries (Black, 2005)

For all people with VaD, reducing smoking and alcohol consumption, controlling obesity and increasing exercise helps to reduce risk factors. Reducing restlessness and improving sleep patterns through exercise, relaxation or medication is also beneficial. Reducing associated depression through prescription of optimum medication and relevant input through cognitive therapies can maximise coping skills and abilities and minimise the risk of suicide.

If the family and GP identify the problem and refer to secondary mental health services, this offers the opportunity for a multidisciplinary assessment taking into account the medical, psychiatric and pharmacological factors. This may rule out treatable conditions, organise brain scans to check for significant deficits and generally help to optimise functioning. It also can offer the opportunity for a detailed psychosocial assessment of cognitive function and activities of daily living (ADL) as well as providing much needed psychoeducation, support and monitoring.

Assessment
The benefit of a detailed assessment enables the clinician to tailor their approach to provide person centred care. Depending on the brain deficits shown through neuropsychological assessments and/or confirmed by scans, the person may have specific problems with a range of practical tasks. There may be a history of developing gait disturbance, unsteadiness and falls. Obviously, left brain damage may give rise to language, speech and swallowing problems. It may also mean that the person seems slow to respond, cautious in initiating activity and disorganised. Conversely, right brain deficits reduce the person’s ability to judge distance and size, they may become impulsive and a poor judge of their own functioning. The former may lead to huge irritation in family members – the latter to great apprehension.
Reducing stress in the person and their carers through the provision of information, discussion and support helps to normalise what is happening and explain new ways of dealing with difficulties as they arise.

Although the SMMSE (Standardised Mini Mental State Examination; Malloy & Standish, 1997) is routinely used as a screening tool to give a rough idea of someone’s difficulties, in many clinical settings both in primary and secondary care, it is not very specific for VaD. Neuropsychological screens may contribute to knowledge about a person’s relative strengths and weaknesses. Where the scores obtained on the tests are very patchy, and show fluctuating awareness over sessions, or within sessions it is more likely that the pattern will be predictive of VaD. The common pattern is for cognitive and motor retardation to be present, with impairments of attentional, information processing and executive functions with relatively preserved insight and personality. More specifically, performance on Trail Making (Reitan & Wolfson, 1993) verbal fluency, clock drawing, mazes, and digit span backwards may all be reduced. Impairment on executive function tasks (such as impaired ability to organise thoughts, cope with timed materials, switch tasks, inhibit responses, stay focused, make poor judgments, or have difficulties with abstraction) whilst having preserved recognition memory are common in people with VaD. The assessment helps the person, their family and the team to understand the difficulties and to monitor and regulate the rate of decline.

If the decline is severe this has implications for someone’s ability to manage their home and finances, drive or care for themselves and their family. However, maintaining well-rehearsed skills may enable a person’s strengths to help overcome any weaknesses and increase their independence for as long as possible. Also, practising tasks may improve performance. The regular and consistent use of memory aids like signs, cards, clocks, diaries and calendars may also help for a time. Computerised reminders, bells, buzzers and family prompts may also be beneficial. Regular reinforcement of patterns of behaviour can lead to re-installing patterns that have been disrupted and the use of behaviour therapy to reduce unacceptable behaviours through negative reinforcement is also useful.

For both clients and carers a particular cause for concern is the fluctuating pattern of performance common in VaD where a task can be accomplished one day and not the next. This can lead to frustration but also questions about whether someone is ‘taking the mickey’, i.e. pretending to be unable to carry out the task. Previously close couples and families may become polarised if no one is able to explain clearly that this is a feature of the disease. The fact that the person retains both personality and insight does not help in this case. So, depression, apathy, social withdrawal and cognitive slowing all contribute to disengagement which can be seen as awkwardness. In addition emotional lability, aggression and impulsivity are commonly seen. The more formally described Behavioural and Psychological Symptoms of Dementia (BPSD) features of the disease may not show themselves until 40 to 50 months’ post-diagnosis.

**Interventions**

Providing both formal and informal support to carers, and developing and maintaining sound relationships based on a person’s assets is key to the provision of successful care for people with VaD. Cognitive rehabilitation may also be an option for people with relatively well-preserved insight and organisational skills.

Many of the techniques developed in stroke, head injury and cardiac rehabilitation are also effective with people with VaD. Gaining the person’s confidence and helping them see that there is a possibility for positive change is beneficial. Practical advice and information about maintaining good physical health gives both client and their family back some control over the situ-
This is essential where untreated TIA’s or atrial fibrillation may increase risk factors adversely. Research suggests that 20 to 30 per cent of strokes lead to dementia type symptoms in three months and following a stroke a person is nine times more at risk of developing dementia. Unchecked atrial fibrillation can cause seven per cent brain damage in a year. Warfarin can reduce this by up to two-thirds (whereas aspirin only reduces it by 22 per cent; Black, 2005).

Small practical exercises to develop and increase attention span by chunking or reducing distraction are helpful. Encouraging the person to process information in more than one sensory modality also helps. Basic memory aids may not be a normal part of someone’s daily repertoire, so a notebook and pen in a top pocket may be just as beneficial as a technical aid such as Neuropage. Crosswords, Scrabble and Suduko tap into well-retained skills and should be encouraged. Route planning and finding can be improved through the addition of visual or verbal cues.

When developing such strategies it is important to ask the person what they find helpful and not interrupt their attempts at communication – sometimes people butt in too soon. It may be better to allow the person with VaD to think through their own associations than to provide them with yours. For some people first letter cueing is helpful – and it can be beneficial for families to understand the principles of errorless learning (Clare, 2003). Using simple phrases like ‘let me see’ or ‘give me a minute’ may be enough to help in the early stages of cognitive slowing. Simple preparation before attending events to cue people into where they are going, what will be happening and who may be found there can help to reduce feelings of helplessness. Having permission to take ‘time out’ when feeling overwhelmed with information can reassure people with VaD that they are not ‘cheating’. When all else fails if the person cannot be changed, their environment can often be made more logical for them.

Putting together the VaD group

The aim of the group was to assist people to look at some of these issues and to learn from them. The members of the group have given their permission for us to share the process of setting up the group and their experiences of being in it in this article.

Our aim was to run a group for eight sessions for those recently diagnosed with VaD and their carers to help them to come to terms with the diagnosis, discuss any queries they might have, help them with the process of emotional adjustment and to signpost services. A number of practical difficulties arose in setting up the group including: difficulties in recruitment (only three clients were referred); changes to the local management structure; having a consistent day, time and room for the group; and difficulties with transport.

Six initial sessions were set on a Wednesday and Thursday. The participants were contacted and the nature of the group was discussed with them. The detailed content of the group was prepared with their needs in mind and adjusted on a weekly basis to meet any additional needs. Following discussion with group members it was decided to provide a brief formal input and then give the opportunity for people to share feelings and respond to each other. Measures of mood and carer strain – Perceived Stress Scale (Cohen, 1983) and the Revised PGC Morale scale (Lawton, 1975) – were given in the first and last sessions. Due to the participant’s failure to complete or return the measures on time, the data reported here are qualitative.

Group members

Yasmin, a smart and articulate 59-year-old, had been working as a teacher until she was given her diagnosis. Following the diagnosis she was asked to take ill health retirement. She had found it very difficult to adjust and was often tearful within the sessions. She missed her active working life, her independence and her role within the family. She reported frequently having difficulty finding...
the right words to use and failed to remember practical things, such as whether she had turned the oven on. Yasmin had asked her daughter to attend with her but, sadly, always attended alone and felt upset that she seemed less important than the rest of her daughter’s life.

Irene, an 81-year-old female, had moved into a residential home after the death of her husband and her son. She would often talk about her home, believing that she still lived there, and of her son, husband and father’s deaths, often confusing them. She was extremely upset about her son’s untimely death, from cancer. The previous year she had developed memory loss and was beginning to isolate herself in her bedroom. Staff reported that they had seen a deterioration in her behaviour and that she was accusing others of stealing her property. She was accompanied to the group by a formal carer, though not always the same one. She had limited insight but huge empathy for the other members of the group and a great deal of warmth and humour. Part way through the group one of the carers who accompanied her disclosed that her own husband had recently had a stroke and that she was finding the information helpful for her home situation.

Mavis was 67-years-old and lived in her own house with her husband. Her husband reported that her memory was declining and he was concerned that she was not always remembering to take her medication. She did not display any insight into her memory difficulties or her reliance on her husband and was adamant that she wanted to maintain her independence. She was diagnosed formally in 2006 and has had numerous medical problems and a history of depression. Mavis had little insight and disliked the title of the group, initially denying she had any kind of memory problems or that her husband was of any help. After the first session she was suddenly called to Sheffield for an operation for trigeminal neuralgia and complications meant they both missed the second and third sessions.

Content of the group

The first formal group session began by describing the development of dementia and where impairments might be found in intellectual functioning (particularly in the areas of memory, language skills, perception and reasoning or judgement), normal activities or relationships. Different types of dementia were outlined, followed by a more in depth focus on the causes and symptoms of VaD. It was emphasised that the symptoms and rate of decline differed with each person. A discussion was facilitated on the types of symptoms that people might present with and which ones the group members felt they had. Due to the potentially vast amount of information received and the tendency for information overload, in a potentially stressful new social situation, we gave the group members a collection of handouts which explained the areas covered within the group for them to read and digest at their own pace. These could be brought back to subsequent sessions to be queried or for further explanations.

Session 2 focused more on the factors that might increase the risk of developing vascular dementia initially or might prevent further decline. The types of interventions that were available were discussed. The session focussed on psychosocial strategies such as memory aids, routines and structure. The emotional reactions of depression and challenging behaviour were considered and explained in relation to their common link with dementia. Although they were not applicable at present to the group members, it was felt important that they were aware of them. This session led to wide ranging discussions of experiences and fears.

The group requested more information on the psychosocial strategies for Session 3. Different memory strategies were discussed, and group members shared their own strategies. The different local activities available, such as University of the Third Age (U3A), beauty treatments at the college, attendance at classes or social groups at community centres or day centres were also discussed.
The importance of keeping oneself occupied to prevent boredom and frustration was emphasised as well as the need to provide a forum to interact with carers and family in a positive manner.

Session 4 continued to emphasise the importance of good communication and social support. The group suggested tips to improve communication, such as reducing distractions to improve attention. In terms of social support different types of relationship were looked at and the different functions they served were discussed. This encouraged the group members to share their feelings and regrets about relationships. This session also addressed the issue of guilt which was a common theme in both the person with dementia and the carer. The group shared reasons why they might feel guilt and supported each other in normalising this.

Session 5 provided a chance to discuss legal issues. There was discussion on the need to care for family members, the implications of the Mental Capacity Act, making wills, power of attorney and arranging funerals.

In the final session an Occupational Therapist, attached to the team, attended the session and discussed with the group different aids that were available. These were both specifically designed objects, for example, medication boxes, or strategies such as using everyday items in a novel way, for example, a doorbell when lost out shopping.

**Group members’ responses**

The following discussion is presented to illustrate interactions within the group. The group took time to warm to Mavis who often was more focused on her physical than her mental symptoms, despite acknowledging she was tearful and depressed. She had not read anything from the first group session. She was dismissive of her husband, who had found her hospital admissions difficult, ‘He has no patience, he jokes and is sarcastic, and I hate that.’ Irene, who fluctuated in awareness of where she was living or the amount of time that had passed since her husband and son’s death, was supportive. ‘Well you go to bed for a cuddle’, ‘He’s looking after you, you want to look beautiful for him.’ Mavis was dismissive of this suggestion.

The conversation moved on to forgetting: ‘Have you ever been to the cupboard for something…?’ They shared frustrations.

Yasmin replied, ‘If they would give me time, if they come in too soon, it’s not the words I want’ when talking about the family’s attempts to help with her word finding difficulties. Mavis’ husband chipped in, ‘Mavis does that. I put the words in then she says no and five minutes later she says the same thing. It’s frustrating.’ Irene responds, ‘Calm down it will come’, ‘But then I give up and I will not talk’, says Mavis. ‘I can’t accept I have dementia. Some days I am clear headed. There’s no one like that in our family. I start panicking, it helps to calm down and think. I hate myself for being stupid.’

Yasmin replies, ‘I like my independence, not to have it taken away from me but my head is like a sponge, it won’t take it in – it’s a pink candy floss day. It’s hard with strangers to say I have a problem. I see things visually. With a healthy brain it’s all one colour. Ours have some missing, it’s not a convenient blob, the message in between takes longer.’ My daughter works in a school for children with mental and physical [problems], she cares for them, not for me. She says, ‘You have a brain cell use it, pea brain.’ It’s hurtful, she says, ‘You should do this easily.’

By the third group session the sharing between members had increased. Yasmin talked of her grandson who had solved her problems with cooking and was thinking of ideas to encourage her to externalise her memory. She brought a wooden spoon in with a ribbon through the handle which she hung round her neck to remind her she had something in the oven or on the cooker, an idea he had come up with. She talked of her pleasure at regaining some confidence with a computer, and having an Learning Support Assistant (LSA) to help in her adult education class. She uses a laminated alphabet card to help prompt her, and a Dictaphone, ‘I don’t like to be told I am ‘coping’. I like ‘managing’ better.’
In Session 5, Mavis’ husband added to the analogies. ‘A question is like a pinball – if they get a big score, they remember, but five minutes later they only get one point or miss altogether. The thing is, I don’t know how far to go between doing things for her or letting her be independent.’ Mavis interrupted. ‘He has a memory problem, he forgets a lot.’ The group discussed their fears about what happens if a carer becomes ill too. Irene responded, ‘Always write it down – it’s helpful just to talk you know.’ Mavis asked, ‘Do you get angry?’ Her carer commented, ‘She gets cross about her son’s death.’ Irene responded, ‘You’ve got a good husband, neither of you look starving to death’, which provoked laughter. Mavis responded, ‘I help in the kitchen and with housework. I get too tired, I don’t like asking. If he can’t...’ Which lead to more laughter.

The group then became serious with people sharing their fears. ‘It’s hard when your friends die, it’s hard making new friends. I don’t shop alone, I am nervous, he watches the money, I get it wrong’, said Mavis. By this session the group members were more open with each other and expressed the desire to meet again over the summer.

The process of feeding back to the team about the progress of the group and clients sharing their opinions with their key workers began to have an effect and a number of referrals for a continued group in the Autumn were received.

In the ‘Hearts and Minds’ seminars I (Cath) was struck by the openness of people and their carers about the difficulties they were facing. For example, a consultant suffering with dementia talked of the need for communication and a role in which one could feel valued. She highlighted for her the importance of person-centred care. The VaD group seemed to provide a space where people could ask questions and receive information, but also talk about their hurts and their fears. Even though they were able to rationalise the hurt as being unintended, it still caused them pain.

The most poignant responses from the clients and carers were in relation to their adjustment to their diagnosis and the condition. This had often begun to take place many months before they were referred to services and often resulted in a withdrawal from family, familiar activities and society. For someone whose self-perception is that they are going mad, any negative comment can be very wounding. For one of our group, to be told that they could not be trusted to baby sit for their grandchildren and that they were no use any more led to great feelings of shame and worthlessness. Perhaps, being able to share their experiences in some way such as in a group, may help to ameliorate those feelings.

Acknowledgements
We would like to thank the group members for their contributions and Sarah Day (Hearts and Brains project manager) and the participants of the Hearts and Minds conferences (2006).

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Peterborough, PE3 6DA.
References

Alzheimer’s Scotland Action on Dementia. 
www.alzscot.org/pages/info/vascular.
Postgraduate Medicine Online, 117(1). 
www.postgradmed.com/issies.
Chichester: Wiley.
Abingdon: Taylor & Francis.
Dementia: National Institute Neurological Disorders. 
www.ninds.nih.gov/disorders/dementias
Kingshill Research Centre. 
www.kingshill-research.org

www.nice.org.uk/CG42
NINDS and Stroke information pages. 
www.ninds.nih.gov/disorders/multi_infarct_dementia
Vascular dementia – Hearts and Brains Project. 
www.alzheimer’s.org.uk

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Depression is a common and distressing consequence of stroke, estimated to affect one-third of all stroke survivors (Hackett et al., 2005). It can develop within days, or even hours, after stroke (Post, 1962). It is clinically important not only because of the distress caused, but also because it is associated with increased mortality (House et al., 2001); physical, cognitive and language impairments (see Turner-Stokes & Hassan, 2002, for a review); and poor participation and gains in rehabilitation designed to address these impairments (Gillen et al., 2001; Sinyor et al., 1986). Biological models suggest that post-stroke depression is a direct consequence of focal or generalised brain damage (e.g. Aben et al., 2006; Narushima et al., 2003). However, this has not been consistently supported by research (e.g. Carson et al., 2000) and does not explain evidence of associations between post-stroke depression and psychosocial risk factors pre-dating stroke (see Whyte & Mulsant, 2002, for a review).

The Self-Regulatory Model (SRM; Leventhal et al., 1980) suggests that people develop cognitive models of illness that guide their efforts to cope with their condition and determine outcomes. This model provides a useful framework for conceptualising the representations people develop about illness and their relationship to outcomes including depression. The model has not yet been applied to stroke.

Aims
The main aim of the current study was to inform the development of psychological interventions for early post-stroke depression by investigating illness perceptions of stroke during hospital treatment and their relationship to post-stroke mood disorders. A secondary aim was to extend the theoretical framework of the SRM to stroke.

Method
The study used a cross-sectional, within-groups correlational design. Forty inpatients from four hospital sites in East Anglia (average age=73, range=47–95; 58 per cent female, 97.5 per cent white British), participated in the study, two to six weeks after a first stroke. Demographic and illness information was obtained from hospital notes and interview and the Hospital Anxiety and Depression Scale (Zigmund & Snaith, 1983), Illness Perception Questionnaire – Revised (Moss-Morris et al., 2002) and Mini Mental State Examination (Folstein et al., 1977) were administered face-to-face.

Results
Positive correlations were found between negative beliefs about stroke symptoms, duration and consequences and between positive beliefs about illness coherence and personal and treatment control over stroke. A high rate of depression (37.5 per cent) was found, the severity of which was associated with negative perceptions of illness severity, chronic duration, serious consequences,
poor illness coherence and emotional consequences. Beliefs about the seriousness of the consequences of stroke, older age and left hemisphere damage predicted greater severity of depression (Adjusted $R^2=.695$) and of these, a negative perception of the consequences of stroke was the greatest predictor of depression. A high rate of post-stroke anxiety (42.5 per cent) was also observed, the severity of which was associated with negative perceptions of the consequences of stroke. The only significant difference between post-stroke depression and anxiety was that depression was more strongly associated than anxiety with negative perceptions of the chronic duration of stroke.

Conclusions
The current findings indicate that stroke inpatients develop a cognitive model of their condition during hospital treatment and that specific perceptions of stroke are associated with early post-stroke depression and anxiety. This supports the applicability of the SRM to stroke survivors and further investigation of this approach to understanding the nature of post-stroke mood disorders in this population. Further research is required to test whether perceptions of stroke are causally linked to post-stroke mood disorders and if so, whether psychological interventions targeting these variables would reduce early mood disorder after stroke.

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References


Laura Sutton & Ross Chernin

I (Laura) developed ‘CALMER-OPS’ as a tool to introduce trainees to neuropsychological assessments on their generic older adults placements. I found that even when trainees came with backgrounds in neuropsychological assessments, for example, as assistants, they still liked the framework to ‘contain’ their assessments.

Ross Chernin, our current Trainee Clinical Psychologist, explains: 'I found the ‘CALMER-OPS’ booklet particularly helpful. I had a level of neuropsychological knowledge, but lacked a fundamental grasp of the basics. The booklet provided information in a simple and straightforward manner that helped me to fill in these gaps. It describes a comprehensive picture of the brain functions; what they mean; where in the brain they are thought to be located; and how they relate to the well-known neuropsychological tests that measure them. It was a great kick-start to my current placement with older adults which has involved a number of neuropsychological cases.’

We thought it could be something to offer to PSIGE for our East Anglian edition, so, here it is!

‘CALMER-OPS’
The third edition of Neuropsychological Assessment by Muriel Lezak came out in 1995. It is a huge volume, which, as its cover states, is ‘Well-known as the ‘bible’ in its field’. It is organised into seven key areas of cognitive functions:

- Orientation and attention;
- Perception;
- Memory;
- Verbal functions and language skills;
- Construction;
- Concept formation and reasoning;
- Executive functions and motor performance.

When you are doing a neuropsychological assessment you need to keep all this in mind. In order to remember all of them, I put the initial letter from each area on a piece of paper, then shifted them about until I got an acronym. The one I liked best was CALMER-OP, because as a novice clinical psychologist (as I was at the time) I could be calmer about what seemed like a lot of neuropsychological ‘operations’ (tests and functions) (see Author’s note).

I later added ‘S’ for speed of information processing as this was becoming important in the assessment of dementia.

Cognitive tests
Fuelled by my new-found confidence, I became intrigued by the acronym. It occurred to me I could see if known test batteries ‘fitted’, for example, the Middlesex Elderly Assessment of Mental State (MEAMS; Golding, 1989):

MEAMS subtest
C copying a star
A arithmetic
L comprehension, naming
M names learning, picture recognition
E motor perseveration, verbal fluency
R [no subtest]
O orientation
P fragmented letters, usual/unusual views
S [no subtest]

Clearly, the MEAMS did ‘fit’. When I’ve looked at various memory clinic test batteries or protocols I’ve found a similar pattern. You could try this out with the assessments in your department.
As I tried out different batteries using the acronym, I found that I could start to understand their differences. The MEAMS, for example, unlike some memory clinic batteries, contains subtests of perceptual problems. I realised that, of course, the MEAMS was developed at the Rivermead Rehabilitation centre in Oxford, which was for people with acute brain injuries. Therefore, you would more often see people presenting with perceptual problems, compared with, say, those presenting to a memory clinic because perceptual disturbances for various dementias can appear later in the illness rather than initially. In other words, you start to see that the biases are relevant to the context of the service area.

Brain areas – practising the links to function

Our brain has three main parts; the ‘hindbrain’, ‘midbrain’ and ‘forebrain’ (see illustration). The first two deal with basic functions, of swallowing, respiration, etc., for the hindbrain, and grasp reflex, crying, laughing, etc., for the midbrain. The forebrain has ‘diencephalic structures’ (notably the thalamus and hypothalamus) and the ‘cerebrum’. The forebrain ‘cerebrum’ then has two cerebral hemispheres, the outer layers of cells of which comprise the ‘cortex’ (hence, ‘cerebral cortex’). It is the cerebral cortex of our forebrains which is the most highly organised area of our brain (Lezak, 1995).

Lobes

There are four main lobes to the cerebral cortex of our forebrain; occipital, parietal, temporal, frontal (Lezak, 1995; see illustration). At the same time, the cerebral cortex has two hemispheres, left and right. In right-handed people, the left hemisphere deals with verbal functions and the right with non-verbal functions. In left-handed people, the distribution is more even. It is possible to understand the main areas of higher psychological functions in terms of their main brain areas:

Occipital

The occipital lobe deals with complex visual abilities. Damage to this area can make it hard for an individual to recognise what they are seeing (visual object agnosia) or make it difficult to see the whole – the ‘gestalt’ - away from the parts (apperceptive visual agnosia). For example, I asked a woman to tell me what the poster on the back of the door was. She said it was a ‘map of Africa’. Indeed, the outline did have the shape of the outline of Africa, but in fact it was a vase of flowers. She could perceive an outline but could not recognise the features.

Parietal

The parietal lobe deals with constructional abilities. An individual with damage here might have difficulty with drawing in two dimensions or working in three dimensions. Damage may also lead to apraxia, difficulty using gesture and conceptualising motor co-ordination, for example, difficulty striking a match, or complex co-ordination, as in dressing apraxia.
**Temporal**
The temporal lobes are associated with the processing of auditory material and, in association with the deeper structure of the hypothalamus, lead to memory problems. On the left, there can be verbal memory problems, with difficulty remembering words, producing **naming** difficulties, or difficulties remembering lists of words. On the right, there can be difficulty recognising and remembering nonverbal material such as complex patterns which cannot readily be given a name or described in words.

**Frontal**
The frontal lobes are associated with **executive** and **reasoning** functions. These are what make it possible to formulate and execute a plan of action. The component parts can be fine with no damage to other lobes, so no perceptual, constructional, or memory difficulties but the person cannot get these lobes to do their work because the damage to their frontal lobe means they cannot give themselves the right initiatory prompts. I knew someone, for example, who could not get through his garden gate. He could see it clearly, and could **perceive** it was a 'gate', and when prompted was able to manipulate the latch as he had no **constructional** problems. He could also **remember** that he had a gate and that he wanted to go through it, but he could not plan, organise and initiate these abilities together.

With such damage, the person may perseverate, that is, get stuck on doing the same thing repeatedly, or get stuck on the same line of thought, unable to shift behavioural or mental set. They may have impaired abstract reasoning and be able to think only in concrete terms.

**Multiple damage**
Of course, damage may not be restricted to one lobe. If there is right hemisphere damage to **occipital and parietal** lobes then an individual could have **visuospatial** problems. For example, a client who in his carpentry career had been able to register the angle of a door in its space and translate that into the angle for the mitre joint he needed to construct the door, could now no longer work out how to put in a new spindle in his banister. His scan revealed a stroke to his occipital and parietal areas.

If damage occurs in the **occipital, parietal,** and **temporal** areas, it can cause **fluent aphasia** or **Wernicke’s aphasia.** This is where an individual may produce intact sentences but none of what the individual says makes any sense. In the absence of damage to the right hemisphere, non-verbal recognition will not be impaired, therefore, an individual can still respond to, for example, sirens, perceiving the sound fluently and retaining the meaning of the sound.

**Relating tests to cognitive function to lobe – getting started**
Now we can start to practice relating tests to cognitive function and to brain areas. For instance, with the MEAMS: ‘usual/unusual views’ should in theory relate to the visual functions of the occipital lobes; ‘copying the star’ should relate to the constructional functions of the parietal lobes; ‘naming’ relates to the memory functions associated with the left temporal lobe; ‘recognition memory’ in theory would relate in part to the right temporal lobe and ‘motor perseveration’ would relate to the executive functions of the frontal lobes.

Whilst all tests will have a variety of skills from different cognitive domains and areas of the brain, it is helpful when starting out to think about the principal function of the test that indicates the main area of cognitive ability being tested. If the individual performs poorly on the test but you think it’s not that ability that is getting in the way, then the test may not be ‘valid’ due to secondary influences and this can be highlighted.

**Using CALMER-OPS qualitatively – for any severity of dysfunction or disability**
If you’re asked to assess someone, say on an acute ward, with a severe disorder, you can use CALMER-OPS to frame your perception.
In other words, what can you see or hear in each of these areas? You can have the CALMER-OPS as a mental tool to help you have a quick mental check to ensure you’ve attended to each domain.

It’s good to do this before you come armed with tests, for all clients, no matter what their level of disability, in order to ensure that your tests are serving your observational skills, and your hypotheses, rather than you being ‘test-led’.

You could also report your findings within this framework, even if purely qualitative, for instance, if someone cannot or will not do tests or will only complete them partially. Consider what it means, not only diagnostically, but practically to the person and their families?

Simple illustration and advice
How about simple illustration and advice? I had a client, for example, with a moderately progressed Alzheimer’s dementia who, on the MEAMS, was unable to recognise everyday objects when photographed from ‘unusual views’ but was able to recognise them when they were photographed in their ‘usual views’. I illustrated this to his wife and suggested to her that, when he lost his glasses (as he often did) she could offer him his glasses in the open-glasses view rather than the more complex folded up view to assist him. This simple act might help this couple regain an intimacy in simple tasks together, his lost glasses representing his ‘losses’ (being ‘lost’ in relationship to self, others, world) and the usual views something ‘familiar’ (‘found’ in relationship with self, others, world).

Conclusion
Ross adds: I hope this can be as useful to other trainees as it was to me. I’d recommend being clear on this information before delving in more advanced neuropsychological literature.

In short, Ross and I find trainees benefit from CALMER-OPS because it gives them a framework into which they are then able to place the detailed neuropsychological tests.

Author’s note
You may notice that I have separated out Lezak’s (1995) category of ‘orientation and attention’, putting ‘orientation’ on its own, and then added ‘concentration’ to ‘attention’. This is because, in my experience in services, ‘orientation’ is often assessed separately from Short Term Memory (STM) as it (orientation) can relate to states of confusion (as in ‘acute confusional state’, for example, from urinary tract infection) rather than to specific areas of primary neurological damage. STM, experimentally, is memory for items within the immediate short term memory span, viz up to two minutes. Recall in excess of this, experimentally, is classed as ‘long term memory’ (LTM).

Our notion of STM is at odds with lay notions, as when people say ‘my husband’s STM is bad – he can remember years ago but not five minutes ago’. Experimentally though, five minutes’ recall takes you into ‘long term memory’, specifically episodic memory. Our psychological notion of STM from experimental psychology incorporates both ‘simple attention span’ (as you need for remembering a telephone number someone has just said to you) and ‘working memory’ (WM). WM is where you need to ‘work’ a bit more: subtraction is like this where you have to hold in mind the numbers and then do an operation on them, so it relates to the ability to ‘concentrate’ (all within the two minute span). Hence, I have put attention and concentration together, as simple attention span and WM respectively.

Remembering from five minutes ago can be a problem for people early on in dementia because it is new learning, rather than recall that is affected. If the person cannot encode information from STM into LTM then they can’t recall it. Memories from long ago were encoded prior to disruption in this process so can be recalled.
Comment
Finally, it’s worth noting that in the history of the study of memory in psychology, we moved from the early ‘storage’ models (as in STM and LTM ‘stores’), to ‘process’ models. As computers themselves have developed, so our metaphors have shifted.

I expect this is linked to social change. I had a client, for example, who was upset because she couldn’t ‘read’ the receipts from cash point machines. In time, we understood that she grew up with teaching and learning ‘by rote’: society was rigidly hierarchical, so had a social ‘structure’ – you ‘knew your place’; with official letters, name and address top right, ‘yours faithfully’ if you didn’t know the person you were corresponding with, and ‘yours sincerely’ if you did know them. The new bank slip didn’t do this: she couldn’t find the date, or address – nothing was ‘where it should be’. I realised that society’s hierarchical structure wasn’t there for her any more, yet it was what had, until recently, framed her mode of perception: she was all too directly experiencing the fragmentation of the (her) past to our ‘post-structural world’.

It will be interesting to see where our metaphors go now!

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References
Experiences of using an identity map model
Rachel Wenman

This is a description of my experiences of work with a client using an identity map model. This model of working, from the traumatic brain injury literature, was used with a client with cognitive and physical impairment thought to be degenerative in nature. Although I had read about and used the identity map model with respect to brain injury, I had not used the identity map model with an older person whose abilities are declining.

The identity map approach

The identity map approach was developed by Ylvisaker and Feeney (2000) as part of a comprehensive brain injury rehabilitation programme. The identity mapping approach is based within cognitive theory, specifically the interacting cognitive subsystems model (ICS; Teasdale & Barnard, 1993). Within the ICS model there are two levels of meaning: (1) The propositional level relates to specific meanings that can be evaluated based on factual evidence; (2) The implicational level of meaning is generic, holistic, more implicit and related to intuitive belief. It is derived from recurring patterns of features and specific meanings. Only the implicational code is directly related to emotion (Teasdale, 1996).

The identity map approach uses concrete visual maps to represent aspects of an individual’s sense of self. The sense of self is theorised to have a generic holistic meaning at the level of the implicational code (Ylvisaker & Feeney, 2000). As such, it is directly related to emotion and is hypothesised to be at the level of an intuitive or ‘gut feeling’. Initially, an identity map to formulate the current difficulties is jointly generated. This clarifies the way in which emotions or behaviours, which may be perceived as problematic, have been developed to maintain a perceived sense of self. Further work is then invested in creating an alternative identity map using a metaphorical identity and associating it with alternative goals, behaviours or strategies and feelings, which remain congruent with the implicational code.

About Stuart

This identity mapping process was used as part of my work with Stuart (not his real name), a 62-year-old man. He was admitted to hospital in 2002 with sudden onset of a febrile illness with weakness, falling to the left, nausea and confusion. His gait was abnormal and has remained so (showing slow speed, poor balance and wide base). He tires quickly. Since this time, he and his wife feel he has deteriorated physically. His wife reports he has declined cognitively and his personality has changed. Neurologists differentially diagnosed: possible sudden onset Lewy Body Dementia; possible encephalitis; or a vascular syndrome. He and his wife were referred for psychological support by his local neurologist.

Cognitive assessment indicated that Stuart’s verbal memory and working memory had declined. His speed of processing is slow and he has difficulty initiating and maintaining task performance without prompts.

Stuart’s wife feels that his personality has changed and he has withdrawn from others and become quiet and irritable, whereas he previously enjoyed spending time with other people and being very ‘laid back’. He feels anxious, especially when he feels tired or physically unbalanced. He engages in little independent activity at home although at times he attempts large tasks all at once (for example, painting the skirting boards, laying tiles). He dislikes crowds and wants to be with his wife all the time. His wife also feels more comfortable when she is with him as she worries that he will fall or be unsafe if she leaves him alone.
Since his illness, Stuart sees himself as unable to do things and as relying on other people. However, he perceives offers of support as people trying to control him and take over. This is incongruent with his pre-illness view of himself as an able perfectionist person who had a strong role in supporting and helping others. People around him have also altered their behaviour to compensate for his difficulties, leading him to feel anxious and frustrated and to lack confidence and trust in himself and his abilities.

The discrepancy between Stuart’s pre-illness view of himself and his altered physical and cognitive ability may have contributed to his emotional distress (Higgins, 1987; Nochi, 1998). There has also been a significant alteration in his marital relationship, with his wife caring for him and his increasing dependence on her. This has led to a shared view of Stuart as someone that is unable to do things and requires special care. Stuart and his wife wanted to work on ways to cope with his difficulties and to help manage his anxiety and frustration. His scores on the Hospital Anxiety and Depression scale were in the severe range.

**Intervention**

An identity mapping approach was used to develop a joint understanding of how Stuart’s perception of himself had changed since his illness. This was constructed between Stuart and I with some input from his wife. This explored his thoughts, feelings, behavioural responses and to some degree his perception of others’ behaviour towards him. His label for this identity was ‘Frightened Stuart’ as he perceived that many of his thoughts, feelings, behaviours and interactions with others originated from the fear he experienced during and following his time in hospital. Stuart found the process of trying to identify specific automatic thoughts and hold them in mind to challenge them tiring. He was also reluctant to keep diary records of his thoughts and feelings. His cognitive problems and fatigue are likely to have influenced this in addition to it being quite different to his view of himself as a very practical person. Using the identity map and ICS model allowed us to move away from these more traditional Cognitive Behavioural Therapy techniques.

Stuart and his wife developed a number of basic strategies to manage his anxiety and low mood and to increase his adjustment to his current situation within a cognitive behavioural model. This work was done jointly with his wife in order to offer her support and to encourage implementation. Specifically, they jointly planned his time to help manage his memory difficulties and increase his activity levels. This included planning breaks and planning for tasks to take longer in order to help manage his fatigue. He began to take on small tasks around the house, and to engage in mentally stimulating activities. He learnt some basic anxiety management strategies including relaxation, controlled breathing and self-statements. Stuart and his wife used a cue card and a wristband to aid his memory of these approaches.

During this time, Stuart began to develop an alternative identity map. He identified this as ‘Steady Stuart’. A similar process of identifying thoughts, feelings, behaviours and others’ responses was carried out in developing this map. This identity map incorporated the use of strategies to enable him to do things ‘steadily and get there in the end’ and to aid him to feel calm and acknowledge the differences in how he managed situations. This map continued to hold at its core aspects of Stuart’s self which were central to him prior to his illness, i.e. engagement in practical tasks, ability to help others and do things well. Maintaining these core definitions allows the novel strategies to be applied rather than rejected (Ylvisaker & Feeney, 2000). This is in keeping with the identified need for continuity with pre-illness sense of self identified in qualitative research where identity emerged as an important theme in coping with dementia (Preston et al., 2005). The identity map was also helpful for his wife in her adjustment to Stuart’s altered ability and speed.
Stuart began referring to the maps as a way to think about how to manage in difficult situations and whether he had been feeling more like ‘Frightened Stuart’ or ‘Steady Stuart’. He also requested several little maps to keep with him, and a credit card-sized ‘Steady Stuart’ card to keep with him to aid his memory. He was able to think about the central label he assigned to the identity as a key to thinking about how he could manage situations in an alternative way.

The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1994) was completed at the end of the intervention phase and his score on both scales had reduced to fall within the normal range. He and his wife reported that he engaged in more activity (both independently and with encouragement) and tried to do tasks in small chunks. They continue to prefer to spend time together to limit both their anxieties and his wife continued to comment on his reduced speed.

**Reflections**

Stuart found constructing the map tiring and the decision making involved (for example, a name for the map) difficult. Given his cognitive difficulties, the extra demands of using a concrete mapping process need to be weighed against the benefits of being able to refer back to the map and the strategies included. Although Stuart began using alternative strategies, I think their continued use was facilitated by the alternative identity map and its congruence with his pre-illness sense of self. Stuart and his wife found looking at the difference between the two maps useful and felt they had learnt from developing and using the maps. Stuart’s wife found it helpful to have something external to use as a prompt to help Stuart to apply new strategies. They were pleased that they had both been involved in developing and using the map.

Using the identity map framework provided a useful structure and visual tool to aid the cognitive behavioural-based work with Stuart. He appeared to make good sense of the maps and to some degree internalise the meaning from the use of the label. It seemed to offer him hope within a disempowering context and it was on issues concerning the maps that Stuart generated his own ideas and questions, without referring to his wife for answers. He, for example, requested smaller maps to keep in his pocket so he did not have to ask his wife for a reminder. This method of providing a shared formulation required relatively little abstraction and few complex ideas to be held in mind. The identity maps offered a way of positioning sense of self and how this can change dramatically at the centre of our work within a very concrete context that Stuart was able to retain. Using this approach within the ICS model also facilitated an alternative approach to cognitive behavioural intervention with less focus on identifying and evaluating automatic thoughts, which Stuart had found very difficult due to his memory difficulties and processing speed.

Ylvisaker and Feeney (2000) discuss using an admired figure as a metaphor for the new identity map. This was not tried in this case because of my concern it could seem patronising to someone who held far more life experience than myself. It was felt that in this case an alternative but still very familiar identity could be used and this seemed acceptable to Stuart. It may be that more dramatic results could have been achieved if the metaphor identity had been attempted.

Stuart suffers from a degenerative condition. This was one of my first experiences of working with someone with a degenerative condition for longer than the length of a six month placement because of my transition from trainee to qualified psychology post. A striking contrast for me between using the map with Stuart and with people suffering from a discrete illness or brain injury is that even with good strategies, his abilities will continue to decline and the family will continue to struggle with this. This has been something which continues to be difficult to be confronted with during my work in this
area. This approach, however, had relatively low cognitive demand, was acceptable to Stuart and his wife and its implementation was supported by his wife. It offered a way to help Stuart benefit from and implement strategies and make sense of the physical and cognitive changes he has been experiencing in spite of not having a clear understanding of the medical cause of them.

Acknowledgements
I am grateful to Stuart and his wife for their permission to write about our experiences of using this approach.

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References
First steps towards a solution-focused older people’s mental health service

Nick Oliver

This article describes an ongoing piece of solution-focused (SF) development work located within an NHS mental health service for older people. This initiative was prompted by an invitation to a colleague and myself to provide SF training to all staff in the Trust. In a departure from previous training and development approaches within the Trust, the local manager wished that all of the staff within the clinical teams in the service should receive training in order that all would share an awareness of, and ability to use, the SF model in their work with older people. An opportunistic evaluation was undertaken of the impact of the training intervention – an SF training workshop – and service development, both in terms of immediate changes at the individual level, and longer term changes at the team and organisational level. This article is a summary of a dissertation I submitted as part of the MA in Solution-Focused Brief Therapy at the University of Birmingham.

Solution-focused approach

STEVE DE SHAZER, INSOO KIM BERG and colleagues at the Brief Family Therapy Centre in Milwaukee developed Solution-Focused Brief Therapy (SFBT). Historically, the approach has roots in both the family therapy and brief therapy traditions and has been substantially influenced by the work of Milton Erickson (Cade & O’Hanlon, 1993). In SFBT there is a strong focus on identifying and recognising difference as a vehicle and indicator of change. For example, a client might be asked ‘What differences will you notice when you are feeling a little better?’ The therapist seeks to help the client identify differences that are noticeable, meaningful to them and grounded in their own life and experience. The therapist takes a ‘one-down’ position of recognising that the client and not the therapist has expertise about their life (Anderson & Goolishian, 1992).

Solution-focused methods and techniques

There is a basic assumption within the approach that change is occurring all the time and is inevitable (de Shazer, 1985; Walter & Peller, 1992). The purpose of questions within the SF approach is, therefore, not solely to gather information but to effect some degree of change (de Shazer, 1994). There is a strong emphasis on clients’ self-determination and SFBT values the inherent dignity of all people.

The SF approach asks clients to focus on their future, i.e. how they would like their life to be and the ‘solution’ is this ‘...end product of a process of discovery’ (Lipchik, 2002). The therapist explores the client’s hopes for the future rather than the problems of the present or the past and helps them to describe what is already working. This approach to therapy de-emphasises client history and instead focuses on defining clear behavioural goals, and shifting and reframing interpersonal interactions (de Shazer, 1991). People’s skills and strengths are identified as resources that they can use to help them move towards their hoped-for future.

Within the SF approach a common technique used to explore the future is the ‘Miracle Question’. The client is asked to imagine that while they are asleep a miracle occurs which means that their difficulties are resolved. They are asked to describe how they would notice that this had happened, what would be different, how they would feel...
or think or behave differently, how other people would notice this, etc. (de Shazer, 1988). The client is also asked to what extent these things are already happening and to consider what they are doing to assist this. The times when the problem is happening less or elements of the preferred future are happening more are called ‘exceptions’ (Lipchik, 1988).

Another technique is using scales to rate progress and change, where 10 on the scale is the preferred future and 0 is, for example, the worst things have been. Clients are asked to rate where they are currently and describe how they know they are at that point, what resources and strengths they have used to get there, and how they would know if they were a little higher up the scale. Further types of SF interaction include problem-free talking and giving positive feedback and compliments.

Solution-focused approach to services

In the literature, the SF approach is most often considered as an approach to delivering direct therapy or interventions either in one-to-one or group settings. There have also, however, been developments in other domains including as a model for delivery of aspects of health and social care. In the health setting the use of the SF approach varies from specific communication skills to its employment as a set of principles for organising all of the usual tasks of the service.

Examples include the work of Kay Vaughn and colleagues in Colorado, US, where the SF approach was used as the service model in a psychiatric unit from the intensive in-patient facility through to the day services (Webster et al., 1994; Vaughn et al., 1995, 1996). Their evaluation demonstrated a significant reduction in the lengths of stay of their service users with no increase in the rate of re-admission. In this country, Bowles et al. (2001) reported on the impact of training in SF communication skills with general nurses and health visitors. They found that ratings of confidence, competence and willingness to work with ‘troubled people’ significantly increased. Similarly, within a mental health setting, Stevenson et al. (2003) demonstrated that their SF training package led to increased knowledge of the approach and some demonstrable changes in practice. They also sampled some of the clients involved and reported that all found the approach to be helpful.

The literature relating to the use of the SF approach in teams and services in both the UK and US suggests a number of benefits. There is evidence that the training interventions were effective in increasing staff’s knowledge of SF practice. Relatively brief training interventions were able to impart the values and techniques of the SF approach with reasonable effectiveness. In the US, a whole-system approach demonstrated a positive impact of SF by decreasing the in-patient bed usage with no corresponding increase in readmission rates.

There are also many comments in the literature about some of the wider benefits noted by staff of utilising the SF approach as a care model. These included greater satisfaction, confidence, efficacy and empowerment in their working roles, increased optimism and hope for their clients, and positive changes to aspects of team working and conflict resolution. Importantly, it was also suggested that service users found the SF approach helpful although no comparison with an alternative approach has been reported.

The current literature in the area of using the SF approach in a service setting, suffers from a number of shortcomings. Numbers of participants are generally small and may come from different teams or services. There is generally no comparison of the SF training with any other model of training, or even a group with no training and follow-up is usually short-term. In designing this evaluation we aimed to address some of these issues. There was a management commitment that all staff in the service would attend the training which was intended to lead to a ‘critical mass’ of
exposure to the approach within teams (Brooker & Brabban, 2004). A comparison group was recruited to attempt to: (a) control for trust-wide changes; and (b) strengthen the argument that changes were related to the training intervention and service development.

Focus of evaluation
Two issues were explored in relation to the SF training and service development project. At the individual staff level, we explored the impact of receiving training in the SF approach on working with older people with mental health problems. Secondly, at the broader team level, we explored the impact of training all of the staff on team functioning, job satisfaction and well being.

Design and procedure
This project used a pre-test/post-test design with two groups of staff. One group received the training and the other was a non-intervention comparison group. Participants were recruited from the older people’s mental health service of the Trust. Staff in two localities (called A and B for convenience) was invited to participate in the evaluation. Locality A, at the request of the service manager, received a SF training package and Locality B did not. At the time of the project, the researcher was working as a full-time clinical psychologist within the service based in Locality B.

A Steering Group in Locality A made up of the service manager, team managers and staff representatives oversaw the service development. I was also a member of this group along with my colleague and we attended to support and facilitated the ongoing service development.

The project used a quantitative methodology for gathering and analysing data. Based on reports from previously published research on SF approaches within teams and services, a range of measures were selected to attempt to evaluate the impact of the training and service development. These were, the Theoretical Orientation Scale for Clinicians (Osborn and Johanson, 2001); General Health Questionnaire (GHQ-30; Goldberg, 1978); work-related self-efficacy (Schwarzer & Jerusalem, 1995); CMHT Effectiveness questionnaire (Rees et al., 2001); and job satisfaction items from the 2005 NHS Staff Survey (Healthcare Commission, 2005). In addition, a small number of scaling questions were asked, derived from Bowles et al. (2001), relating to working with people with mental health issues.

Questionnaire packs were sent to all participating staff before and after the training workshops, and then again 12 months later. The same packs were sent to participating staff from the comparison locality at the same time. The data were analysed using repeated measures tests.

Training workshops
A CPN, who was working at the time as the Older People’s Practice Educator and I organised and ran the workshops. We are both practitioners of SFBT and have received external training in the approach. The workshops were designed to provide an introduction to the SF approach that was grounded in practitioners’ own work rather than presenting it as a model of psychotherapy.

A one-day workshop was designed for non-qualified staff covering the values and techniques of the SF approach such as exploring the preferred future, scaling, and giving compliments. This was grounded in the work contexts of the attending staff. A workbook was devised to summarise the material and facilitate understanding of the ideas and techniques and application to the work situation. This was constructed in consultation with the Trust’s training department with the intention that staff could use the completed workbook as evidence of reflective practice for National Vocational Qualifications where appropriate.

The qualified-staff workshops were held over two days and included all of the core material from the one-day workshop. In addition, there was opportunity for extended practice of the techniques, appli-
cation to contexts such as team meetings and supervision and consideration of ways in which the approach could be adopted into the practitioners’ day-to-day working. This recognised the additional roles that qualified staff undertook such as management, supervision and care-co-ordination under the care programme approach (CPA). There was also consideration of some of the issues surrounding implementation and transfer into practice. These were raised explicitly within the workshops for discussion; group problem-solving and realistic goal-setting (Tziner, Haccoun & Kadish, 1991).

Summary of results
In Locality A, letters and information sheets were sent to 74 staff, 40 qualified (54 per cent) and 34 non-qualified (46 per cent). The response rate was 26 per cent (of the eligible staff group) before the training, 15 per cent immediately afterwards and 12 per cent after 12 months. In Locality B, letters and information sheets were sent to 27 staff, 17 qualified (63 per cent) and 10 unqualified (37 per cent). The response rate was 44 per cent (of the eligible staff group) before the training, 33 per cent immediately afterwards and 15 per cent after 12 months. This low response rate significantly limits the power of the statistical tests and increases the risk of bias in the results.

In total, nine workshops were conducted with 65 staff in Locality A. Of these, 35 (54 per cent) were professionally qualified and 30 (46 per cent) were non-qualified. The total number of staff trained corresponds to 88 per cent of the available staff group.

For the SF staff group there was a significant increase in reported levels of confidence, competence and willingness to work with troubled people, after the training workshops. Effect sizes ranged from 0.45 to 0.77. This change was not seen in the comparison group suggesting that the workshops had been successful in influencing staffs’ perceptions of themselves and their work. The difference between the groups was maintained at the 12 month follow-up.

There was also a non-significant increase (with medium effect size) in rating of general self-efficacy in the SF group with no such change in Locality B.

There was no change in levels of endorsement of the SF approach for either group at post-training and 12-month follow-up, both initially having started quite high anyway. At the 12-month follow-up there were also no differences in levels of well-being on the GHQ-30, team effectiveness, or work-related self efficacy. Interestingly, the comparison group showed increased levels of job satisfaction and team working, which was not seen in the SF group.

Qualitative feedback
Alongside the quantitative evaluation, qualitative feedback was also sought through the service steering group. Anecdotal feedback suggested that the SF approach was being used in the different areas of the service and in a variety of formats. There were accounts of SF work in assessment on the in-patient wards, in discussion with service users about their plans on discharge, in clinical supervision and team meetings, among others. The potential conflict of interests with being both facilitator and evaluator is noted.

Reflections
In the spirit of the SF approach it is relevant to ask, ‘What went well?’ and ‘How did I help that to happen?’ Managing to train nearly nine out of 10 of the staff group in a one-month period was quite an achievement and demonstrated the commitment of the service and team managers to the project and the co-operation between them and us as trainers. It also reflected the engagement and enthusiasm of the staff within the service to participate in such a way. Feedback from participants of the workshops and personal reflection indicated that we covered relevant and helpful material and in a way that facilitated an interactive learning environment. As trainers, we felt that we had succeeded in presenting the ideas of SF practice in a way that was applicable to the day-to-day work.
that staff performed, from helping someone to have a bath to changing their medication to supporting them through emotional and psychological difficulties.

There was some disappointment at the lack of positive results in some domains of the evaluation. Reflecting on the process of the project, the difficulties in providing further follow-up input and the intrusion of trust-wide changes has helped to contextualise these results. The Trust reorganisation removed the post of Practice Educator and services were also under some pressure in an uncertain environment. In this context, we were unable to provide the follow-up support that we had anticipated at the start of the project.

Critical appraisal
There were a number of issues with the design and method of the evaluation that need to be considered when interpreting the results. The small number of participants significantly compromises the statistical power of the tests used, making it harder to identify a difference if one existed. The measures used may not have been sensitive enough to change, and in fact, there is no reported data related to this for the theoretical orientation and team effectiveness measures.

It was unfortunate that this service development coincided with the mental health Trust undertaking a major reorganisation of its management structure and shifting from a locality to specialty directorate focus for organisation and delivery of services. Together with a range of cost-efficiency measures this led to the period of this evaluation also being a period of uncertainty and disruption for many staff within the service. Perhaps this was not the ideal time to be trying something new.

The use of a comparison group helped strengthen the interpretation that something did change in the SF staff group. The nature of the design, however (SF training vs. no intervention) leaves open the possibility that the impact was related to general training factors rather than specifically as the result of the SF elements themselves. Further research comparing SF with other forms of training (e.g. psychosocial interventions) would help clarify this.

Next steps…
Within the service we are currently engaged in some ongoing work to implement the next steps of this service development. This has involved a process of receiving feedback from the staff group about their experience of the training, which parts they have found useful, which parts they have used, and their needs for further development of their understanding and use of the SF approach. This feedback started with the Steering Group whose members are currently cascading a semi-structured set of questions through the staff teams via their clinical supervision or one-to-one meetings. Suggestions to date include, refresher training and initial training for new-starters, training around specific issues such as using the SF approach in CPA, ongoing clinical supervision or case discussion groups and the establishment of a SF practice action learning set to assist with embedding the approach and its development within the services.

This is a report of a piece of ongoing service development within our Trust. Progress has been slower than initial hopes and expectations, which have been optimistically high. It is encouraging to see that there is a continued enthusiasm and commitment to the SF approach in our service. My best hopes now are that we can continue to work with the staff in the service to move up the scale.
Acknowledgements
My special thanks go to Adrian Wilkinson, Jill Hudson, Julie Hare and all the staff from the East Cambs, Fenland and Huntingdon older people’s mental health services who participated in the training and evaluation.

References
Introduction

What is low self-esteem?
Self-esteem refers to the way in which people think and feel about themselves. It has been suggested that self-esteem is always ‘in process’ (Carlock, 1999) and can be enhanced at any age (Shub, 1999). Having low self-esteem means having a low opinion of yourself (Jenkins & Fennell, 2004). Most people are affected by some degree of low self-esteem on specific occasions and experience moments of self-doubt. However, for some people, low self-esteem can develop into a more general opinion about themselves and begin to interfere with their lives. In these cases, people can experience reduced confidence, anxiety and low mood. People with low self-esteem are often critical of themselves and doubt their sense of self-worth. Other common feelings are guilt, frustration, shame and anger. People with low self-esteem often tend to ignore their strengths, compliments and achievements and focus more on criticisms and faults. Low self-esteem can affect thoughts, feelings, body state, behaviour and relationships (Jenkins & Fennell, 2004).

How does self-esteem relate to mental health difficulties?
Low self-esteem is described as lasting negative beliefs about the self and has been identified as being associated with a range of mental health difficulties including depression, eating disorders, social anxiety, etc. ‘Low self-esteem ranks amongst the best predictors of emotional and behavioural problems, yet relatively few people have directly focused on attempts to improve it’ (Rigby & Waite, 2006).

Cognitive model of self-esteem
Cognitive theory suggests that our experiences within the world can lead to the formation of negative beliefs about the self, others and the world – the ‘Negative Triad’ (Beck, 1967, 1976). Fennell (1997, 1999) proposed that these negative beliefs lie at the heart of low self-esteem. Based on these negative beliefs, Fennell suggested that people with low self-esteem develop strategies or guidelines for living often referred to as ‘dysfunctional assumptions’. These strategies or rules enable a person to maintain self-esteem as long as their conditions are met. In some cases, however, a person might tend to avoid opportunities and challenges, which, although helpful in the short-term, actually serves to maintain low self-esteem in the longer term.

The cognitive model of self-esteem (Fennell, 1997) proposed that focusing on negative thoughts about ourselves affects how we feel. Negative predictions about what might happen in certain situations could lead to heightened anxiety. Similarly, considering self-critical thoughts could lead to depression, guilt and shame. Experiencing heightened symptoms of anxiety and/or depression can contribute towards changes in behaviour. Depression and/or anxiety, for example, can lead to withdrawal and avoidance of other people. This can add to or confirm some negative thoughts associated with low self-esteem. Withdrawing from social situations could confirm a belief that other people are not interested or do not care. Therefore, a vicious circle can be formed that serves to maintain low self-esteem.

Cognitive therapy for low self-esteem aims to identify and break unhelpful
patterns that keep low self-esteem going. The process of therapy aims to support people in building more balanced and realistic beliefs about themselves as a person.

To date, only a few research studies appear to have examined the efficacy of cognitive therapy for improving self-esteem. Of those reported, the evidence seems to suggest that cognitive therapy appears to be effective in increasing levels of self-esteem. Hall and Tarrier (2003), for example, found that following a short-term cognitive therapy intervention with psychotic patients, increased levels of self-esteem and social functioning were reported. Chatterton, Hall and Tarrier (2007) reported a single case study with an older adult with depression. They used cognitive therapy for low self-esteem with the client, who subsequently reported an increase in level of self-esteem and a decrease in anxiety and depression symptoms.

As Rigby and Waite (2006) highlight, social anxiety is prevalent in individuals with low self-esteem. Taking this into account, the facilitators felt that group participants could serve a useful role in terms of the group offering a social experience. Fellow group members could play an important role by providing an opportunity for participants to test out some negative thoughts and predictions. This led the facilitators to decide to run a cognitive therapy group specifically for people with low self-esteem as a pilot study.

Method
Group participants were recruited from both the Adult and Older Adult Community Mental Health Teams. To date, two groups have been completed. Six participants were offered places in each group including four older people. Results for these four participants are reported here.

Each group met for 90 minutes on a weekly basis for 12 weeks. The group sessions were adapted from Fennell’s (1999) work, using cognitive therapy techniques to understand and overcome low self-esteem. The first four to six sessions focused on building participants’ understanding of their sense of low self-esteem, developing personal mini-formulations and sharing their experiences. Following this, three interventions were introduced: thought records, behavioural experiments and positive data log. These were introduced with the aim of enabling participants to: evaluate their negative thoughts; test out negative predictions; and enhance self-acceptance. The final three sessions were focused on reviewing personal formulations to identify alternative guidelines that participants might continue to work towards, developing a plan for this and reviewing the group. Handouts and worksheets were used throughout the group with an emphasis on encouraging participants to make changes and continue the work between sessions.

In order to evaluate the pilot study, three measures were used at five time points throughout the group: two baseline measures; mid group; end group; and three month follow-up. Self-esteem was assessed using the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965). This is a short self-report scale that is widely used in research and clinical settings. Symptoms of anxiety and depression were assessed using the well-established Beck Inventories, i.e. the Beck Depression Inventory-II (BDI-II; Beck et al., 1995) and the Beck Anxiety Inventory (BAI; Beck et al., 1988).

Participant A
Participant A was a 66-year-old gentleman who had a reported history of inter-personal difficulties connected with symptoms of anxiety and depression. He identified a number of childhood experiences that he felt had contributed towards him developing negative beliefs about himself and about others being rejecting towards him. He engaged in a number of avoidance strategies that served the purpose of pushing others away, before they could reject him. He would, for example, take a book he perceived as ‘intellectual’ to read in public places as he thought this would put other people off attempting to talk to him. He also avoided
making eye contact with others. These strategies appeared to offer him a means of isolating himself from others and subsequently acted to maintain his loneliness.

**Participant B**
Participant B was a 69-year-old married lady diagnosed with depression and agoraphobia. She had been involved with mental health services for a number of years but had not engaged in formal cognitive therapy previously. Participant B attended the first session of the group but then chose to disengage. She subsequently engaged in one-to-one cognitive therapy.

**Participant C**
Participant C was a 66-year-old lady who presented with depression and anxiety. She had recently been widowed and lived with her son. She identified a number of past experiences that she thought were significant in contributing towards her low self-esteem. Participant C described holding rules related to not upsetting other people and putting other people’s needs first. She described, for example, having thoughts such as ‘If I say no to someone then they won’t like me.’ This led her to work hard to ensure she addressed other people’s needs for fear of upsetting them. Consequently she felt that her own needs were neglected and at times, felt used by others.

**Participant D**
Participant D was a 71-year-old divorced lady who presented with depression. She described having reduced confidence in herself and her abilities. She held beliefs about ‘paying her own way’ and not wanting to rely on or burden other people. Participant D admitted fearing that she might ‘say the wrong thing’ and upset other people. She also felt reluctant to develop close relationships with other people and identified feeling lonely and isolated as a consequence of this. Participant D’s ex-husband died during the course of the group, which understandably had a significant impact.

**Results**
Figure 1 shows symptoms of depression reported by participants over the course of the group, as assessed using the BDI-II. Participant A’s scores on the BDI-II suggested a clinically significant change between the mean pre-group score and both the end group and follow-up time points. The BDI-II scores suggest that participants C and D did not report any clinically significant change in symptoms of depression.

There were no clinically significant changes in any of the participant’s reported symptoms of anxiety, as assessed using the BAI. BAI scores are illustrated in Figure 2.

Figure 3 shows the participants scores on the RSE over the course of the group. A higher score indicates lower self-esteem. Participant A had a clinically significant reduction in his RSE score at follow-up. Participant C had no clinically significant change in her score. Participant D had a clinically significant reduction in her score (i.e. an improvement in reported self-esteem) at the end group time point but this improvement was not maintained at follow-up.

**Discussion**
Examination of the results of the three measures over time suggested some improvement in symptoms of depression and self-esteem for participant A. Participant C did not show any significant change on the measures completed. Participant D’s scores on the measures suggested some improvement in self-esteem. None of the participants showed any significant change in measurement of symptoms of anxiety.

Some changes were noted throughout the course of the self-esteem group that are not reflected in the scores on the measures. Participant A, for example, identified some avoidance strategies. These included avoiding eye contact so that others would find it harder to get to know him as a person. During the group participant A was able to test out using more eye contact. This allowed him to discover that maintaining eye contact is ‘not as bad’ as he predicted and he
planned to try this out in other situations. At the end of the group Participant A reported feeling that attending the group had been helpful in allowing him to develop a better understanding of his low self-esteem. He admitted having some concerns that he might find it difficult to continue to work on improving his sense of self-esteem outside the group as he continued to report feeling lonely outside the group.

Participant C made some changes in terms of her behaviour and way of thinking. She tested out, for example, putting her own needs before those of others by not cancelling her own plans to provide last minute childcare. She identified alternative rules that she would like to work towards, for example, ‘I like to help people sometimes but my needs come first sometimes.’ She also started to plan more time for herself.
Participant D continued to feel somewhat reluctant to develop close relationships with other people, but reported that she had found it helpful to attend the group and felt she had learnt from other people’s viewpoints. All the participants reported that they found it helpful sharing experiences within the group and developing an understanding of their difficulties. A number said they learnt that they were not alone in managing their low self-esteem and felt less isolated as a result.

This was a pilot study and the facilitators do have plans to continue running similar groups in the future. In addition to the formal measures, it was felt it would be useful to include more individual measures in order to continue evaluating effectiveness. These could, for example, include ratings of belief in rules held and behavioural changes. It is hoped that this might offer the opportunity to assess changes that the formal measures used may not have shown. Interestingly, there was no significant change observed in reported anxiety symptoms. It is possible that this reflected behavioural changes for group participants where they were exposing themselves to more anxiety-provoking situations.

The group facilitators felt that the earlier sessions of the group that focused on formulation were useful in terms of encouraging change. It was felt that running the group across working age and older age services was useful as it provided the opportunity for a wider perspective on group participants’ cognitions. This was perhaps illustrated by comments from some of the participants that it was useful hearing perspectives from different generations. It will be interesting to explore this further in future groups.

Acknowledgements
We would like to thank Dawn Echlin and Claire Lussignea for their time and support.

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References


Using Cognitive Analytic Therapy reformulation to guide indirect working in dementia services

Julie Clarke

IT HAS BEEN ARGUED that the management of people with major mental health needs, people with learning disabilities and forensic patients would benefit from giving a more central role to psychological understanding of these conditions (Ryle & Kerr, 2002). Cognitive Analytic Therapy (CAT), for example, is increasingly being used in consultative work with teams with CAT reformulations used to guide care planning and multidisciplinary intervention. This has been applied to a range of areas including: learning disabilities (Lloyd & Williams, 2003); an in-patient unit for people with enduring mental health problems (Carradice, 2004); and older adults with Borderline traits (Hepple, 1999).

Systemic, or contextual, CAT (Ryle & Kerr, 2002) is a way of working indirectly with staff, where problems are often located in the system. ‘We believe that CAT has a major contribution here, offering a distinct, coherent, and teachable model of social and interpersonal interaction which can help individuals and staff groups respond helpfully, rather than collusively, to their patients, and which may have applications outside clinical practice’ (Ryle & Kerr, 2002, p.5).

The behaviour of people with dementia is often described as challenging by caregivers (Swearer et al., 1988). When faced with a situation that provokes fear, the majority of staff experience feelings of powerlessness, unease and vulnerability (Rutledge & James, 2007). Most report coping responses involving rationalising or reframing the event positively, but a small number are resigned to the unpredictability of the behaviour or experience increased wariness (Rutledge & James, 2007).

The attributions staff make and the attitudes they hold about behaviour they find threatening or challenging can influence both their management of clients (Apel & Bar-Tal, 1996; Crichton, 1997) and their relationships.

The importance of changing staff attitudes was recognised in the National Service Framework for Older People (2002) to facilitate the introduction of person centred care. Staff training in person centred dementia care takes account of an individual’s history in order to appropriately address his or her needs. Awareness of a person’s life history can make sense of confusing behaviours, which seem out of ‘context’ and guide a number of creative interventions (Stokes, 2000). It can also help develop so-called ‘thick’ descriptions (White, 2004) that may help to reduce the negative effects of labelling (Crichton, 1997).

Untrained caregivers are guided by their own idiosyncratic perspectives rather than psychologically informed understanding of the underlying causes of any given behaviour. Thus they are unlikely to reflect on and revise their perspectives based on contextual factors around the client’s life history and interpersonal patterns. This lack of understanding can increase caregiver perceptions of burden and subsequently impair their relationships with clients. The ‘social malignancy’ (Kitwood, 1997) that still prevails in attitudes towards people with dementia has been shown to result in outpacing and depersonalisation of clients and invalidation of their emotional experiences. Without space for guided reflection, carer hopelessness and burnout may ensue.
This article offers suggestions on how to develop and use Contextual CAT reformulation with staff in dementia care services. It also integrates some aspects of McGill’s (1993) framework for understanding difficult behaviours in clients with learning disabilities and Kitwood’s (1997) paradigms around person centred care and dementia. When McGill (1993) wrote about challenging environments in learning disability services and the impersonal practises that he had witnessed, he was referring to Kitwood’s (1997) concept of ‘social malignancy’. McGill (1993) outlined a simple three-faceted interactive framework which is both comprehensive and accessible to staff. This may be helpful in building simple formulations around behaviours that caregivers find challenging both in dementia and learning disabilities services.

One part of McGill’s (1993) framework – challenging needs – referred to those features of the individual associated with a higher probability of challenging behaviour occurring. These challenging needs include sensory impairments, need for unusual amount or type of social contact, history of abuse/institutionalisation and communication/comprehension difficulties. A further part of the framework drew attention to challenging environments. Challenges faced may include noisy and un-stimulating environments where there may be poor communication between staff and teams. The final part of the framework is challenging behaviours.

In highlighting the message value or ‘functions’ of challenging behaviours in people with learning disability, McGill (1993) was emphasising the behaviours as understandable manifestations of the person’s relationship with features of their environment and the complexity of their needs. These ‘functions’ might be renamed in CAT terms, as ‘aims’ of the person with dementia, which represent an unmet need; for example, for meaningful activity or emotional validation.

CAT is well placed for looking at the interpersonal and contextual origins of a person’s distress, given that it has concepts that can be helpful in recognising what is going on currently between the client, carers and the environment.

### General CAT concepts

In CAT, the following concepts are used in the assessment to assist in building the reformulation: reciprocal role, dialogical sequence and self state.

#### 1. Reciprocal Role (dialogical pattern)

These concepts were derived originally from object relations theory with the aim of making relationship patterns more understandable (Ryle, 1975). They have since developed with the work of Mikael Leiman who introduced the idea of internalised interpersonal activity in the form of ‘signs’ (language tools and concepts). Ryle (1975) emphasised the dialogic as opposed to the monadic nature of these signs. Reciprocal Roles (RR’s) consist of internal templates representing a role for oneself and a role for another. They can be positive and adaptive, or negative (sometimes abusive), and restricting. In CAT diagrams they are drawn in boxes representing relationships between ourselves (with ourselves) and others, as shown below:

![Reciprocal Role Diagram](Image)

The bottom role is often child derived (e.g. nurtured) whilst the top role represents the adult derived position that the child comes to internalise (e.g. nurturing). In Ruttledge and James’ (2007) study in which fear-provoking incidents occurred during staff-resident interactions, the RR could be drawn as:
Given the reciprocal nature of the dialogical pattern, the top role in this relationship could also encompass the frightening unpredictable nature of environmental events, leaving the client in the bottom role and the carer being experienced as frightening/unpredictable in the top part.

2. Dialogical Sequence (procedure)
This refers to sequences of aims, beliefs, emotions and actions that keep the RR dynamics going. They can either reinforce patterns of RR’s or lead to switches into another RR.

3. Self State
This concept refers to partially dissociated RR’s, where clients might only be aware of one pole of the RR. In more destabilising environments (e.g. noisy, threatening, crowded), system shifts may occur whereby, under extreme pressure or stress, individual team members may reactively ‘switch’ poles in parallel with the clients chaotic internal world. These state shifts are represented in Figure 1 below.

Figure 1: Example of state shift by staff in fear-provoking situation.

X = Switch

Aggression from client ➔ attack staff ➔ staff angry/fearful/pressured ➔ limited space for reflection ➔ (switch in approach)

X
Verbal reprimand

X
Try to reassure

X
Avoid reject

X
Withhold privileges

With different negative consequences, e.g. client feels angrier/invaded/misunderstood/confused.
Thus different members or subgroups of the team may shift between the different poles. For example, a caregiver may want to rescue the person with dementia by over-investment but exasperation ensues leading to him or her giving up and avoiding further contact. Alternately, care staff might enact just one particular role. Without recognition of the potential for response shifts, the risk is that staff are likely to replay the procedures over and again, without the guidance of a framework to understand how to step back from these re-enactments.

**Functions of Sequential Diagrammatic Reformulation (SDR)**

In individual CAT the diagram provides a 'scaffold' for emotional containment and therapeutic focus. In contextual CAT, the secure base of the reformulation diagram and the emotional attunement of the facilitators guiding the process, can provide a space for staff reflection. This in turn can help to identify disowned feelings and re-enacted role repertoires, therefore avoiding unhelpful reciprocations (Lloyd & Williams, 2003). It can enable staff to talk about increasing feelings of pressure and start to recognise shifts in their individual and team approaches. This can enable more understanding of the forces at play behind inconsistent practises.

Ryle and Kerr (2002) propose that systemic CAT reformulation can help identify the potential for team splits, and thus work out system exits for the whole team. Team splitting refers to the different responses (emotional, behavioural, cognitive and relational) made by individual team members. There might be clients whose high level of need and challenging behaviours elicit feelings of powerlessness in staff, leaving them overwhelmed and with limited space for reflection. Consequently, this could lead to disengagement with the client, which confirms their sense of helplessness. In contrast, other staff might be drawn into feeling strongly protective, leaving the client feeling invaded or controlled. Ultimately the staff member may feel defeated by the different approaches of the team and the client’s responses to them.

**Evolving formulations**

Figures 2 and 3 are based on fictitious case examples created from my own clinical experience and incorporate elements of McGill’s (1993) three-factor framework. Figure 2, outlines the CAT formulation of a person who is needing more autonomy and control, who has suffered the trauma of past abuse, and experiences fear and mistrust in her relationships with carers. Thus care is experienced as controlling, in relation to a powerless position. As a result, this person may self-harm or hit out in order to regain a sense of control. Staff exits might be include offering time to listen to the client and encourage ventilation of angry feelings. In addition, adapting care routines to promote greater privacy and independence would enable a more collaborative relationship pattern.

Figure 3 illustrates RR procedures of a client with limited verbal communication skills who seeks more meaningful activity through various behaviours, for example, withdrawing, pacing or fiddling with objects. Given the individuals lack of history and his communication difficulties, staff might offer activities in which the client is unable to participate. In CAT terms, staff relate to the client in an outpacing – outpaced manner, or detach themselves, resulting in an ignoring – ignored relationship pattern. This leaves the client in a cutoff and distant state from others. Some exits might be to engage in wandering with the client and to use appropriate signs/symbols and activities that increase the sense of being with another.

These two examples outline possibilities rather than certainties. In order not to outpace carers, constructing the diagrams usually starts with the RR’s being drawn out.
Figure 2: Example formulation of client requiring more autonomy.

Figure 3.
First meeting with staff
Following introductions, the life history of the resident is a good starting point and is shared and jointly built up with the staff group. Exploring what we do and do not know or do not speak about can help staff to own the conceptualisation/reformulation. In CAT, the idea of what is not voiced by the client is deemed helpful in picking up what types of relationship patterns they might not have experienced. Thus in terms of indirect work, promoting discussion with staff about the life history of the client, including what we do not know, aims to help establish which types of RRs might be present. Education into the type of dementia a client has can enable more confident predictions around behaviours in some cases, in addition to helping staff to reconsider their expectations. It is always important to speak with family and staff regarding a client’s earlier life experiences, which can elicit ideas about the client’s preferences and set the context for understanding apparently muddled or repetitive behaviours.

As the next step I might focus on introducing a context for CAT, starting with some information about RRs. I have found it valuable to explore with staff their aims in working with a particular resident, and how this might differ from the resident’s aims in terms of challenging behaviour. This can help to highlight and validate staff behaviours and intentions, increasing awareness of how our own interactions can replay unhelpful procedures. Moss (2007), makes an important point when he describes how the system never refers itself for help. Asking about our aims as professionals can help create more ownership of the systemic needs and highlight unrealistic or vague expectations (e.g. ‘making the client better’).

Another question that I have found useful to ask is ‘What can we realistically expect from this client, given their cognitive abilities, and life history?’ This enables us to reflect on where we might be outpacing clients, leading to pressuring-pressurised RRs. Thinking with staff about the advantages and disadvantages of the behaviour (Fossey, 2005) has been helpful in encouraging people to think beyond the behaviour itself. White (2004) talks of thinking beyond ‘thin’ descriptions (for example, attention seeking), to richer understandings (for example, prone to boredom, and needing a higher level of stimulation and social interaction). It is important to offer a follow-up session to staff to avoid old patterns of interaction re-emerging (Fossey, 2005).

‘We should not work with the client where the client cannot be’ (Mikeal Leiman, 2003)
Some clients are psychologically difficult to reach or are too fragile to confront the painful reality of their history. This can also apply to; working psychologically with staff groups, destabilising environments, constant National Health Service reforms that outpace and other pressures. These factors sabotage the possibility for contextual working with teams. Working in East Suffolk, the issues that have been significant in aiding indirect work with staff have been the support of the nursing home manager, the willingness and robustness of the staff group to learn about psychological concepts and reflect on their own practises or feelings in relation to clients. High staff turnover and resistance to external training have been contra indicators to commitment to this work.

Conclusions
The type of work that I have been doing, with the support of an Assistant Psychologist over the past 14 months, has been well received in some nursing homes, with mixed reactions in others. It has helped to stimulate staff reflections about their relationships with residents, and promoted dialogue around feelings and possible system exits. Whilst formal evaluations of this work have not been undertaken, qualitative approaches would enable us to deepen our understanding of what factors help the joint development of the reformulation, and how staff’s narratives of residents’ behaviours might
evolve. A tracking tool could be developed to establish team splits. Team members could complete a questionnaire similar to the psychotherapy file (a questionnaire used in individual therapy; Ryle & Kerr, 2002) at both initial stages and follow up. In situations where there is a high level of expressed emotion in staff and/or system change, the use of CAT letters with staff groups (which include the Psychologist as part of the staff group) might be useful to trial, as a first attempt at containment and engagement.

CAT offers a powerful explanatory framework for team shifts and splits, providing clarity for carers in their conceptual understandings, whilst not losing sight of their human relationships with residents. This paper does not suggest a revolutionary approach but it aims to highlight some of the possibilities of using CAT reformulation when working with care staff.

Acknowledgments
I would like to thank Clive Sims and Elizabeth Stephens for their helpful comments and Léonie Wing for formatting the diagrams.

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Growing from a kitten: My experiences whilst completing a Postgraduate Diploma in Cognitive Analytical Therapy

Liz Carter

Developing my interest in Cognitive Analytical Therapy

In September 2005, I was lucky enough to be given the opportunity to commence the two-year postgraduate diploma in Cognitive Analytical Therapy (CAT) at the University of East Anglia (UEA). I had developed an interest in CAT following my job as an Assistant Psychologist in Huntingdon, where there were a range of practitioners who regularly carried out the approach. My interest developed further whilst I was a Trainee Clinical Psychologist at the UEA between 2000 and 2003. I had a specialist CAT placement in my final year of training in Huntingdon Adult Mental Health Service, under the supervision of Annette Newton, Clinical Psychologist.

After qualifying, I gained a full-time position in the Older People’s Service in the Fenland area of Cambridgeshire and Peterborough Mental Health Partnership NHS Trust. I began to use CAT with the older adult population, again having regular supervision in Huntingdon. During this time, I was encouraged by the way in which older adult clients engaged with the approach and how important the use of a reformulation letter, providing a narrative for their difficulties, appeared for them. I was keen, therefore, to apply for the postgraduate diploma in the spring of 2005.

The application process

After submitting my application I was called for interview in the June and I was offered a place a few weeks later. This was a relief in itself as, throughout the summer of 2005, education budgets within NHS Trusts were being cut and it was not clear whether there would be a great enough number of successful applicants, with sufficient funding, for the course to be run. Nevertheless, it was, and I felt incredibly lucky to have the course funded by the Trust. I believe this was due not only to being in the right place at the right time, but I also argued my case for further CPD training almost immediately after starting my job, and I had a very supportive boss!

The course structure

Academic component

The course involved attending four teaching days throughout October, 2005, and then one day a month until June, 2006. We had a summer break, and then we were required to attend another teaching day each month running from October, 2006, to July, 2007. Each teaching day involved being taught by an external speaker introducing the basic components of CAT in the first year, such as target problems, target problem procedures, reformulation letters, sequential diagrammatic reformulations and goodbye letters. We also attended seminars at the end of each teaching day, which involved discussing each of these components in relation to our clients. Throughout the second year, the teaching topics specialised around, for example, dialogism, CAT and psychosis, CAT and adolescents and CAT in groups, which allowed us to create a broader breadth of knowledge in the application of CAT.

Overall I am pleased to say that travelling the four-hour round trip to Norwich for these days was well worth it, especially during the second year. I was privileged to have had the opportunity to hear Ian Kerr, Steve Potter, Laura Sutton and Alison Jenaway.
In addition to attending at least 80 per cent of the teaching days and seminars, as part of the course requirements and also those of the Association of Cognitive Analytic Therapy (ACAT), there was a high academic component to the course. Within year one, we were required to pass an academic essay (5000 words), two taped process reports (2000 to 3000 words) and one case report (4000 words). Within the second year we were required to complete two further taped process reports and a case report. This, I have to say, was the worst part of the course. Even though most of the coursework was based around the clients I saw in my day-to-day practice, a huge commitment was needed to carry out the academic component outside of work time. I had not researched widely enough to realise that there are many types of courses for those interested in CAT. Practitioner courses are run in London and Oxford, for example. Here the academic requirements are less and they too lead to accreditation from ACAT. As Agenda for Change does not stipulate what level additional training needs to be for Clinical Psychologists… I urge others to bear this in mind!

Nevertheless the amount of further reading one carries out whilst doing the diploma is up to each trainee. I certainly found the introductory text by Ryle and Kerr (2002) invaluable in answering the question ‘Well how do I do it then?’ and Ryle’s earlier text (Ryle, 1995) gives a sound introduction to the theoretical basis of CAT.

**Clinical component**

Besides the academic element, the diploma also required you to complete eight CAT cases. Ideally these would have been in the form of 1 x 8 session CAT, 1 x 24 session CAT and 6 x 16 session CAT. Few of us, however, found the opportunity to do an eight session CAT due to working within secondary health care settings with more complex cases. Therefore, many of us, including myself, saw an extra client for 16 sessions. Whilst working with these cases, you need to be supervised on a weekly basis by an accredited ACAT supervisor. In my local area, there are not many of these but again I was very lucky to be supervised by Alison Jenaway, Consultant Psychiatrist. I was part of a group of three to five other CAT trainees and the groups were invaluable as part of the learning process. ACAT allow you to use two clinical cases prior to commencing the course as part of your eight, again as long as an accredited ACAT supervisor supervised these. I took advantage of this. All of my cases were seen within the Older People’s Mental Health Service. The main presenting problems were depression, anxiety, care related stress and difficulty adjusting to impending old age. None of my clients dropped out and all subjectively reported benefiting from the therapy! For example, one client said ‘She felt like a completely different woman.’ Another reported she had never been able to relate to others the way she was now able to. One gentleman, however, was content with having gained an understanding of his difficulties and knowing what he would need to do if he decided he was ready for change. Looking back, I recognise I did not undergo therapy with a client formally diagnosed with a ‘personality disorder’ and I wish I would have had the opportunity to work with this challenging group using CAT. My clients were mainly on the neurotic continuum and I feel this limited my learning experience. I believe, therefore, I need to see a wider range of client’s before I would call myself confident in using the approach across the whole range.

**Experiencing CAT first hand**

The final element of the course was the option to have your own personal therapy. Completing a course of therapy was not required in order to obtain the postgraduate diploma but it was required to be accredited as a CAT practitioner by ACAT. I relished this opportunity and underwent a soul-searching experience during the beginning of my second year of training. Experiencing
each component of CAT first hand was invaluable as a trainee and it also helped identify my own reciprocal roles and procedures and how they might impact on my practice. I know from my experience whilst training as a clinical psychologist that personal therapy is not a pre-requisite for qualifying, but following my experience I believe this ought to be encouraged! Experiencing how a client feels during each stage of therapy can only serve to increase our awareness of the dynamics that occur between therapist and client. Being on the other end of the power differential is enlightening. Finally being aware of our own ‘psychology’ can help us distinguish what the client and what we as therapists bring to therapy. Without this, there may be a tendency to attribute any difficulties in therapy towards the client and this would become unhelpful in the therapeutic process.

Final thoughts
Overall, despite the long drives, the huge amount of coursework and the constant thinking about CAT for two years, I am so pleased I was given the opportunity to do the course. I have benefited so much professionally and I now feel as though I am becoming a ‘specialist’ in something rather than feeling the ‘jack-of-all trades and a master of none’ newly qualified psychologists often feel. The question that remains is where do I go from here? I hope I will be able to continue attending my supervision group, however places in these groups are limited and as new cohorts begin the course, those who have already qualified may lose their place. This then leads to problems for further professional development. If I want to become an accredited ACAT supervisor to help reduce the shortage of supervisors, I am required to see another 12 clients under supervision, observe a supervision group for six months and then run a supervision group myself. As you can see, this will require a lot of time and commitment on behalf of my NHS Trust and myself, and in the current climate all I can do is watch and wait!

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In 1996, I reported a piece of research on elderly mentally disordered offenders (EMDO's) in this newsletter (Sims, 1996). A survey of arrests, probation orders, detention on any section of the Mental Health Act (1983) including S136, and informal admissions for a period of six months produced a zero return of older adults with mental health problems who had committed offences. Indeed, of all the arrests recorded very few were of older adults, confirming the adage that crime is a young person’s activity. More recently, Barak et al. (2004) found that only about one per cent of crimes were reported as having been committed by men over 65 years of age. As might be expected, within weeks of the study being completed a murder was committed by an elderly man, who was subsequently found to have advanced cerebrovascular disease. A short time later, there was an attempted murder by a gentleman originally thought to be suffering from Paraphrenia but later found, following neuropsychological assessment, to have atherosclerosis. Since then, in the 10-year period to date, only two older adults have been referred to the local Forensic Psychology Services. Of those, one was a former Special Hospital patient who was causing concern but, in retrospect, did not require specialist forensic intervention whilst the other was a patient alleged to have committed Grievous Bodily Harm, where there was no evidence of psychological or neuropsychological disorder, and where the legal defence was self-defence.

A survey of the very sparse literature on EMDO’s from the UK and the US presents a similar picture to that at the time of my first paper. Even when the varying definitions of ‘elderly’, from 45 to 65, are taken into account both the absolute numbers and the relative numbers to the total offending population in the UK remain low (Home Office, 2007). Indeed, there is an overall uncertainty regarding the true extent of crime committed by older persons. Natu, Mahomed and Shah (2005) put forward several possible explanations. These included, the possibility that much of older adult crime remains undetected, and where it is detected, it may not be reported due to reluctance by the general public to report older adults, who may be perceived as being ill or frail, to the police. Even if they are reported, the Criminal Justice System (CJS) is usually only willing to prosecute if it is in the public interest, i.e. more serious crimes. Minor offences are usually discontinued. Where there is a mental disorder present, Home Office circular 66/90 encourages the diversion of mentally disordered offenders from the CJS wherever it is possible. As Taylor and Parrott (1988) demonstrated, even where older adults were proceeded against they were likely to be treated leniently. The record of overall offending rates, therefore, is likely to be particularly unreliable.

The older adult who commits a serious offence is rare and it is those who are likely to become the subject of offending statistics. Statistical data show that the conviction rate for older adults has remained stable over the past ten years (Home Office, 2007). There is evidence, however, to suggest that change is occurring, although in part this change has been artificially generated as a result of legal changes over the past 10 years. Despite the stability of conviction rates, the number of older adults in the prison population almost quadrupled between 1990 and 2002.
The main reason behind this seems to be changes in sentencing practice. Whereas, in the past older adults tended to be treated with greater leniency, there is some evidence, particularly from the US, to suggest that they are now treated with equal severity if not more severely than younger offenders for similar offences (Yorston & Taylor, 2006). This is particularly apparent in the area of sexual offending, and reflects the greater knowledge and understanding which we now have in comparison to nearly two decades ago when Taylor and Parrott (1988) produced their paper. The advent of indeterminate life sentencing (Criminal Justice Act, 2003), where the prisoner has to satisfy the Parole Board that he or she is no longer a threat to public safety, has and will result in an ageing population of prisoners who have committed very serious offences. Indeed, violence is a feature of 10 per cent of elderly offences (Barak et al., 2004).

Whilst crime is not a mental disorder, nor is it evidence of one, the prevalence of mental illness among elderly offenders is higher than among younger age groups who offend. Also, there is evidence, albeit in a younger offending population, that the mentally ill have an increased vulnerability to detection and arrest when compared with non-mentally ill offenders (Robertson, 1988). Needham-Bennett et al. (1996) found that 26 per cent of older adults arrested in Essex had a diagnosable mental disorder. There is also evidence, for example, Hucker and Ben-Aron’s (1985) Canadian study of sex offenders, to suggest that mental illness is more prevalent amongst those older adults who commit serious crimes such as sex offending, violence and murder than within the younger offending population who commit similar crimes. It is these crimes that attract the higher tariff prison sentences, including indeterminate life sentences, or detention and possible restriction under the Mental Health Act (1983) in secure forensic psychiatric units. O’Sullivan and Chesterman (2007), in a study of 282 older adults, subject to Home Office restriction orders in Special Hospitals or Medium Secure Units, found significant differences between those who had committed their index offence below the age of 60 (N=245) and those who had committed their offence over that age (N=37). The patients in the older group were less likely to have previous convictions and, whilst functional mental illness predominated in both groups, there were marked differences in the diagnoses at the index offence. The older group, tended to have diagnoses of delusional disorder, depressive illness or dementia, whilst the younger group, were likely to have been diagnosed with some form of personality disorder. Interestingly, 75 per cent of the former group showed no sign of cognitive impairment on neuropsychological assessment. Of the two groups 43 per cent were awaiting step-down transfer to conditions of lower security.

The implications of an ageing prison population and an ageing population subject to restriction orders are significant to mental health services and particularly to forensic mental health services. Prison inreach services, which frequently come under the aegis of forensic psychiatric services, have usually worked with adult or younger adult prisoners experiencing mental health problems. Low secure forensic units, to which step-down restricted patients will eventually be admitted, will usually only accept adult patients (18 to 65 years). The question is, therefore, whether existing services can meet the needs of the elderly offender or whether specialist service provisions are required? At present, the jury is out. More research is required but, undoubtedly, there are already major training issues to be addressed. Within clinical psychology, the majority of forensic clinical psychologists have limited experience of working with older adults, whilst psychologists specialising in working with older adults have little experience of offenders, particularly those who have committed serious offences, and of the Criminal Justice System. There is, perhaps,
a case for a joint working party from PSIGE and the Faculty of Forensic Clinical Psychology to explore the needs of older adults who are incarcerated or in secure psychiatric units and how those needs may best be met in the first part of the 21st century. As the population ages, there will be a growing need for psychological services for older adults who offend. As a profession, we should be ready to address that need.

References


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Peterborough Cathedral at night, printed with kind permission of Peterborough Cathedral Chapter.
Dr Rostock’s Journey
Jack Alster
Published by Mike Wilson, Burstall Hall, 40 Ridlington, East Yorkshire, YO16 7GA.

Reviewed by Cath Burley

As a prequel to his earlier autobiography *Once we had a Country* (reviewed in an earlier PSIGE newsletter), Dr Jack Alster has written the biography of his father-in-law. Part fact, part fiction, it traces Dr Rostok’s footsteps in a 4000 km walk across Europe. As a member of the Austrian army, he was captured by the Russians and held in a prisoner-of-war camp near Murmansk, from where he walked to Olovo (southern Yugoslavia). The story embellishes the family narrative told to Jack and his wife, Ann, by summarising romantic encounters along the way. Ann idolised her stern, intelligent doctor father. Jack on the other hand, approaches the story with his zest for life, the search for a romantic, even passionate engagement and subjugation in a relationship. There is the tendency to focus optimistically on the positive – and the touching searching for an idealised father figure already revealed in *Once we had a Country*.

Although writing about the beginning of the last century, the themes of war, subjugation, exile and the intense desire to belong to a new community are common to the Eastern Europeans joining our cities today. In his writing, Jack continues to make sense of the narrative of his life and to voice the needs he recognises have steered his life. Although written as a biography, there are echoes of Jack himself who comments: ‘brood, speculate, look inside yourself instead of out and you were done for’ (p.7).

In his relationship with the farmer’s wife, Dr Rostok had to make himself indispensable by working very, very hard but at the same time he must not arouse feelings of guilt by getting too friendly with the woman. In the story, the interpretation and reinterpretation of other’s thoughts and motives creates a fantasy life that was perhaps a necessity for sanity on this journey.

In Jack’s account about the boy thief, he transposes his own need for a father. ‘We are winning respect for each other, as time goes by – he reminds me of a ‘father’ and my admiration for him grows every day’ (p.25). Gradually the father-son relationship gelled, ‘slowly they’d got to trust each other, to share everything, even their thoughts and a sort of love had developed’ (p.27). There is a sense of over investing in relationships, of attributing, to them, too eagerly, everything. Then comes the hurt and deep despair of rejection or being let down when the fantasy world does not match with reality. Yet throughout Jack’s innate optimism about people or the future is attributed to his father-in-law. Is this religion or luck?

On approaching home, he broods: ‘Of course, there was the distinct possibility that some other man was now sitting comfortably in HIS kitchen and petting HIS wife and hugging HIS daughter’ (p.42). As Dr Rostok reaches home, he vacillates about whether or not he should actually confront fantasy with reality and face his fears.
The life story and the journey continue and further fears are faced and overcome, including the fears of pain, death and loss. The writing of the book draws together themes from Jack’s own life and his reflections about facing the future in a poignant and powerful way.

About the author
Jack has a PhD in English literature and is a member of the Writers in Peterborough group. Following a stroke some years ago he lost confidence in his ability to write and became quite depressed. He had very much wanted to have his name in print but felt that editors should accept his work on merit. He had a number of setbacks in achieving this. After some discussion in therapy about the importance of telling his story, Jack made the decision to publish the story of his move from the Viennese Ghetto to England during the war – *Once we had a Country*. This was well received and he went on to write and publish this account of his father-in-law’s story.

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Peterborough Cathedral, west front, printed with kind permission of Peterborough Cathedral Chapter.
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Notes for Contributors

Articles
Contributions in the form of short articles on any aspect of psychological theory or practice with older people are always welcome. As the Newsletter aims to cover a broad, cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication.

Articles should be submitted three months before publication (i.e. October for the January issue, January for the April issue, April for the July issue, and July for the October issue).

Research Updates
The Newsletter is particularly keen to publish contributions concerning ongoing research. These can reflect any stage in the research process, e.g. ideas for discussion or early stage results, which are not ready for formal publication. Try to keep them below 500 words.

The Editorial Board reserves the right to make minor changes to any submissions. Where major editing is necessary, the authors will be informed. All contributions must be typed.

Images
The Newsletter is published in black-and-white. It is not advisable to send complicated, colour diagrams. If you are unsure, try printing the image or photo out on a mono laser printer to check for clarity.

Please send original image files (.tif, .jpg, .eps or the like), not simply a Word document with the pictures imported into it, as these do not print properly.

Submission Procedure
Please submit articles as a Word file via e-mail to aja3@st-andrews.ac.uk
Language should be inherently respectful to older people and consistent with the British Psychological Society's guidelines. Formatting should be consistent with the Society's guidelines.

When submitting articles please send the following information:
  - Full name;
  - Affiliation (title, place of work);
  - Contact details (should you be willing to be contacted by the membership);
  - Acknowledgements (as appropriate).

Finally, if you are reporting research, please indicate whether or not Ethics Committee approval was awarded, and by which Ethics Committee, or whether the work was carried out as an audit/service evaluation project.

Letters to the Editor
The Editor welcomes correspondence which combines brevity with rational argument. Letters may be edited if more than 250 words in length.

All contributions should be sent to: aja3@st-andrews.ac.uk
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