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Psychology Specialists Working With Older People

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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Letter from the Editor

Louisa Shirley

YOU WILL BE AWARE that our Chair, Don Brechin, has been working hard to clarify the relationship between PSIGE and the British Psychological Society, including the printing and distribution of the PSIGE *Newsletter*. Happily, this situation has been resolved and back copies of the *Newsletter* are filtering through for production. Many apologies for those of you who have been waiting for the appearance of your submissions in print, and, to those who have submitted more recently – bear with me and I'll be in touch.

This edition has been jointly edited by myself and our outgoing editor, Arlene Astell. The papers reflect the breadth of work we undertake in our roles as psychologists working with older people, and it has been interesting to reflect on this during local and national discussions about amalgamating older people's and working age services. Lincoln, Bauman and Radford describe a further validation of their proposed cognitive test battery which has the potential to help standardise the way in which decisions about driving are made, and highlights the need for further clinical information to be taken into account. Dansey and Leonard report on the success of a memory group which has developed in line with the government's increasing emphasis on the promotion and maintenance of independence in dementia. Their work highlights one of the challenges of this area – the effective measurement of the psychological gain made by the attendees. Both of these pieces of work illustrate the client-group specific expertise held by psychologist working with older people in addition to their generic psychology skill base as clinicians and researchers.

Anne Crawford-Docherty and her colleagues examine the issues surrounding discharge of older adults from a day hospital service and the need for this to be well-

planned. The notion of 'graduation', which suggests successful completion of a stage in one's life is applied to the process of moving on from Day Hospital to counter the negative perceptions of loss often associated with this transition. The article highlights the key issues to be addressed in good discharge planning and provides useful tips and advice for readers providing similar services.

One paper sure to attract interest is that by Penny Garner and Oliver James on their SPECAL method. This approach has attracted a lot of media attention on the back of a book written by Penny and Oliver and has been adopted by a number of care providers. However, in the absence of scientific evidence to back up the authors' claims, SPECAL has been greeted with scepticism and also concern from the psychological community. Hopefully this article will enable reader's to make up their own minds about the claims made for this approach and enable them to respond to queries from dementia care providers about this approach.

The paper by Mike Lewis and his colleagues summarises research they have carried out in Northampton examining the way that older people cope with life's challenges, with particular emphasis on the role of religious beliefs. The findings suggested that a faith in humanity and belief in the basic goodness of humans were strong predictors of happiness and satisfaction in later life with religion and spirituality less prominent as coping mechanisms.

Finally the research update by Katherine Berry and her colleagues reports the establishment of a study in Manchester to examine the efficacy and cost-effectiveness of a nurse-led psychosocial group for older adults with schizophrenia. I am sure this will be of interest to many readers who will avidly await the findings.

Goodbye from Arlene

In signing off I would like to say how much I have enjoyed receiving and reading the many and varied submissions to the newsletter over the past two-and-a-half years and to wish Louisa all the best in taking the *Newsletter* forward.

Changes

I would like to say thank you to Arlene for her time as Editor and introduce myself as the new Editor.

I originally trained as a nurse for people with learning disabilities in Northumberland before doing my undergraduate degree at Durham University as a mature student. I then completed a PhD in child development at Durham before qualifying in Clinical Psychology from Teesside University in 2003. I have been working in Northumberland County Challenging Behaviour Team for the last three years.

My decision to apply for the *Newsletter* editorial position is a direct reflection of my learning style – if I don't have a deadline to read something, it doesn't get read. Therefore, this seemed like an ideal opportunity for some CPD under pressure as well as a way to make a contribution to the PSIGE group. Another opportunity this brings is the possibility of introducing some differences in the *Newsletter* and gauge the support for the changes.

We currently produce four *Newsletters* a year – January (Regional), April (Open content), July (Regional) and October (Conference) – the content of which depends (generally speaking) on the submissions received for each copy. I am proposing that we introduce a themed edition of the *Newsletter* on an annual basis to replace one of the regional editions.

This special edition would be centred around a specific topic, and ideally have articles with different emphases around this topic. For example, there may be one or two

pieces of original research, a description of service development or audit, a literature review, and case study/studies. This type of format might encourage trainees to write up their small-scale research projects, and submit their literature reviews or case studies. I would hope to include some commentary on the topic from either within the PSIGE group, or an external commentator. Possible themes might be personality disorder, grief, behaviour that challenges, organisational change, or working with families.

In order to retain the regional feel of the *Newsletter*, I would suggest that this edition feature one of the regional groups for a 'Spotlight' article which would consist of a report of the region's activities, developments, and have key addresses and contact details for people to follow through a mutual interest. Many PSIGE members publish externally to the organisation, and it may be also be useful to have a section highlighting these publications.

Since sending these suggestions out through geographical group convenors, I have received very positive responses and a number of suggestions for themes. As we are still catching up with getting the *Newsletters* printed and sent out, I can't be certain when the first themed edition will appear. Two areas of interest expressed so far are in personality disorder in older adulthood and sex and sexuality. Could potential contributors who may have something to add to these topics get in touch soon.

In the meantime, please continue to submit papers to louisa.shirley@ntw.nhs.uk and I would be very happy to hear of ideas for themed editions. If you belong to a group with a special interest, submit a few papers and I'll try and chase up the rest ... Failing all that, I'll be on the telephone calling in favours, so watch out for me!

Louisa

Letter from the Chair

Don Brechin

Hello everyone.

In your previous newsletter Sinclair wrote his last letter as Chair. At that time, the national committee had decided to proceed with the annual conference and we were looking forward to meeting up in Cardiff. What a lot has happened since then!

Hopefully, you will have received my letter via the geographical group circulations updating you as to the reasons for cancelling the conference and subsequent communications with the subsystems office regarding access to the Society's office services. These events led to the national committee and geographical group leads having discussions as to how to move forward in the short and medium term, and some significant decisions were made. These issues were summarised in my letter to you and I would like to thank those of you who e-mailed me in response to this. Your comments were very helpful and much appreciated.

In November the national committee met with Mike Laffan (British Psychological Society Director of Corporate Services), Russell Hobbs (British Psychological Society Treasurer) and other office staff to agree: (i) the amalgamation of PSIGE bank accounts into the Society's financial system; and (ii) the transfer of the PSIGE database into the Society's membership database. The membership database has now been transferred over successfully to the Society and newsletter printing and mailings has recommenced! The transfer of bank accounts will take place during this year and our treasurer (Alice Campbell) will be in touch with geographical group treasurers regarding this process and the new systems for accessing your local monies.

The national committee has been taking the opportunity to re-visit PSIGE's priorities and strategy for the coming year and I have also been liaising with DCP colleagues and other partner organisations to determine where strategic linkages may be of benefit to us. We will discuss these developments during the January national committee meeting and we will be in touch with you after this regarding our proposals for how to move forward this year whilst ensuring that we remain on a secure financial footing.

In the meantime, normal activities are going ahead. CPD events are being organised locally and nationally, and plans are going forward for the one-day annual conference/AGM on 1 July this year and the two-day annual conference in Scotland in 2011. We continue to respond to policy consultations sent through the Society, and we are fielding members for national committees (e.g. the Memory Services National Accreditation Programme – thanks to Sue Watts and Esme Moniz-Cook for agreeing to sit on the accreditation committee).

So, all that remains to say from me is Happy New Year!

Don

Discharge from day hospital: An alternative perspective based on recovery and social capital

Anne Crawford-Docherty, Eleni Theodosi, Bal Chauhan,
Julie Clift, Dawn Fallon, Roberta Hall, Gurdave Kumar,
Jan Liddell, Jean Tibbetts & Suzanne Whitehouse

The challenge of discharge

DISCHARGE from services presents as a challenge for many organisations, and none more so than older adult mental health services. Walker, Hogstel and Curry (2007) stated that, often, the numerous and complicated needs with which older adults may present can make discharge planning complicated. More recently, Prowse and Coombs (2009) commented that, particularly for those people that have been in the service for a long time, discharge is often 'ad hoc' (p.13), rather than carefully thought about, and that often service users are seen by professionals for longer than is 'clinically required' (p.13).

It is important that discharge is well-planned so that the potential negative impact of hospitalisation, for example, can be minimised (Amador et al., 2007). However, this is often not borne out in practice. As services become recovery focussed, services and the managers that are responsible for them, need to adjust their practices (Prowse & Coombs, 2009), moving from targeting symptom reduction and coping skills to incorporating community re-engagement and maintaining well-being. Day hospitals are often considered to provide an important pathway to the community from inpatient wards (Janes & Trickey, 2005), yet older adult service users often stay in day hospital services for significant periods of time. Why is this so? Perhaps the staff do not perceive a need for the service user to move on, or perhaps the

service user doesn't think they are 'ready'. Alternatively, the service user (and his/her family) may be deemed too anxious about the prospect of discharge for this process to be fully realised, and then become labelled 'dependent'. Anxiety on the part of the health professional may also be common and should not be overlooked as a factor. Staff may lack the skills and interventions, or the confidence to facilitate moving on. Indeed, discharge may not be discussed until it is almost looming because it is perceived negatively, specifically as a loss. Ideally, it should be seen as a reason to celebrate as a marker of recovery – a 'graduation' (Janes & Trickey, 2005). It is likely that difficulties discharging older adult service users are actually a manifestation of some, if not all, of these factors.

Recovery

In searching for literature about recovery in older adults, the absence of narrative about mental health and recovery is striking, with literature typically referring to recovery from physical health conditions. When specifically exploring literature about recovery and mental health, all of the articles retrieved related to the working age population. As such, it remains to be seen whether this work will generalise directly onto work with older adults.

Brown and Kandirikirira (2006) encapsulated the concept of recovery as 'embracing the identity and self-determination of a

healthy and hopeful person, rather than living the life of an ill person' (p.4). Recovery has been described as an experience, a process and a model but the precise definition of each of these is not consistent across the literature. Davidson and Roe (2007) believed that the inconsistencies evident in the use of the term 'recovery' derive, in part, from the inadvertent combining of two different conceptualisations; recovery 'from' and recovery 'in' mental health problems. Recovery **from** mental health problems is 'the amelioration of symptoms and other deficits associated with the disorder to a sufficient degree that they no longer interfere with daily functioning, allowing the person to resume personal, social and vocational activities within what is considered a normal range' (p.461). In contrast, recovery **in** mental health problems 'does not require remission of symptoms or other deficits, nor does it constitute a return to normal functioning. Rather, it views mental illness as only one aspect of an otherwise whole person ... Recovery refers instead to overcoming the effects of being a mental patient ... in order to retain, or resume, some degree of control over their own lives' (pp.461–462).

Jacobson and Greenley (2001) differentiated between internal and external conditions of recovery. Internal conditions include the individuals' attitudes and change processes, whilst external conditions relate to the policies, practices and events that facilitate recovery. These conditions together constitute the process of recovery and have a reciprocal effect on each other. Key internal conditions are hope, healing, empowerment and connection. These elements are found in many professional and service user derived accounts of recovery (e.g. Bonney & Stickley, 2008; Mead & Copeland, 2000; Ridgway, 2001). Hope is regarded as a key ingredient, especially in terms of individuals' and professionals' belief that recovery is possible (Ahern & Fisher, 2001).

Healing relates to recognising one's self beyond mental illness and to regaining a

sense of control. It involves 're-discovering' one's self by establishing a relationship with the mental health problem as one aspect of the self, not as the only aspect of self. Control is evident in the individual becoming an 'active agent' in their life again and in taking control over symptoms and stress. Such 'active coping' (Ridgway, 2001, p.338) involves the development of personal self-help strategies, resources and coping skills. As Mead and Copeland (2000) state, '[w]hen our perspective changes from reaching out to be saved to working to heal ourselves and our relationships, the pace of our recovery increases dramatically' (p.318).

Empowerment can be conceived of as 'a corrective for the lack of control, sense of helplessness, and dependency that many consumers develop after long-term interactions with the mental health system' (Jacobson & Greenley, 2001, p.83). Service users take more responsibility for themselves, especially in terms of setting goals, taking steps to reach those goals and engaging in self-care, moving away from being passive recipients of care to being experts because of their experience. Self-management is achieved through service users being empowered to develop those strategies that suit them, that are derived from their own experiences and strengths. A key example of such an approach is Mary Ellen Copeland's Wellness Recovery Action Plan, a system developed from her own tools for everyday living (Davidson, 2005) and the basis of our day hospital WRAP group (Bywater & Hartley, 2006). Connection is based on the recognition that recovery is a social process, involving recovering ways of being with others or building a life. Connection is about finding roles to play in the world. Such connection can also reawaken a sense of meaning and purpose in life derived, in part, from making contributions to others (Ridgway, 2001).

Recovery, therefore, involves 'living a full, free, and self-determined life' (Davidson & Roe, 2007, p.466) either beyond or with one's mental health problem. Services

promoting recovery therefore need to focus on facilitating the reclaiming of life through 'enhancing the person's capacities for living with, managing and pursuing his or her own life' (Davidson & Roe, 2007, p.466), rather than a narrower focus on symptoms and functioning.

Social capital

According to Putnam (2000) 'the core idea of social capital is that social networks have a value ... social contacts affect the productivity of individuals and groups' (pp.18–19). Social capital includes social networks, norms of reciprocity, social support and social trust (Ferlander, 2007; Islam et al., 2006). It facilitates certain actions of individuals within the social structure (Coleman, 1990) and has three key characteristics. First, social capital generates positive external benefits and relationships for group members; secondly, these are attained as a result of shared trust and norms and, in turn, their effects on expectations and behaviour and, thirdly, these shared norms and values derive from informal social networks, association and organisation (Durlauf & Fafchamps, 2004). Social capital can be analysed at four different levels; macro (e.g. countries), meso (e.g. neighbourhoods), micro (social networks of individuals) and individual psychological (e.g. trust) levels (Islam et al., 2006). Our work has focused on the micro and individual psychological levels; at the micro level there is limited research about how to facilitate moving on from older adult services (Janes & Trickey, 2005).

The concept of social capital has been broken down into many forms. 'Structural' and 'cognitive' refer to objective and subjective elements of social capital. **Structural** refers to structures and social connections, for example, roles, rules, networks and institutions. **Cognitive** social capital refers to values, attitudes and beliefs that produce cooperative behaviour (Colletta & Cullen, 2000; Ferlander, 2007). Direction of ties and levels of formality have also been used to

differentiate different forms of social capital (Ferlander, 2007). Horizontal and vertical ties refer to egalitarian and hierarchical relationships respectively, whilst informal and formal connections reflect friendship and family connections and connections with organisations.

More recently distinctions have been made between 'bonding' and 'bridging' capital. **Bonding** social capital is derived from networks of similar people, which tend to be inward-looking whilst **bridging** social capital derives from linkages between groups and is outward-looking (Ferlander, 2007). Bonding capital is important for establishing social norms, producing reciprocal helping relationships and protecting the vulnerable (Islam et al., 2006). Bridging capital provides the opportunities to interact with heterogeneous groups of people. The value of different forms of social capital has been summarised by Briggs (1998), and, therefore, will not be covered extensively here. However, bonding social capital is vital for 'getting by' whilst bridging social capital is crucial for 'getting ahead'. It is this differentiation and potential that we aimed to harness in our recovery work in Sandwell.

According to Putnam (2000), in no other area of outcome 'is the importance of social connectedness so well established as in the case of health and well-being' (p.280). Indeed, Durkheim (1897), in his study of suicide, was one of the first theorists to posit a link between social structure and psychological health. He found that the higher the level of social integration in a population, the lower the level of suicide. McCulloch (2001) was interested in whether level and amount of social capital were related to mental health difficulties and found that men in the low social capital groups (level of social capital was determined using responses to eight items about their neighbourhoods) were nearly twice as likely to reach 'psychiatric caseness' (assessed through the General Health Questionnaire (Goldberg & Williams, 1988)) compared to men and women with higher levels of social

capital. Furthermore, in a recent systematic review of quantitative studies examining the potential link between social capital and mental illness, De Silva et al. (2005) found a strong inverse association between levels of cognitive social capital and common mental health problems such as anxiety and depression. Higher levels of social capital were associated with lower risk of developing mental health problems. Studies have also demonstrated an inverse association between structural social capital and common mental health problems as well as structural social capital and risk of developing common mental health problems. The dominant view regarding bonding capital is that, in the main, it is good for mental health. However, strong bonding social networks, where external information rarely penetrates, can promote unhealthy norms of behaviour (Berkman et al., 2000). Whether the 'human tendency to follow one's peers' (Ferlander, 2007, p.122) is helpful or harmful depends on the norms held by the network. Cattell (2001) found that restricted networks were associated with poorer health, as rated by participants. However, higher levels of bridging capital and, thus, more diversified networks, are associated with better mental health (Erickson, 2003; Mitchell & LaGory, 2002). Ferlander (2007) suggests that bridging capital may provide access to a range of resources and information, enhancing the ability to problem-solve and exert control over circumstances.

So, it seems that different kinds of social capital have different implications for mental health. Social capital may then be part of the problems and solutions in relation to mental health problems (Kunitz, 2001). A balanced distribution of different forms of social capital, especially bridging and bonding, can promote a healthy society (Ferlander, 2007). Increasing social capital could be said to contribute to recovery from and in mental health problems through re-establishing connections with life outside of mental health services and, thus, reclaiming one's sense of self.

The day hospital

On admission to the day hospital, much focus is on developing the 'bonding' of the new client with services and people with mental health problems. As individual clients' recovery progresses, the focus needs to shift to them bridging into other social groups as means of rediscovering their whole sense of self, moving beyond an identity of mental health patient. Older adults experience great reduction in their social networks as friends and family pass away (Anderson & Warner, 2005). Interventions based on concepts of bridging could address such reductions in social capital so facilitating successful discharge and enhanced well-being. As such, the principles of bridging and bonding were integrated into the recovery work undertaken in the day hospital. It was hoped that this could be done in such a way as to be empowering and respectful and thus increase self-determination.

Given the potential importance of bridging capital to mental health (Erickson, 2003), this was targeted through the development of the New Opportunities group. The group aimed to address and increase service users' levels of bridging capital and to facilitate the development of self-management strategies (Ridgway, 2001). This would enable service users to realise their expressed recovery goals (Green, 2003). Janes and Trickey's (2005) older adult discharge group's aims were also adopted: to empower members to make decisions about their discharge, to discuss anxieties around the process of discharge, to reframe discharge as a positive transition and to encourage a more positive approach to discharge by the day hospital system overall. In so doing, it was hoped that members would be able to maintain their mental health in the community post-discharge and to experience a level of well-being, rather than ill being. Group members had all attended a cognitive-behavioural therapy group prior to joining the New Opportunities group.

Structural social capital was addressed by helping to socialise group members to the

rules and roles of different groups external to the day hospital (e.g. lunch groups, reading groups, and dancing groups). This facilitated group members to bridge out of the day hospital and to bond with new members of the public, so forming relationships and connections with those people, and reducing the strength of the bonds to the day hospital. Cognitive social capital was addressed by helping members to identify their beliefs and values and to seek out activities congruent with these. In so doing, it was hypothesised that relationship needs typically fulfilled by day hospital staff would be met through wider community relationships (Islam et al., 2006), so rendering the staff relationships redundant or less significant.

The group programme commenced with exercises aimed at helping members to bond, and using such bonds to develop group norms (Islam et al., 2006). Members were then asked about how the day hospital benefited them individually, so identifying which components of the service would need to be considered in the group's bridging work. This enabled individuals' internal and external recovery needs to be identified. Further sessions involved consideration of perceived obstacles to discharge and fears about the process, again to highlight any specific bridging and bonding needs. Information folders of local non-statutory organisations offering activities in the community were collated and made available to members, thus facilitating bridging into life outside the day hospital and expanding connections with their community. This was complemented with discussions about members' hobbies and pastimes, with reflection on what they had achieved when they were younger, as well as what they were interested in currently and had not yet had the opportunity to explore. This provided a focus on and between members as people, rather than mental health service users (Davidson & Roe, 2007).

Further sessions involved life story work, further highlighting recovery by considering ways life stressors had been overcome in the past, enabling recognition and identification of adaptive coping strategies and previously unrecognised strengths. Members also mapped out their social networks including levels of intimacy, enabling work on them reconnecting with their existing networks, and addressing any network gaps through engagement with group activities outside the day hospital. Group members were further encouraged to explore their local community with the support of staff. This took the form of graded hierarchies, with staff reducing their support as members drew more on their coping strategies and developed their confidence (for example, shopping in the local centre fully supported by staff, to staff only advising members of relevant destinations).

So what did the New Opportunities Group achieve? Members bridged into the local community, developing relationships and so bonding with people outside of the day hospital. What staff found particularly helpful was celebrating success when someone moved on. For example, some members went for a celebratory meal upon discharge from the day hospital, marking their successes and saying goodbye to other members and staff. Overall, the group was a resounding success with nine of 12 members successfully discharged or, rather, making the day hospital service redundant! Some group members left after successfully engaging in new activities in the community, others after deciding they were satisfied with activities with which they were already engaged, requiring minimal support from the group. These were both viewed as positive outcomes. It's important to remember that recovery is an individual journey, and one size certainly doesn't fit all.

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Filling the Void: How can we improve the effectiveness of groups to help people manage their memory difficulties?

Diane Dansey & Lucy Leonard

We describe the development and formal evaluation of a group for older people with memory problems. The group aimed to help members develop skills and coping strategies to manage their day-to-day memory problems more effectively and incorporated strategies to maximise the potential of the group over the seven to eight week duration. The group has run four times to date, with a total of 33 members, from a range of ethnic groups. The outcomes were positive and we discuss which measures may best capture the work of the group.

THE NATIONAL DEMENTIA STRATEGY (Department of Health, 2009) emphasises the need to improve support for people with dementia and their carers. Memory groups are in line with the recommendations of the NICE Guidelines for dementia (2006), which state that services should promote and maintain the independence of people with dementia, help them to adapt and develop skills and minimise the need for support. There is evidence that help with memory may maintain or enhance daily functioning and well being and reduce excess disability (Reifler & Larson, 1990). Memory groups are also consistent with the recovery model, which emphasises facilitating self-management and supporting people to manage their difficulties in order to live life to their full potential. Low mood has a negative impact upon memory functioning. Groups can provide an environment in which people with similar problems can share experiences and therefore help reduce feelings of isolation and embarrassment (Yale, 1995). Memory groups offer practical support in managing memory difficulties whilst also giving people a place where their feelings can be heard and shared within a supportive environment. There have been no controlled studies evaluating the impact of memory groups for people with memory problems, although there has been more attention on the impact on carer well-being (e.g. James & Sabin, 2005; Zarit et al., 1982). Studies of memory groups have

produced some positive results. Whilst it is commonly suggested that there may be difficulties in achieving or maintaining gains a number of studies have identified positive improvements in memory scores (e.g. De Vreese et al., 2001; Moore et al., 2001).

In an attempt to maximise the impact of the memory group we employed three main strategies, firstly to involve carers as far as possible, secondly to offer a mid-group home visit and thirdly to actively involve group members in practical exercises. Although some memory groups have involved carers within sessions, (e.g. Illingworth & Forest, 2008) or run parallel groups for carers (e.g. Scott et al., 2002) it was felt that their concerns may detract from the focus of the group and half of the members did not have carers, which would have created a noticeable imbalance. A number of studies have also found that memory groups have had some negative effects on carers (e.g. James & Sabin, 2005, Zarit et al., 1982). Moniz-Cook et al. (1998) noted that carers did not use written advice on supporting people with memory management unless they were actively encouraged. Therefore we involved carers in the assessment, mid-group and post-group visits where they were encouraged to support the use of strategies at home. The mid-group home visit aimed to maximise the practical benefits of the group to each member's lifestyle and priorities and culminated in an individualised sheet of

priority strategies for each member to focus upon. This sheet was added to the memory folder, which was built up over the sessions with strategies that were discussed in the group. We started to develop practical exercises within and between sessions for members to try new strategies, e.g. asking them to remember to call us on a certain day before the group and to remember to bring their memory folder.

The group was evaluated using a range of self-report and carer-report measures.

Referrals and assessment

Referrals were accepted from local CMHT's and had to meet the following criteria:

- MMSE score of 13 or more
- Memory impairment (of varying aetiologies, e.g. confirmed or suspected dementia, stroke, mild cognitive impairment)
- Some insight into difficulties and a desire to learn ways of managing difficulties

Exclusion criteria included significant hearing or visual problems that would affect participation, current drug or alcohol abuse and acute physical or mental illness.

We received 62 referrals. Some people were unavailable or not interested in attending. Thirty-eight people were assessed at their home and carers were involved where possible. The following measures were included in the assessment for each person; the Hospital Anxiety and Depression Scale

(HADS, Zigmond & Snaith, 1994), the Rating Scale for Anxiety in Dementia (RAID, Shankar et al., 1999) and The Cornell Scale for Depression (Alexopoulos et al., 1988). The Mini Mental State Examination (MMSE, Folstein et al., 1975) was completed when this had not been done in the previous six months. Other measures were also given but are not reported as they were not given consistently across each group. Five of the people assessed were not considered suitable for the group, for various reasons including lack of insight into their memory problems.

The group members

Thirty-three members attended one of the four group programmes. Twenty-eight of these (13 males and 15 females) attended most or all of the sessions. Five people attended only one to three sessions due to anxieties about the group or health difficulties. Of the 28 regular members the mean age was 78 (ranging from 63 to 91, standard deviation 6.7) and the ethnic diversity reflected the cultural diversity within Lambeth (see Table 1), where 38 per cent of the population are from ethnic minority backgrounds and 50 per cent are white British (2001 census). Table 2 gives the diagnoses of members. All group members were living in the community and 14 of the 28 members lived alone. The mean MMSE score was 22 (ranging from 13 to 28).

Table 1: Ethnicity of group members.

Ethnicity	<i>N</i>
White British	17
Caribbean	6
Other white/mixed European	3
Ghanaian	1
South African	1

Table 2: Diagnoses of group members.

Diagnoses	N
Dementia in Alzheimers	12
Unspecified dementia	6
Dementia in Alzheimers and F32 depression	1
Vascular Dementia	4
Mild cognitive disorder	3
Stroke and adjustment disorder	1
Mild cognitive disorder and F25 Schizoaffective disorder	1

Group programme

The first three groups were facilitated by two assistant psychologists and a support worker and were supervised by a clinical psychologist and the fourth group was facilitated by an assistant psychologist and clinical psychologist. There were a series of sessions, each focusing on a different topic, i.e.

Session 1: Introduction.

Session 2: Memory aids.

Session 3: Adapting the environment.

Session 4: Well-being, for example, managing feelings, healthy living and routine.

Session 5: Mid-group recap (when the group had to have a break for Christmas or Easter).

Session 6: Managing routes when going out.

Session 7: Social situations, for example, names and word finding difficulties.

Session 8: Overview.

Sessions were made as interactive as possible in order to facilitate enjoyment and learning, including presentations, demonstrations, group discussions and problem-solving exercises. Strategies were introduced by experiments (e.g. asking members to try to remember a shopping list with and without using memory aids) and games (e.g. two teams trying to remember objects on a tray, one using aids and one relying on memory). It was demonstrated that members could write things down but then try to remember themselves before checking

what was written, as some members were keen not to 'give up' on their memories. Members were encouraged to write themselves messages to try the strategies that were discussed between groups and this was followed up the week after. Each member was given a memory folder with handouts added each week and they were encouraged to look at these with a carer to gain support with implementing strategies at home. Members were given various exercises to practise strategies, for example, to bring their memory folder each week, remember the names of group members and to call us on a particular day before the group. Strategies for managing these were discussed between members and the group also problem solved for difficulties individuals raised.

Mid-group home visits were initially just for members who lived alone and/or had difficulty in implementing recommended strategies. However due to the reported success these were offered to all group members by the third group. The facilitators looked around the house with the group member and carer and discussed which strategies were being used and identified others which could be used or improved, for example, creating a memory table, using colour in messages or adding retrospective information to diaries. On the basis of these visits and the information given during group sessions each member was given an individualised advice sheet in the last

session, detailing the strategies that it was felt they could benefit the most from. Following the group care co-ordinators were asked to follow up these strategies with patients and their carers where possible.

Outcome evaluation

The pre-group assessment measures were repeated following the group (except for the MMSE) and an evaluation form was given. Twenty-four out of the 28 group members completed pre- and post-group measures. Four people did not complete the post-group measures due to either health problems that arose towards the end of the group or difficulty contacting them after the group.

The results on the clinical outcomes show that the average scores for anxiety and depression declined slightly on the HADS and Cornell and there was a significant decline in the number of problems reported on the RAID.

Feedback from members

The feedback was overwhelmingly positive, with the only negative comments relating to transport difficulties. Participants said they had found the group helpful and enjoyable

and most seemed to quickly embrace the strategies, as evidenced by self-report, carer report and the observations of facilitators during home visits. Feedback also demonstrated the value of peer support as members appreciated sharing their problems with others in the same situation. Three group members had declined attending a day centre prior to the group and afterwards said that they would then consider this support. A number of members arranged to stay in contact. Members made the following comments after the last session:

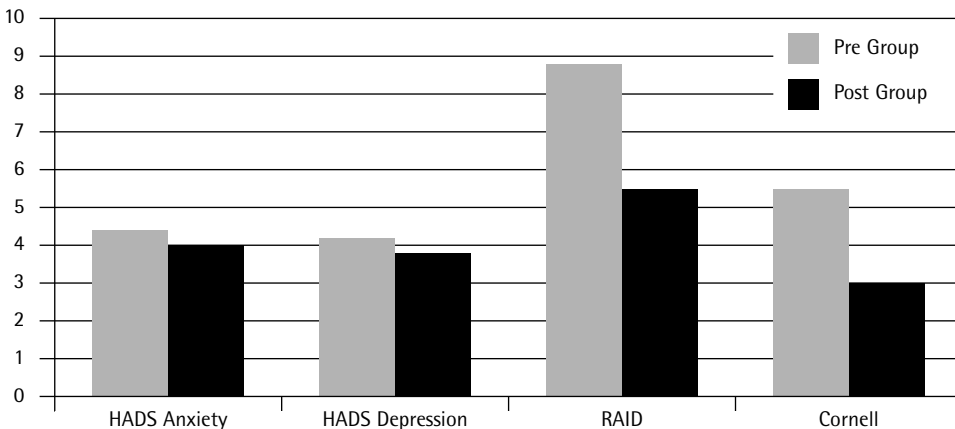
'I enjoyed it very much – I was surprised how much. It was good to be told, 'you are not daft, you are not silly.' Female, 78 years.

'I have tried to take the strategies in, especially with using the pad and pen and being more careful what I do with things.' Male, 82 years.

'I did know things but didn't register their importance until coming to the group. It really struck a chord. I found it very helpful.' Female, 75 years.

'It is good to find that you are not alone in your situation.' Female, 80 years.

Figure 1: Outcome measures.



Discussion

The outcome measures for the group showed some improvements in the reported anxiety and depression. However over the course of the groups it was felt that there were substantial problems with the use of the measures. Inherent in the completion of each of the measures is the individual's ability to remember the relevant facts in order to give the most accurate answer, which posed a real problem. Half of the members assessed did not have a carer and the RAID and Cornell require carer ratings. These were, therefore, filled in based upon reports by the individual and other mental health professionals who knew the individual. When carers were present they were not always willing to contradict the person giving answers, sometimes commenting afterwards that they would have disagreed but did not like to argue or upset the person.

It was felt that measures of depression and anxiety were not able to capture the outcomes that it was hoped that the group might achieve, i.e. to improve the self esteem of the individual, to reduce their anxiety about their memory problems, to increase the number of memory aids that they were using and thus improve their chances of remembering things. As the groups progressed we began to use measures which were more able to reflect these things (e.g. the DEMQOL, Smith et al., 2005; Rosenberg Self Esteem Scale, Rosenberg, 1965) and measures of which memory aids they were using at home. We also began to explore whether we could use each member's performance on the memory exercises (e.g. bringing their folder, telephoning us, remembering names) as an outcome measure over the course of the group. It would also be interesting to gain more quantitative outcomes from carers regarding whether there are any changes during and after the group. These measures would need to be routinely used and evaluated over a further number of groups.

Carers were encouraged to be involved in the pre-, mid- and post-group home visits

and were asked to help members to incorporate memory strategies into their daily routines. Some of the carers said that this helped to educate them in what they could do to help. However, half of the group members lived alone and so could not benefit from this support. It would be interesting to separate the outcomes for members who did and did not have carer support at home to assess whether the additional support facilitated more positive outcomes. Gaining feedback from the carers on the process of the group may be helpful in identifying whether they felt that they received sufficient information and support in order for them to support the person they were caring for and also to identify the needs of the carers. It might be beneficial to incorporate one or two sessions for carers, possibly before and during the course of the group. This would fit in with the recommendations of the NICE guidelines (2006) that carers of people with dementia should be offered peer-support groups and problem solving in caring for people with dementia. Previous studies that invited carers to the group or ran a parallel group have identified mixed outcomes, with some negative impacts on the carers (James & Sabin, 2005; Moniz-Cook et al., 1998; Zarit et al., 1982) and so these findings and their implications would need to be carefully considered.

Some members hoped or believed that attending the group would improve or even cure their memory. This was despite frequent reminders, both verbal and written that this was not the case and this was also reinforced with carers. It was recognised from the outset that the advice of Scogin (1992) was paramount, 'one should avoid fostering over-optimistic expectations and to warn them that there may be difficulties in maintaining gain'. More thought may however need to be given to this, possibly through discussing with group members and carers exactly what their hopes and expectations are.

Whilst qualitative feedback has identified clear benefits of the group there is clearly scope for the development of more appro-

appropriate measures that might better capture outcomes. A measure of which strategies are being used before and after the group would be valuable, in addition to monitoring people's performance on specific memory tasks over the course of the sessions. Where possible carers were involved in the pre and post group assessments and mid-group home visits in an attempt to maximise the impact of the group. However there may be scope for developing this further in order to improve the effectiveness of the group. It would be interesting to evaluate the long term impact and assess whether a follow up group session or home visit some time after

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- the end of the group could help to consolidate gains, through supporting and reinforcing the use of strategies.

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Not a one trick pony: The SPECAL method as a comprehensive system of interacting clinical techniques

Penelope Garner & Oliver James

CURRENT ESTIMATES put the number of people with UK with a dementia diagnosis at approximately 700,000. This is set to rise as the population ages. A review of all the studies of the main conventional methods for managing the condition suggests they are mostly as good as useless, and, in a few cases, worse than useless (Livingston, et al., 2005). Given this finding it is small wonder that many patients are mentally ill (Sava, et al., 2009), and that desperate staff prescribe anti-psychotics. Unfortunately one-quarter of these drugged patients die prematurely as a direct consequence of the side effects (Ballard, et al., 2008).

Fortunately there is another solution. SPECAL is an independent dementia charity with the overall aim of promoting lifelong well-being for people with dementia. SPECAL offers an innovative method of managing dementia, based on a disability model. SPECAL can be introduced at any time after diagnosis, preferably as soon as possible, and used by everyone involved in supporting the person, whether family, friend or professional carer. The development of SPECAL's method has been through practice informing theory, over a period of unbroken study now entering its 20th year.

There was a positive report of the method in the 1990s by the Care Consortium of the Alzheimer's Disease Society (John & Pride, 1997), and an evaluation by the Royal College of Nursing Pritchard & Dewing, 1999). The evaluation findings were that SPECAL patients experienced a sustained sense of well-being, took fewer drugs, stayed at home longer, moved into care with less distress, were supported by carers who felt less guilt and who reported a plateau effect

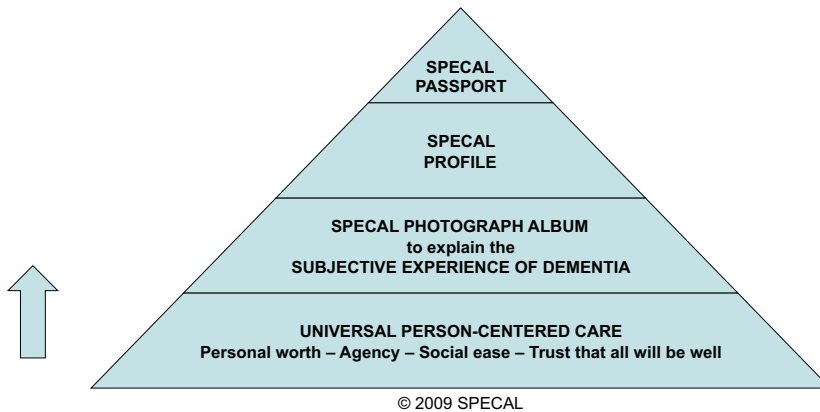
in the disease process. SPECAL has been trying for some time now to get proper empirical impact studies, and is currently conducting a number of collaborative projects.

One of the commonest objections raised to the method is that it is a 'one trick pony', consisting only of the use of a 'Primary Theme' in order to develop something its critics describe as 'Therapeutic Lying'. This unfortunate misconception has been repeated a number of times in a number of different contexts (Stokes, 2008).

To the best of our knowledge nobody who has first hand experience of this method or training in it has ever raised this objection. In this paper we demonstrate that the technique contains not just one, but many elements, some of which are wholly original and some with a measure of similarity to existing established methods. Therapeutic tools such as Person-Centred Care, Validation Therapy, Reality Orientation, Reminiscence Therapy, Distraction and others, have a part to play in the overall management mechanism, but no one tool on its own has the capacity to sustain lifelong well-being. Individualised dementia care is not a straight drink: a cocktail is required, and SPECAL has spent many years refining the methodology around the mix in order to produce an economic, effective, sustainable and humanitarian approach to the management of dementia.

Here, we offer an overview of why and how the SPECAL method works. The use of the word SPECAL as an adjective has become shorthand for 'taking account of the person's experience of dementia and tailored to the individual with the condition'.

Figure 1: SPECAL PYRAMID progression from person-centre care to individualised dementia care



Person-centred care

All human beings require four global subjective states to be present in order to experience well-being (Kitwood, 1996). Feelings of personal worth, agency, social ease and a sense of trust that all will be well are fundamental to the experience of well-being for everyone, regardless of medical condition. Person-centred principles provide the **first layer** of the SPECAL approach.

The SPECAL Photograph Album

The **second layer** concerns the subjective experience of dementia, explained by the SPECAL Photograph Album (Garner, 2008). This uses a metaphor to describe the memory system and to explain how normal memory works, the impact of ageing, and the single change in the memory process which is introduced in dementia.

Memory is presented as analogous to a photograph album. In the album the photographs record what has just happened in our life are continuously and unconsciously stored, for each of us. These photographs contain the facts of the event in question and the feelings associated with the facts.

We reference the most recent photographs almost continuously to provide us with the contextual information we need to make sense of what is currently happening in our lives.

With age, the process of storage and consultation continues unchanged, although the speed with which we access photographs progressively slows.

With dementia, the unbroken sequences of stored factual information are interrupted by a new type of photograph which records only the feelings of what has just occurred, with no facts attached. This new fact-free, feelings-only, dementia-related photograph is known as a 'blank'.

Randomly, intermittently, and increasingly frequently, blanks reoccur. With the progressive interruption to new factual storage, the latest album pages become increasingly compromised in terms of a factual reference point. Feelings continue to be stored in the usual way, and if any feelings of ill-being enter the storage system they become potentially catastrophic for the person, who has no idea of the facts which were attached to the ill-being experience.

Once the message of the Photograph Album has been understood, the need for a new way of communicating with the person with dementia is obvious. Common sense will not serve us at all. We need to take the experience of the person with dementia constantly into account, and to compensate for the deficit of recent factual information which lies at the heart of the disability. The Photograph Album model distinguishes

what is known as Alzheimer’s type dementia from other conditions, and requires a distinctive and, perhaps, unprecedented approach, one which begs questions of the assumptions underlying, and the implementation of, current dementia care practices.

The SPECAL Care Profile

The **third layer** introduces the profiling required to take account of the life history of the individual and the impact of dementia. SPECAL achieves this through a themed reconstruction of their background biography. A number of selected themes and explanations are built into a personal profile, based on a consideration of who this person was before dementia; who they are now; who they would have been without dementia, given their life experience and age; and the sort of life they had always hoped to lead.

The SPECAL Passport

The **fourth layer** provides a distillation of the care profile, linking past intact memories to the activities of daily life today for the person, within a single page of A4 known as a SPECAL Passport. The Passport identifies all the infor-

mation any carer needs to know in order to sustain well-being for the person with dementia, 24 hours a day, every day, for life.

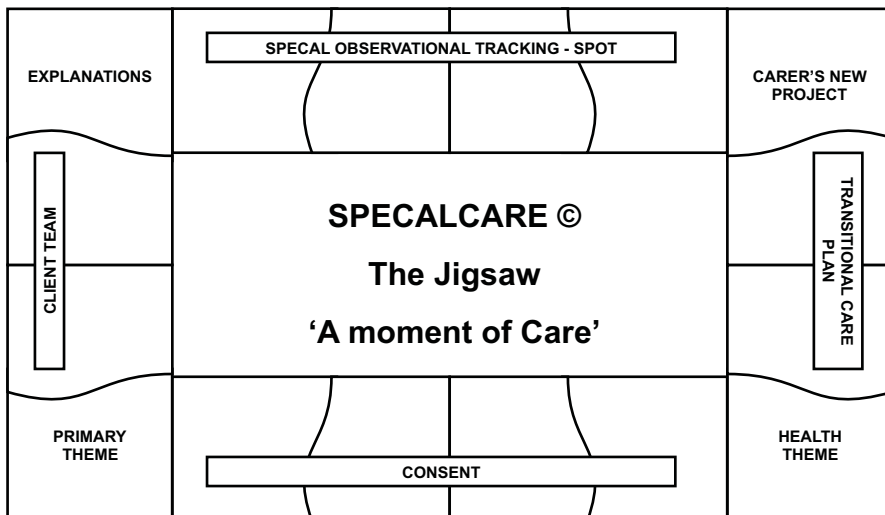
The SPECAL Jigsaw

The aim of SPECAL is to build a 24 hour routine of contentment for the person with dementia. The component parts are like the pieces of a jigsaw, each one interlocking to form the complete puzzle. Four corner pieces are held in place by four straight edges to provide the outside framework. Given training and preparation, it is then a relatively straightforward task for any companion to assemble the few pieces that are left, and to create the possibility of sustainable contentment for the individual person, 24 hours a day, every day, for life.

Primary Theme

The Primary Theme is an enthusiasm of the person with dementia (for convenience we use the term ‘client’) from their past, before the onset of dementia. The Primary Theme has the capacity to restore feelings of self-worth, independence and control for the client, generated through helping people less able than themselves in that particular area.

Figure 2



Examples of a Primary Theme have included architecture, bird watching, walking, heraldry, fishing, knitting, jungle warfare, cooking, bridge, making stuffed toys, travelling, shopping, painting, reading Agatha Christie books, preaching sermons, swimming, night flying and even grumbling.

An individualised vocabulary and reference points is used to link past sequences with all the normal activities of daily life for each individual client, so that activities such as going to bed, dressing and undressing, eating and drinking, bathroom routines, going out and coming in, sitting, standing and moving about, can be achieved by the client with minimum help and maximum ease.

All SPECIAL care is concerned with managing transitions as the client moves from one moment to the next. Transitions can relate to activity, environment or companion. Because of the memory change all transitions become increasingly problematic for the client unless some compensation is made. The Primary Theme has a key part to play in helping the client to manage transitions in acceptable ways without a focus on dementia.

Health Theme

The Health Theme reflects a health-related issue from the client's pre-dementia past, associated with an acceptable outcome for the client. This theme is used to reassure the client that it is acceptable to be dependent on another person in certain circumstances. The Health Theme is crucial in providing equilibrium for the client. It is an important risk management tool.

If the Primary Theme is seen in terms of client validation, then the Health Theme provides client orientation; there is no focus on dementia in either case.

Explanations

We all, regardless of dementia, depend on easily accessible information to make sense of what we are doing, on a continuous basis. Those of us without dementia can find the information we need from sequences of photographs which have just entered our

album only moments before. With dementia, the sequences are interrupted by the presence of blanks and become less and less useful as a reference point. People with dementia have an increasing need to access useful sequences from their pre-dementia past, and use these as a replacement for more recent information which is potentially confusing. Whilst each client will have a variety of differing concerns and questions about what is happening, there are four key explanations which they will all require:

(a) Explanation for departure

The person with the client needs to explain their departure from the presence of the client, without raising anxiety. This explanation is usually associated with the carer's personal care, and is designed to trigger a response of 'Off you go, you don't need me!' from the client.

(b) Explanation for absence

When the carer is taking a well earned break from their caring role, there is a need for a well-rehearsed explanatory phrase to explain their absence, if the client should enquire. The explanation for absence carries the message that the carer is going to be absent for a while and will return safely in due course; this reassurance can be repeated to trigger a sense of relief and contentment in the client. They have no wish to go off to find the missing person.

(c) Explanation for presence

It is important that anyone with the client has a reason for being there which is related to client expertise rather than client dependency. The explanation for presence implies that the client can be of help to the other person. The phrase used will have some sort of link to the Primary Theme and will promote feelings of self worth in the client.

(d) Altruistic Trigger (the bottom line)

A person with dementia will often express a wish to 'go home' when they move to a nursing home. The altruistic trigger, or

bottom line, is a mechanism to encourage the client to place the interests of another person ahead of their own and to accept willingly the offer of interim hospitality wherever they happen to be at that moment. It is an essential carer tool whenever the client's wish to depart from their current environment presents a risk which needs to be managed safely. The client retains the ability to reason, but needs information stored before the onset of dementia with which to reason. Like the other client themes, the altruistic trigger presents the client with a line of logical thought which draws on useful information stored in the pre-dementia pages of their photograph album. One of the positives of managing dementia in this way is that it embraces the kind of repetition which sits well with the disability.

Carer's new project

SPECAL supports the principal carer so that the all-important relationship between the carer and the client can be sustained. The carer is supported to ensure that they do not become dependent on their caring role. This is achieved by introducing a new focus of interest over and above their already well-established pursuits. The new project represents a new positive addition to their personal lifestyle, balancing the negative element introduced by the dementia diagnosis. As the client's dependency on the main carer reduces through the expansion of a support team, so the carer's new project expands. This jigsaw piece has a crucial part to play in reducing guilt if and when the client moves into a formal care setting. Reduction of carer guilt is essential if carer well-being is to be sustained.

Consent

The client identifies the most significant other person in their life, the person whom they would most trust in the future to take decisions on their behalf if ever they were themselves compromised. This global consent enables the appointed person to act in an advocacy role, and all delegated responsibilities cascade from this appointment.

Given the extraordinary change in the way memory works for the client, the need to safeguard the emotional well-being of the client is critical. The emotional power of attorney appointment is a crucial aspect of SPECAL care and ensures that emotional risk to the client is successfully managed.

Creating a client team

The client team comprises everyone coming into contact with the client. Each member needs a form of induction adjusted to suit their relationship with the client. Family, friends and key professionals all need to be identified and to understand that their contribution is unique and important. Once everyone is pulling together and using the same language, a continuity of acceptable experience for the client becomes a realisable aim.

SPECAL OBSERVATIONAL TRACKING – SPOT

SPECAL carers need to heighten their powers of observation, and to find new ways of recording information. The client transmits a wealth of signals which need close observation and analysis. Put simply, carers must learn to spot the signs of what is OK and what is not OK for the client.

SPOT is a system of recording behaviour patterns for each client and creating pathways of contentment from the client's own starting point. As with all SPECAL tools, SPOT is simple to grasp and far-reaching in its application. There are implications both for the carer and the client. The SPOT process informs the moment by moment promotion of SPECAL care. The client is expert at knowing what is acceptable to them, and it is up to the carer to interpret the signals. Carers come to embrace SPOT as their greatest ally in managing dementia in a SPECAL way.

Transitional Care Plan

The value of a transitional care plan as an insurance policy cannot be overestimated. The earlier the plan is put in place the less

likely it is to be needed – for a considerable length of time, if ever. The Royal College of Nursing found that SPECAL clients stay at home longer than their counterparts, in spite of the concrete plan for a move into care. There are two key pieces of work attached to the plan – first, the selection of a future care home of family choice, and secondly, identifying the tipping point when the balance of advantage to the client shifts in favour of a move away from home.

Passport

The SPECAL Passport is a single A4 sheet summarising the key information needed to provide 24 hour wraparound care for the client.

The Passport forms an integral part of the Transitional Care Plan documentation shared between the family and their chosen care home, and is prepared when the tipping point is reached.

The Passport provides the care home with the practical distillation of a vast amount of background biographical information previously gathered during the profiling process. It offers an easily accessible and highly practical database for busy care home staff.

Strategy to manage risk

There are both emotional and physical aspects to risk. It is important to make the emotional aspect the primary consideration for the SPECAL client, on the basis that the physical implications then become relatively easy to accommodate. The reverse approach to risk management has been shown to be less effective in promoting a continuity of acceptable experience for the client.

Conclusion

In the coming years the clinical efficacy of each of the individual elements described above, and the way that they interact, will be subjected to empirical investigation. The overall effect of the method will soon be better known through impact studies. At present the most convincing evidence that it is helpful to carers and professionals is its widespread adoption since its publication in book form – it would appear that word of mouth has been positive.

On a broader plane, considerable interest has now been shown by political parties in the wider adoption of the techniques described here. Lord McColl, a former Shadow Health spokesman and distinguished doctor, speaking in the House of Lords recently in response to the new government dementia strategy, stated that, ‘Alzheimer’s disease does not need to be hellish, as it is possible to create a sense of well-being for the patient ... SPECAL creates a lifelong sense of well-being, rather than the rage and confusion that are triggered by the conventional responses to dementia. The methods advocated by the charity SPECAL are much better than smothering the patients with excessive drugs.’¹

Should this observation prove to be empirically validated by the impact studies currently being conducted, considerable issues of social administration will be raised as regards the best means for training carers, health service practitioners, social care practitioners, those working in nursing homes and those in the charitable sector.

In summary: SPECAL offers a raft of carefully chosen strategies in a comprehensive programme described by one carer as the ‘best kept secret in dementia care’.

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¹ *Hansard*, House of Lords, 25 June 2009.

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Do older people use religion as a coping aid?

Michael J. Lewis, Anthony C. Edwards & Mary Burton

Why conduct this research?

THE CURRENT rapid increase in the number of retired paper, at least in developed countries, has been well publicised. The UK Office for National Statistics (ONS) reports that the number of 'pensioners' (currently aged 60-plus for women, and 65-plus for men in the UK) now comprise 18.7 per cent of the whole population, and this is projected to increase to 19.4 per cent by the year 2010 (website published 22 August, 2007, drawing on mid-2006 estimates). Based on 2005 figures, the ONS reports that, on average, men can expect nearly 17 years of retirement, and women over 19 years. To enjoy these later years, it is important for people to be able to cope with adversity in the face of the inevitable changes in physical and mental faculties that occur with age.

Evidence from the literature

A research team at The University of Northampton has conducted a number of studies into coping mechanisms used by older people, and two specifically concerned the role of spiritual beliefs and religious practices. There are previous reports in the literature that these factors can indeed help people cope with life's difficulties. For example, Koenig et al. (1990) cited findings that showed that religious behaviours and beliefs can help elders' coping with stressful life changes, and that a positive association between religion and well-being had been demonstrated. Hood et al. (1996) suggested that older adults frequently use religious coping mechanisms, and that turning to God in prayer may help to combat loneliness and depression. In later reports, Koenig (2001; 2002) stated that nearly 90 per cent of medical in-patients aged 60-plus used reli-

gion to help them cope, as it provided them with a form of control over their health matters. Finally, Kass et al. (1991) administered their original INSPIRIT spirituality measure to participants up to the age of 72 years, and found a significant and positive relationship between core spiritual experiences and both life satisfaction and a reduction of medical symptoms.

First Northampton study

The purpose of this study was to investigate the extent to which people might use religion as an aid to coping with a specific traumatic event, namely, the transition from living at home to full-time residential care (Lewis et al., 2005). We interviewed 36 women and 14 men (total 50, mean age 85.2 years, range 74 to 94) who had moved to a care home within the previous 12 months. The reasons for the move were not formally recorded but, from informal conversations with the participants, it appeared that in most cases they were living alone and were deemed by either themselves or family members as not being able to cope with essential daily activities. The interview schedule comprised validated scales to measure each of: overall life satisfaction (LSES, Salamon & Conte, 1984), spirituality (the INSPIRIT measure, see above), organised and solitary religious participation, the use of religion as a coping mechanism, and a secular faith in the power of nature and humanity. Whilst no assessments of cognitive impairment were carried out, the care home management were asked to nominate individuals whom they believed were capable of responding to the questions, and the researchers only proceeded if this was confirmed in practice.

We obtained significant correlations between the scores on several of the variables, but the most revealing illustration of the findings was through path analysis. This statistical procedure involves successive step-wise multiple regression analyses. The objective is to firstly identify the variable or variables that most strongly predict that which is nominated as the 'criterion', which in this case was overall life satisfaction. The second step is to repeat the procedure with the criterion removed and the predictor entered in its place, to determine what predicts this particular variable. The process continues in like fashion until a chain of predictors has been identified, and ceases when the outcomes are no longer statistically significant. Figure 1 summarises the outcome from this first study.

It will be seen that the main predictor of life satisfaction is in fact the secular faith in nature and humanity although, interestingly, the use of religion as a coping strategy is the strongest predictor of this nature/humanity variable. Another way of interpreting this is to regard nature/humanity as mediating between coping religion and life satisfaction. Next back in the predictive chain are the scores on the spirituality measure. An impor-

tant point to note, however, is that none of the religious variables yielded a direct and significant relationship with the criterion of life satisfaction. Taken at face value, the implication is that religion/spirituality did not directly and significantly help people cope with the trauma of moving to full-time residential care (as assessed by the level of current life satisfaction). Before commenting further, however, it will be useful to review the second Northampton study on the role of religion.

Second Northampton study

In contrast to the care home residents surveyed for Study one, we now directed attention to retired people still living independently in the community (Lewin, Edwards & Burton, 2009). A total of 133 men and women (mean age 72 years, range 60 to 93) completed a battery of self-report measures, including some of those used in the earlier study but also with some new ones. Using similar statistical analytic procedures, the outcome of the path analysis is shown in Figure 2. It will be seen that two variables, used for the first time here, namely (internal) locus of control, and self-assessed health were the joint main predictors of life

Figure 1: First study: Predictive pathway leading to life satisfaction.

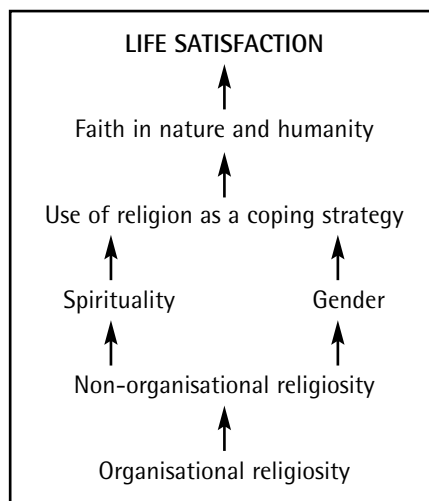
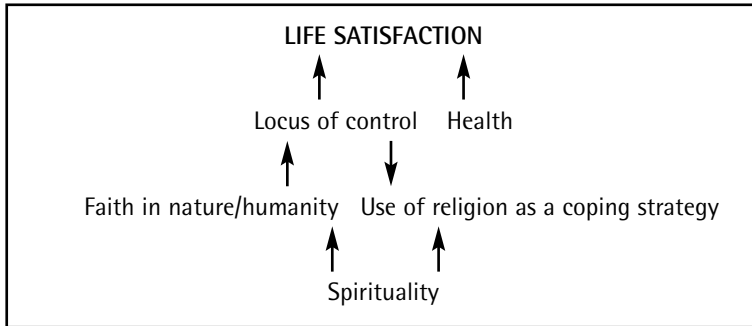


Figure 2: Second study: Predictive pathway leading to life satisfaction.



satisfaction. However, with regard to the religious and nature/humanity variables, again it was found that neither the use of coping religion nor spirituality directly predicted the criterion, and that the nature/humanity variable appeared to play a coping role equal or superior to that of religion.

Discussion

Why did the outcomes of the two Northampton studies fail to confirm that religion and spirituality play significant roles as coping mechanisms for older people, as has been found in similar studies reported in the literature? Should it be concluded that people are now tending to turn away from religion to help them cope with the adversities of later life, and instead adopting a more secular faith in nature and humanity? It might be that such a conclusion is a little premature.

Firstly, in the case of the community dwellers, some participants had volunteered comments to the effect that they did in fact turn to God for help and guidance, even to the extent that they believed that God controlled their lives rather than they themselves did (resulting in a negative correlation between coping religion and internality of locus of control).

Secondly, non-participation in religious activities does not necessarily mean that people do not have spiritual needs. Culliford (2002) noted that, whilst actual church attendance may be low, 76 per cent of people surveyed admitted to having had religious and spiritual experiences. In the Northampton study with care home residents, only eight per cent of participants stated that they were not religious, but 14 per cent recorded 'none' when asked to state religious affiliation. Thus, some feel that they can be religious without necessarily attending a place of worship.

Thirdly, in the case of care home residents, there could be restricted opportunity to participate in organised religious activities, compounded perhaps by a lack of accessibility to church premises familiar to them.

Fourthly, studies such as those cited earlier that reported on religious coping mechanisms have usually surveyed participants who are frail or unwell (e.g. McFadden, 2005). Koenig (2001; 2002), inter alia referred to 90 per cent of medical inpatients older than 60 years using religion to help them cope. It may be that, with both of the Northampton samples, the participants were in relatively robust health, and thus only those who already had strong religious convictions stated that they made use of their faith to help them cope with the difficulties of later life.

Conclusions and interventions

The two Northampton studies reported here did not set out to confirm a pre-determined notion that religion is 'good for you', and to explain away any findings that disagreed. Rather, the aim was to see if the relatively frequent literature reports on the use of religion as a coping aid in later life could be supported by research. Our main finding from both studies indicated that the more personal and subjective faith in the force of nature and the goodness of humanity was the strongest predictor of life satisfaction among our retired participants, although the quantitative statistics used here are based on averages and largely ignore individual differences. However, the nature/humanity variable may serve to mediate between some aspects of religion/spirituality and the criterion of life satisfaction.

Shulmanasy (2002) reported that surveys had shown that from 41 per cent to 94 per cent of patients felt that their physicians should ask them about their spiritual needs, and that this included up to 45 per cent of those who considered themselves to be non-religious. It behoves all who work with older

people either as carers, clinicians, therapists, policy-makers, or simply as concerned friends or relatives, to acknowledge and recognise the role that religious and spiritual needs may have in helping people cope with life events, and allow the opportunity for this to occur. What might sometimes seem to be disengagement or periods of introspection may, in fact be evidence of such coping mechanisms at work.

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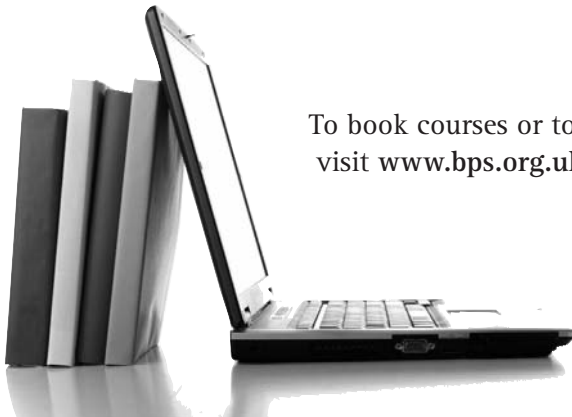
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Research Update: The effectiveness of a nurse-led psychosocial group intervention for older people with schizophrenia

Katherine Berry, Christine Barrowclough, Nitin Purandare & Richard Drake

A RECENT systematic review revealed that in the UK there are no published trials of psychosocial interventions specific to older people with schizophrenia (Berry & Barrowclough, 2008). For younger people with schizophrenia a primary target has been symptom reduction (Wykes et al., 2008). However, psychotic symptoms improve with age and the primary problems for older people with schizophrenia are in the areas of social functioning and independent living skills (Berry & Barrowclough, 2008). People with schizophrenia may be particularly vulnerable to deficits in social functioning, as a result of poor development of social skills, symptoms and social stigma. Older people with schizophrenia have lower levels of social support than their peers, are more likely to report maladjustment in social roles and identify improving social skills as high priorities. As in the general population, living independently is the expressed wish for the majority of older adults with schizophrenia, but many have problems with daily living skills and such problems are associated with social exclusion, nursing home placement and the use of other intensive services in this group (Berry & Barrowclough, 2008).

Given the importance of social function and independent living skills to older adults with schizophrenia, three groups in the United States have developed and evaluated group-based psychosocial interventions for middle-aged and older adults focusing on these areas. Granholm and colleagues (2005) carried out a randomised controlled

trial (RCT) with 76 middle-aged and older outpatients with schizophrenia in which they compared their psychosocial intervention with treatment as usual. In a separate study Bartels and colleagues (2004) reported a non-randomised pilot study involving 24 patients comparing their psychosocial intervention with a health care management programme. Patterson and colleagues (2006) carried out the most comprehensive and well-controlled study in this area to date. Their RCT involved 240 patients and had the advantage of including a time-equivalent attention-control group, which provided a supportive environment for addressing personal problems.

Across all three studies, retentions rates were good and there was evidence of improvements in social activities, independent living, social skills, self-efficacy and negative symptoms (Bartels et al., 2004; Granholm, et al., 2005; Patterson, et al., 2006). Effects sizes were maintained at 12-months follow-up and were comparable to those found for younger adults with schizophrenia (Granholm, et al., 2007).

In our group we are currently conducting a study to assess cost effectiveness and efficacy of a nurse-led group based psychosocial intervention for older adults with schizophrenia. This research will be important in developing an evidence base on which to model services in the UK. The proposed intervention consists of 20, two-hour weekly sessions. Manuals will be developed in collaboration with NHS psychologists,

research groups in the US and service users. Groups will be facilitated by two nurses who will undertake 12 sessions (half-days) of training over three months and ongoing supervision. Intervention modules will closely follow successful US components and those used successfully with adults with schizophrenia under the age of 65 years. We aim to recruit 150 patients who will be randomised to receive the intervention or treatment as usual. Patients will be assessed at baseline, end of treatment and six-months follow up. Primary outcomes are independent living skills (Independent Living Skills Survey) and social functioning. Secondary outcomes include self-esteem, coping, quality of life, depression and psychotic symptoms. Incremental cost effectiveness ratios will be estimated. Data for the cost effectiveness analysis will be collected for all participants in the trial, including use of hospital inpatient and outpatient care, use

of primary and community based health and social care and health status measured by the European Quality of Life measure (EQ-5D). Quality adjusted life years (QALYs) will be estimated from the EQ-5D and associated population utility tariffs.

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Notes

Notes

Notes for Contributors

The *PSIGE Newsletter* welcomes the following submissions for publication: articles, research updates, Letters to the Editor, book reviews. These can be on any aspect of psychological theory or practice with older people.

Articles

Articles form the bulk of contents submitted to the *Newsletter*. 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. These can cover empirical investigations, pilot studies, descriptions of service developments, audits and evaluations. 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).

Articles of any length up to a maximum of 3000 words will be considered. Experimental reports should follow convention in terms of subheadings and sections: Abstract, Introduction, Method, Results, Discussion, References.

References should follow conventional format as in journals such as *Psychological Review*:

- (1) Book reference:
Mischel, W. (1986). *Introduction to personality*. New York: CBS.
- (2) Journal article:
Martin, A. & Fedio, P. (1983). Word production and comprehension in Alzheimer's disease: The breakdown of semantic knowledge. *Brain and Language*, 19, 124–141.
- (3) Paper in a book:
Garrett, M. (1980). Levels of processing in sentence production In B. Butterworth (Ed.), *Language Production (Volume 1) Speech and Talk*. London: Academic Press.

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 these submissions below 500 words.

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.

Book reviews

Submissions up to 250 words reviewing a text of relevance and interest to the PSIGE membership will be considered. These submissions must include full details of the book (including publisher).

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

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 photograph 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

All submissions must be written in language that is inherently respectful to older people and consistent with the British Psychological Society's guidelines.

All contributions must be word processed. Formatting should be consistent with the British Psychological Society's guidelines.

Please submit articles as a Word file via e-mail to the Editor.

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, all reports of research should 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.

All contributions should be sent to: Louisa.Shirley@ntw.nhs.uk

Contents

- 1 Letter from the Editor
Louisa Shirley
- 3 Letter from the Chair
Don Brechin
- 4 Discharge from day hospital: An alternative perspective based on recovery and social capital
Anne Crawford-Docherty, Eleni Theodosi, Bal Chohan, Julie Clift, Dawn Fallon, Roberta Hall, Gurdave Kumar, Jan Liddell, Jean Tibbetts & Suzanne Whitehouse
- 11 Filling the Void: How can we improve the effectiveness of groups to help people manage their memory difficulties?
Diane Dansey & Lucy Leonard
- 17 Not a one trick pony: The SPECAL method as a comprehensive system of interacting clinical techniques
Penelope Garner & Oliver James
- 24 Do older people use religion as a coping aid?
Michael J. Lewis, Anthony C. Edwards & Mary Burton
- 29 Research Update:
The effectiveness of a nurse-led psychosocial intervention for older people with schizophrenia
Katherine Berry, Christine Barrowclough, Nitin Purandare & Richard Drake

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