



The
British
Psychological
Society

Psychology Specialists
Working With Older People

PSIGE Newsletter

No. 100 – July 2007

ESSEX & HERTS
GEOGRAPHICAL GROUP



www.psigе.org



CAMULODUNUM TO BASILDON: FROM ENGLAND'S OLDEST TOWN TO THE NEWEST

ISSN: 1360-3671



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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.

EDITOR

Romola Bucks

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We are most grateful to Peter Ord who took all the photographs of Herts. and Essex scattered throughout this issue.

ISSN: 1360-3671

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PSIGE is the Faculty for Old Age Psychology
(British Psychological Society, Division of Clinical Psychology).

Letter from the Chair

Steve Boddington

AS YOU RECEIVE YOUR COPY OF this *Newsletter*, I will have completed my two years' tenure as Chair of PSIGE, and Sinclair Lough will be picking up the reigns for the coming two years. Full details of the new committee structure will appear in the Autumn (Conference edition).

I hope that you will permit me to reflect a little on my experience. Having been 'converted' to working with older people as an undergraduate (earning extra cash by working as an auxiliary nurse in old people's homes) and qualifying as a Clinical Psychologist in 1993, it took me two years of frustration with the ageism of the health and social care services in which I worked, finally to seek out and join my professional special interest group. PSIGE shared my struggle and passionate desire to promote the well-being of older people and challenge social attitudes towards older people's position in society. I looked forward to each edition of the *Newsletter* and each national conference, as sources of inspiration for applying 'adult-centric' psychology to people in later life, and relief from the struggle of fighting my own little corner.

Over the years I have gradually moved from the fringes (watching the 'senior' members dance the ceilidh in Cardiff) towards the centre (nothing quite as sophisticated from me in Chester I'm afraid!). It has been a fantastic, if a little daunting, experience to chair the National Committee and to represent the faculty within the Society and beyond (both Houses of Parliament, Department of Health, CSIP, etc.).

However, despite all that has been achieved in raising the profile of psychology for older people, we still have so much to do. Possibly, we have more to do now than we did when I first joined. Promoting the psychological well-being of older people whilst the traditional NHS/social care structures collapse around us, and new initiatives such as IAPT begin to emerge, is going to require even greater action on the part of all PSIGE members. We need to be finding ways of influencing policy and practice at a local and national level. In order to do this we must continue to support each other!

The National Committee work incredibly hard on your behalf, and we really value the wider views and input from the membership. Please continue to get involved where you can.

Steve Boddington

PSIGE Chair.

Letter from the Editor

Romola Bucks

WELL I PROMISED YOU A BUMPER issue and here it is. The Essex and Herts group have produced a plethora of papers which should interest and challenge in equal measure. It has been a pleasure reading them. I have been ably helped in my task as editor by the hard work of this issue's Guest Editor, Lindsay Royan, and I would like to thank Lindsay for her editorial skills, and Sara Banks for her organisational ones. We have a wonderful mixture of papers including reviews, case studies and audit or service evaluation reports. It is encouraging to see the wide range of work being carried out by the PSIGE membership and I hope you will feel as proud of our group as I have felt. It is always a pleasure, too, to be able to publish the work of assistant and trainee psychologists.

As many of you will know, this is my last issue as *PSIGE Newsletter* Editor. It has been a short time in post but a very enjoyable one. My heart felt thanks and warm wishes to your Committee, without whom PSIGE would not be the force that it is. When I offered my

services as Editor I thought that my role would be constrained to working on the *Newsletter*. This was not the case. From day one I have been involved in every aspect of the functioning of the National Committee from the fun (e.g. developing a research prize and being involved in choosing the winner) to the critical (e.g. helping to draft PSIGE's response to National consultations). At first, I was not sure of what I could offer to such significant enterprises. After a while, however, I realised that if we (the PSIGE Committee and its members) did not respond, who would? It is an empowering thought. So, my parting shot to you must be, please get involved at local or at National level. I cannot emphasise too highly how important it is for you all to put in your views/ideas/thoughts/criticisms. Honestly, it is not as daunting as you might think!

G'day possums!

Romola Bucks

Outgoing Editor, PSIGE Newsletter.

Letter from the Guest Editor

Lindsay Royan

WELCOME TO THE JULY EDITION of the *PSIGE Newsletter*, from the newest Geographical Group, covering Essex and Herts. A group of old age psychologists meeting regularly at the Petersfield Centre on the borders of London and Essex, to network and share CPD activities, had felt for some time that our geography meant that was difficult for us to reach either central London or East Anglia for meetings in established groups. We work in three Trusts, namely North Essex Mental Health Partnership NHS Trust (this includes parts of Hertfordshire), South Essex Partnership NHS Trust, and North East London Mental Health Trust. Our trainees come from several courses in the area; we have clinical psychology trainees from the University of Hertfordshire, UCL, UEL, and Royal Holloway, as well as psychologists completing their Statement of Equivalence, and counselling psychology trainees from UEL, City, Surrey, and London Metropolitan Universities. We also have assistant psychologists working in many of the departments. Contributors to this edition come from all these areas. We now hold meetings in different venues around the geographical area to enable everyone to have at least one short journey.

We present an eclectic mix in this edition, that reflects some of our interests and areas of specialism. Like most geographical groups, our population comes from industrial, rural, and suburban backgrounds. As an area, we are 'blessed', if that is the right word, with serving old established communities where families have lived for generations, and new towns that were developed during the 20th century to clear urban slums and re-house people made homeless by war, with the promise of a better life 'in the country'. The article by Loretta White, Sara Banks, and Steve Davies reviews the

psychological impact of the mass migration from London to one of these new towns, Harlow, which along with another new town in the area, Basildon, is preparing to celebrate its 60th birthday. My own Trust includes the Becontree Estate, the world's largest council housing estate built between the two world wars, as 'homes for heroes'. Nowadays, this estate in Dagenham shows all the typical hallmarks of urban decay and deprivation but, when it was first built, arguably made the biggest contribution to improving the health of its residents. Huge numbers of people were moved from the vastly over-crowded and infested slums of East London into semi-detached properties in tree-lined boulevards. For the first time, the 'in-comers' had indoor toilets, plumbed bathrooms, proper heating, and gardens in which vegetables and flowers could be grown. Children were able to sleep one to a bed, and new schools, shops, and health and community centres were built.

However, the planners did not take sufficient account of the psychological impact of these mass migrations that led to the break-up of old, established community networks. I began working with older people in the East End of London, and was struck by the frequency with which they blamed their depression on social isolation following the departure of their children to new settlements. (Actually, I don't recall ever hearing an older person back then use a word like 'depression', it simply was not part of the vocabulary, but I understood what people were trying to tell me.) More than a quarter of a century on, I now work with those 'children', who often talk with nostalgic fondness for the social cohesion of their place of birth, whilst acknowledging the material benefits of moving out. Attitudes and awareness have changed enormously in that time,

and many clients have developed a psychological vocabulary with which they can share and reflect on their experiences. Sadly, though, in the modernist world of the 1950s and 1960s, no one thought to research the impact on those who stayed behind, or on the country folk who were 'invaded' by these 'loud, uncultured Londoners'. This article also illustrates powerful cohort effects on societal attitude that has undergone transformation through the lifetime of these generations. It is well known that doctors in the 1960s were far more likely to label women with psychiatric illness than men. Women would frequently be prescribed diazepam simply for expressing concern about their husbands' health to their GP. It is also possible that people choosing to move out differed in important ways from those deciding to stay. Those making the move perhaps felt they had more to gain by leaving, such as escape from a toxic home environment and other stressors that made them more vulnerable to anxiety than others.

Other articles cover a wide range of topics, including work involving different theoretic and therapeutic modalities (Personal Construct and Psychodynamic). We present an initial report on a large-scale study exploring carers of people with dementia and their use of services. In this, the authors also consider the impact of geographical location on participants. We offer some reflections on the use of ecologically valid neuropsychological tests, and on the contributions of different forms of neuro-imaging to the assessment of people with a possible dementia. We report on the views of carers from an audit of a Memory Clinic. One article reports on a survey of staff attitudes regarding ward round conduct. Such work does not simply represent useful areas of study for assistant and trainees, but also reflects the ways that qualified psychologists can demonstrate their 'added value' and contribute to the development of a Trust. It is no longer sufficient to claim the arena of therapies for psychology; many other professional groups argue they can take on this work as well as

psychologists, and on lower Agenda for Change bandings. It is appropriate and proper that other mental health professions develop skills in psychological therapies, but psychologists should not be afraid to offer other skills in addition, such as consultation, teaching, service development, 'psychological-mindedness', research and reflection. The last of these may be more important than some senior managers always appreciate, as we race against time to meet targets and achieve Foundation status by next year. (One of our Trusts already has such status, but obviously, that does not remove performance pressure from its employees.) We can provide invaluable support to senior teams to help them make sensible, achievable decisions whilst holding on to a vision of basic humanity towards its workforce and service users. The final article is a personal reflection on undertaking an older person's placement for the Statement of Equivalence.

We had so many contributions for this issue but were limited by space. These will appear in a future edition, and include an evaluation of an Intermediate Mental Health Team for Older People, an audit of three older people's wards, a review of psychological treatments for re-activated PTSD, and a study looking at the impact of frontotemporal dementia on Theory of Mind. Other recent studies to be published include one into the long-term effects of experiencing both evacuation and the Blitz; the joys and challenges of running a six-discipline research trial into the use of Omega-3 oils for people with dementia, the outcome of a study looking at the effects on carers participating in reminiscence groups with people with dementia; and a mindfulness group for people with dementia. I mention these only to whet your appetite for future publications, and sincerely thank all our contributors for their hard work and creativity. In the meantime, I hope you enjoy this first contribution from us Essex girls and boys!

Lindsay Royan

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Neuropsychological assessment with older people: Ecologically valid measures

Yamna Satgunasingam

The limits of traditional tests

IN RECENT YEARS, neuropsychological assessment has moved away from using traditional tests primarily for diagnostic purposes and detecting organic impairment, towards a more functional approach that allows for questions to be answered in relation to a patient's level of disability in the real world (van den Broek, 1999). There is increasing recognition that psychometric tests traditionally used for neuropsychological evaluation are limited in their scope in predicting how a person is likely to function in daily tasks (Wilson, 1993; Ready *et al.*, 2001). Tests such as the various versions of the Wechsler Memory Tests (Wechsler, 1998) commonly use experimental material (for example, paired associates, word list recall, abstract drawings) rather than tasks that relate directly to every day activities. They also provide percentiles or index scores from which it is difficult to make predictions about the likely nature and frequency of problems encountered in a patient's daily life (Wilson, 1993). Patients have also been demonstrated to perform well on structured tasks in the testing room but on tasks that are less structured or supported, their performance can be impaired (Norris & Tate, 2000). The use of ecologically valid measures has, therefore, been described as a 'pressing issue' in neuropsychology (Norris & Tate, 2000, p.34).

The need for ecologically valid tests

Sbordone (1996) defines 'ecological validity' as 'the functional and predictive relationship between a person's performance on a set of neuropsychological tests and his or her behaviour in a variety of real world settings,

such as home, work, school or the community' (p.16). Ecological validity can be enhanced by gathering further information from other sources such as interviews, self report measures, behavioural observations, and rating scales, to supplement the index test scores with information about the person's capabilities, particularly when further information concerning the individual themselves (for example, motivation and personal style) is needed to predict real life functioning (Wilson, 1993). Tests involving tasks that map directly onto real life behaviour are considered to have greater ecological validity (Spooner & Pachana, 2006).

Assessment with older people

With older people, psychometric tests are commonly employed to identify strengths and weaknesses in cognitive functioning to aid the detection and diagnosis of organic impairment of conditions such as mild cognitive impairment and dementia, or to assess effects of medication change or side effects (Bieliauskas, 1996). However, results of cognitive tests are increasingly required to understand and help predict how older people will manage in the real world and ecologically valid measures can enable questions concerning a patient's care, treatment, or management to be answered (Norris & Tate, 2000). Assessments may be required to predict how older people, including patients with dementia, will cope with activities of daily life when living independently at home, caring for themselves, including managing their health and remembering to take medication, managing their affairs and making informed decisions, including those concerning their finances

(Bieliauskas, 1996; Farias *et al.*, 2003). Ecologically valid measures can also assist in assessing whether the person requires more support at home or requires a placement better suited to their needs. The aim of this article is to outline some of the tests currently available that are deemed to have ecological validity, including those using tasks analogous to every day activities, which could be employed when undertaking neuropsychological assessment with an older person for purposes such as those described above.

Bieliauskas (1996) offers a comprehensive chapter that considers various classical or traditional cognitive tests and how performance on these tests relates to everyday behaviour in the effort to examine or establish ecological validity in these tests. However, since this chapter was written over ten years ago newer tests and measures that are considered to be ecologically valid have been published or are in the process of being developed. Some of these tests and measures will now be outlined including measures that not included by Bieliauskas. Measures of memory, executive function and visuospatial abilities will be the focus of this review.

The Rivermead Behavioural Memory Test (Wilson *et al.*, 1991)

This test of everyday memory (immediate and delayed, prospective, verbal, visual and spatial) uses analogues to real life every day tasks, for example, remembering a new name and recalling a new route around a room. The RBMT also assesses the retention and recall of intended or future activities such as remembering to ask about the next appointment time (prospective memory). The test has been shown to have good face and ecological validity (Goldstein, 1996; Wilson, 1993, 1996). There are four parallel versions (Wilson, 1993) allowing for assessment of progress and change over time, for example, decline of cognitive abilities in a patient with dementia, while minimising the effects of practice. Norms go up to 96 years and there is evidence for use of the RBMT in assessing early dementia (Huppert & Beard-

sall, 1991). Efklides *et al.* (2002) found a group of patients with Alzheimer's disease (AD) performed significantly lower than a group of healthy adults on the RBMT. The test also includes a test of orientation and has, therefore, been described as 'a very useful tool for memory testing, particularly in older adults' (p.64).

Everyday Memory Questionnaire (EMQ) (Sunderland *et al.*, 1983)

In considering ecologically valid memory measures in their study of healthy adults and patients with Alzheimer's disease, Efklides *et al.* (2002), however, stated that 'even this test (the RBMT) does not capture all aspects of everyday memory problems often reported'. Rather, Efklides *et al.* (2002) have turned their attention to the Everyday Memory Questionnaire, which focuses on different daily memory problems similar to those assessed by the RBMT. However, unlike the RBMT, which is an objective measure of memory, the EMQ is a subjective measure of memory performance based on meta-memory reports (awareness of memory problems). The EMQ consists of 28 items associated with different types of memory (prospective, episodic, procedural, semantic, memory for faces, places and routes). The authors found that the better the performance of the Alzheimer's group on the RBMT, the fewer reported problems in the EMQ (Efklides *et al.*, 2002). Performance on the Story subtest of the RBMT correlated to verbal memory problems on the EMQ (e.g. difficulty in following a story on TV; forgetting important personal information), forgetting changes in daily routine (e.g. coming back to check if you have done something you intended to do; forgetting to do the things you planned to do), problems with visuospatial memory (e.g. not recognising places in which one has been in the past) and problems with visual reconstruction memory (e.g. forgetting where your things are) (Efklides *et al.*, 2002). Awareness of problems assessed by the EMQ was found to increase with age in relation to general/

prospective memory and in new learning/repetition of responses (Efklides *et al.*, 2002). Participants with Alzheimer's disease made significantly more complaints concerning semantic memory problems than a healthy control group (Efklides *et al.*, 2002). This is not surprising considering that semantic memory problems are common in patients with Alzheimer's disease (Spaan *et al.*, 2003). This measure could, therefore, be useful in assessing how aware an older person is of their memory difficulties. Patients with greater awareness of their memory problems could be encouraged to learn strategies for managing their memory, for example, by referring the patient to a memory group for older people, which may enable the person to maintain their independence for longer.

The Autobiographical Memory

Interview (AMI) (Kopelman *et al.*, 1989, 1990)

This measure assesses personal semantic memory (recall of personal facts from own past life, e.g. name and place of school, names of school friends, etc.) and autobiographical incidents (recall of earlier life events, e.g. first employment, a specific past accident) across childhood, early adulthood and more recent history (Wilson, 1993). It takes the form of a semi-structured interview schedule and it has been described as having good face validity (Wilson, 1993). It has been suggested that this test could provide information that is valuable for interventions such as reminiscence therapy (Wilson, 1993), which may be particularly useful for older people including patients with dementia where recall of earlier memories is likely to be better than that of more recent events (Woods, 2000).

The Behavioural Assessment of the Dysexecutive Syndrome (BADS)

(Wilson *et al.*, 1996)

This battery of six subtests and a questionnaire measure (DEX) aims to predict problems that arise in daily life as a result of

dysexecutive syndrome (Wilson, 1993; 1996). The subtests are designed to map onto real life tasks that tap executive abilities including practical problem solving (Action Programme), planning, organisation and self-monitoring (Key Search, Zoo Map, Modified Six Elements), judgement (Temporal Estimation) and switching from one idea or rule to another (Rule Shift Cards). It is executive abilities such as planning that have been shown better to predict the capability of older people to undertake activities of daily living compared to more classic measures of cognition, such as memory and intelligence (Cahn-Weiner *et al.*, 2000). The BADS has been shown to have better ecological validity in predicting everyday problems than the Wisconsin Card Sorting Test (WCST; Wilson, 1991). Classification of test performance is provided up to the age of 87 and the BADS has good stability over a period of six to 12 months (Norris & Tate, 2000).

Three-Objects-Three-Places Neuropsychological Test (3O3P)

(Prestia *et al.*, 2006)

More recently, a validation study of an episodic memory test, the 3O3P, for patients with Alzheimer's disease has been undertaken (Prestia *et al.*, 2006). This brief test was found by these authors to be a valid measure for screening of Alzheimer's disease, correctly identifying patients with Alzheimer's in the age ranges of 50 to 65 and 66 to 80 (test sensitivity was found to range between 92 per cent and 100 per cent), with good reliability and internal consistency. The authors describe this as 'an ecological, quick, feasible, reliable and sensitive tool for helping the screening of AD' (p.406), making it more pleasant for older people who can feel uncomfortable with more difficult, classical tests (Prestia *et al.*, 2006; Dubois *et al.*, 2002). The 3O3P is designed to assess long term memory with greater ecological validity, replacing word list recall. The patient is required to name three objects first (a pencil, key and coin) to check

for any language or perceptual difficulties before the objects are hidden in three different places with the patient having seen where the objects were hidden. Following a five-minute delay, the patient is asked to recall the names of the objects and where they were hidden, and to match the object with its hiding place. A common complaint of older people with dementia is remembering where they have left items they have placed around the house such as keys or glasses; thus this task may be considered to map onto an everyday difficulty experienced by older people.

The Driving Scenes Subtest, Neuropsychological Assessment Battery (NAS) (Stern & White, 2003a)

Finally, an important issue frequently raised in relation to older people, including patients who have been diagnosed with early dementia, is their ability to drive a car safely (Brown *et al.*, 2005). Driving enables older people to remain independent. However, this activity can be affected when impairments in cognitive abilities develop. Visuospatial abilities, visual search skills and visual attention are associated with driving abilities in people with early dementia (Duchek *et al.*, 1998; Reger *et al.*, 2004) and these abilities are focused on by driving assessments. Executive tests such as the Trail Making Test and the Porteus Maze Test (Rizzo *et al.*, 1997; Ott *et al.*, 2003) have been shown to have good ecological validity for predicting driving ability. More recently, Brown *et al.* (2005) examined the ecological validity of the Driving Scenes subtest of the Neuropsychological Assessment Battery (Stern & White, 2003a). The Driving Scenes test involves presenting the patient with six road scenes in the form of colour drawings from the perspective of the person sitting behind the steering wheel. The patient is shown another similar scene after 30 seconds, following which the patient is required to indicate anything that is missing or is new in the current scene by telling the examiner or by pointing. The patient is then

shown another scene similar to the previous one and the patient again indicates what is missing or new. The test measures visual attention abilities in relation to driving. It is shown to have good ecological validity in relation to real on-road driving in healthy older people and people with mild dementia. There was a strong relationship between the Driving Scenes test scores and performance on a standardised driving test (Brown *et al.*, 2005).

The authors suggest that a referral for formal evaluation of driving abilities should be recommended if the older person has difficulty with this Driving Scenes test and there is also evidence of poor performance on other tests associated with cognitive aspects of driving, such as the Trail Making Test. Further advantages of this test include two equivalent forms to enable retesting while minimising practice effects, and data are available for a six month retest. The test is not computerised, unlike some other visuospatial tests used to predict likely driving ability, which allows for older people who have less experience of computers to feel comfortable with the assessment (Brown *et al.*, 2005). The test has been described as being an 'appropriate addition' to a neuropsychological battery (p.214, Brown *et al.*, 2005).

This article has outlined measures that are considered to be ecologically valid that could be valuable when used in assessing older people, including people with organic impairments such as dementia, for a range of purposes that requires information on how an older person is likely to perform in everyday life and the nature of their difficulties. Because of the complexity of real world behaviour, many cognitive tests still fail adequately to predict outcomes in everyday functioning. Further research is required to develop more ecologically valid tests that have appropriate norms for older people, are not too long, and are perceived as non-threatening for this client group.

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Some implications of different methods of neuroimaging for clinical (neuro)psychological* practice

Syd Hiskey

This paper considers some of the implications of different methods of neuroimaging for the practising clinical (neuro)psychologist. It focuses on the most commonly used approaches to exploring brain structure (Computerised Tomography and Magnetic Resonance Imaging methods), before briefly considering potential developments in the role of psychology in terms of the newer 'functional' technologies (e.g. Positron Emission Tomography, Functional Magnetic Resonance Imaging, Single Photon Emission Computed Tomography). It concludes that a working knowledge of neuroimaging remains important for (neuro)psychologists in health services and that we should strive to keep abreast of differences in these technologies.

CLINICAL PSYCHOLOGISTS working with older adults are often asked to conduct specialist neuropsychological assessments. Data obtained from neuroimaging investigations can inform this process (Goldstein & McNeil, 2004). However, there are a variety of methods of neuroimaging, which have implications for the utility of the images obtained. A brief introduction into some of these methods and some of the issues surrounding their use is presented here.

To begin with, it seems sensible to discuss those methods psychologists are most likely to encounter. Kessler (1998) cites the three most commonly used imaging techniques in clinical practice are Electroencephalography (EEG), Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI). EEG uses surface electrodes on the scalp to measure electrical activity although, in specific circumstances such as when evaluating patients for epileptic surgery, intracranial electrodes can be used. EEG is mostly used in assessing suspected cases of epilepsy and it is sometimes useful in identifying space-occupying tumours (Kessler, 1998). Routinely, however, psychologists are

required to assess patients whose EEG results (e.g. 'diffuse frontal slowing') would have little diagnostic utility and simply highlight that there is a problem within the central nervous system. By comparison, CT and MRI are thought of as the two most dominant methods in clinical use (McConnell, 1998) and so I will concentrate on these for the first part of this article. I start by outlining the mechanisms underpinning first CT and then MRI before considering some of the implications either method has for clinical practise. Due to the fact they explore changes to the anatomical structure of the brain, CT and MRI are broadly referred to as 'structural' neuroimaging techniques. However newer 'functional' imaging technologies also exist and so, the latter part of this piece will also consider their potential impact upon our profession.

Structural imaging

CT consists of scanning a part of the body (e.g. the brain) with x-rays. X-ray photons are transmitted to the tissue, where their density can be measured. Standard cuts, or passes, of the scanner are created at successive levels of the target and the data obtained

*The term neuropsychologist seems overly specialist for the present purposes, as the majority of those conducting such work tend to refer to themselves as clinical psychologists.

are then analysed by computer to create a series of visual images, which are reproduced onto film. Pathology is observed by variations in normal densities, which show as degrees of darkness on the film (Allen, 2002).

In contrast, MRI does not use x-ray technology. It uses magnetic fields in three directions to allow the spatial location of signal data to be detected and a two-dimensional image to be created. The technology is based upon the idea that when the nuclei of atoms (often hydrogen protons) are subjected to highly magnetic fields they spin and align in specific directions (i.e. towards the field). Radiofrequencies pulsed orthogonally to the field then alter spin angles and the eventual return to a state of equilibrium that follows the cessation of the pulse is related to both the radiofrequency characteristics of the element and its physiochemical environment. Various sequences (T1 weighted, T2 weighted, Flair) are used to make up images and have differing properties. For example, T1 weighted images are good for viewing anatomy (they remove cerebrospinal fluid from the image), while T2 weighted images and Flair are good for viewing pathology (such as lesions).

McConnell (1998) claims there are multiple advantages of MRI over CT scanning. These include higher resolution (notably when exploring white matter in demyelinating disorders), in locating seizure foci in epilepsy (when hippocampal region resolution is good) and in dementias, infarctions, vascular malformations, neoplastic and degenerative diseases. It is also considered the dominant technology for demonstrating evidence of brain tumours (Allen, 2002) and inflammatory conditions (Mellers, 2004), as well as affording greater imaging of the spinal cord and brain stem. Finally, it can also detect minor head injuries that CT might miss due to bone artefact, such as mild orbitofrontal and temporal lobe contusions (Mellers, 2004). In contrast, CT scanning is more readily available as it is comparatively inexpensive, very quick to conduct, and can be used when MRI cannot

(e.g. should the patient have a metallic implant such as an aneurysm clip). It is also the imaging technique of choice in certain circumstances. For example, it is preferable in the evaluation of meningeal tumours, when exploring for evidence of calcification, in cases of acute intracranial haemorrhage (Weinstein & Swenson, 2001), skull fracture and other bone abnormalities (Reitan & Wolfson, 1992). Either type of imaging technique is, therefore, common and plays an important role in clinical settings.

There may, of course, be times when one method is carried out as a matter of routine. For instance, CT scans are generally conducted on those with suspected stroke to rule out haemorrhage, infarct or mass lesion. However, CT scans of very recently acquired stroke damage can show similar densities to normal tissue. A lesion can take three to four days before it can be detected via CT (Weinstein & Swenson, 1998) and so early scans can be misleading. MRI is the better technology for detecting small vessel disease (subcortical strokes) as well as pre-existing periventricular white matter disease. The presence of coexisting lesions in the white matter will clearly have a bearing on interpretations of neuropsychological test results, of likely prognosis and for subsequent management and/or rehabilitation efforts.

An initial implication of these technologies for the practising clinical (neuro)psychologist is, therefore, that different types of scan are better suited to detecting specific types of brain pathology. A second implication is that we should remain aware of the relationship between when damage to the brain occurred and when imaging was subsequently conducted, as this may have a bearing on the utility of the scan.

Kessler (1998) also warns us to remain cautious when evaluating the results of either method. As we have seen, CT can be insensitive to subtle disease states associated with subcortical white matter and Kessler argues that, in general, slight traumatic brain injury (TBI) or vascular insufficiencies are better identified by neuropsychological

rather than neuroimaging-based assessment. Similarly, MRI can overestimate the extent of central nervous system (CNS) involvement in some conditions, as T2 weighted images can exaggerate instances of periventricular white matter disease. Another implication of neuroimaging is, therefore, that it should not be the sole basis for differential diagnosis. Its role is most useful in helping account for the extent of a patient's illness or in informing prognosis.

In cases of TBI, Bigler (2001) reminds us that while local damage can be seen using neuroimaging techniques, movement forces ultimately affect the whole brain. A TBI due to a high velocity impact may be said to have resulted in an identified lesion yet the total damage (due to stretching, rotation and compression of the brain) will always be beyond that which can be identified visually. In other words, a single lesion may be apparent on CT or MRI scan but it should not be thought of as uniquely responsible for any functional sequelae. This could be evaluated more comprehensively using neuropsychological methods to gauge performance on a variety of tasks in light of age-matched normative data and estimates of premorbid ability.

Indeed, Bigler (2001) offers various caveats for the clinical (neuro)psychologist taking neuroimaging into account during assessment of TBI: (1) observed structural abnormalities may only represent the tip of the iceberg of the pathology; (2) the absence of brain abnormality on MRI scanning following significant injury may illustrate changes below the limits of detection; (3) day of injury scans may not always be trusted in that structural changes (e.g. haemorrhage, oedema, midline shift) might not be seen in the initial scan as such sequelae can take time to unfold. Bigler's first and second points complete our list of implications for structural neuroimaging techniques, while his third point reiterates that made earlier in terms of CT and instances of suspected stroke. This article now turns briefly to considering functional neuroimaging and its implications for clinical (neuro)psychological practice.

Functional imaging

In contrast to structural techniques, functional neuroimaging can be thought of as a generic term to encompass methods in which various processes of brain activation (e.g. glucose uptake, movement of blood, blood oxygen levels) are scanned while the patient performs some form of psychological test (Andrewes, 2001). Scans of this type lead to the generation of an image of the metabolic changes that took place during the test phase, with the common assumption that areas of the brain requiring greater blood flow, glucose uptake, blood oxygen, etc., are involved in greater neuronal activity. Various functional neuroimaging techniques exist (e.g. Positron Emission Tomography: PET, Functional Magnetic Resonance Imaging: fMRI; Single Photon Emission Computed Tomography: SPECT) which do not require further description or differentiation here, beyond repeating that each attempts to measure the brain 'in action'.

Silbersweig and Stern (2001) point out that functional imaging allows us to localise circuits and regions of the brain relating to behaviour, perception, cognition and emotion as they happen and argue that such techniques extend the use of the lesion approach in considering the relationship between structure and function. For example, hypotheses regarding the mechanisms affording residual capacity in brain damaged patients (e.g. the region is not completely damaged, other regions have been recruited to help, etc.) can be difficult to test using neuropsychological methods or structural imaging but may be more amenable to a functional approach (Fiez, 2001).

In addition, Bigler (2001) draws our attention to (neuro)psychology's tradition of monitoring recovery of function over time. He notes the difficulties associated with both practice effects and issues of test-retest reliability and suggests that neuroimaging techniques such as fMRI and SPECT can help in tracking recovery of function (although they are at present predominately research tools, Mellers, 2004). Inevitably, as functional

imaging techniques advance (e.g. Kaneko, Momose & Kadoya, 2005) and interface with increasingly sophisticated probes, simultaneous imaging and neurobehavioural assessment will become more common (Fiez, 2001), which may ultimately shape some of the (neuro)psychologist's current role. Indeed, the use of functional neuroimaging in rehabilitation efforts has considerable potential to inform interventions by the practising clinical (neuro)psychologist. An important implication of functional neuroimaging is, therefore, in its potential to draw together previously exclusive methods of evaluation (i.e. imaging and neuropsychology) and to influence treatment.

However, this future may be some way off. For example, Fiez (2001) draws our attention to discrepancies that will influence attempts to integrate neuroimaging and neuropsychological approaches. Using working memory as a paradigm, she argues that neuropsychological research and practice typically do not provide substantive detail regarding the specific site of brain damage and attendant impairment, while functional neuroimaging often employs psychological tasks that have not been well researched (e.g. the psychometric properties of the measures used are, often, yet to be substantiated). A final implication of functional neuroimaging is, therefore, that some of the measures and tasks clinical (neuro)psychologists use may well evolve over time to be more compatible with tasks that can be employed during scanning. Our profession clearly has the expertise to inform this process.

Summary and conclusion

In summary, both structural and functional neuroimaging techniques exist. Implications of structural imaging methods for the practising clinical (neuro)psychologist include; the inherent specificity of the two most commonly encountered techniques (CT versus MRI), issues surrounding when a scan is conducted, that images should not be the sole basis for differential diagnoses, that observed structural abnormalities do not equal functional sequelae, and that imaging cannot always capture extremely subtle damage to the brain. In terms of functional techniques, implications include; the potential to encourage greater collaboration (and negotiation of changing roles) between neuroimaging and neuropsychology, and the opportunity to shape the evolution of some of the tools we traditionally use. To conclude, a working knowledge of neuroimaging remains important for (neuro)psychologists in health services and we should strive to keep abreast of developments in the field so that we can inform, extend and sharpen clinical practice.

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Is a new town good for the mind? A review of mental health problems in planned communities

Loretta White, Sara Banks & Steve Davies

Towns and their history

COLLABORATING IN social groups has been one of the defining achievements of human evolution. Brain structures that support social cognition and behaviour have developed and, in turn, have enabled cohesion and co-operation to occur (Boyd & Richerson, 2005). As a result of this process communities, formed for self-sufficiency and mutual protection, have grown and, as economies have become better established, trade for goods and services have led to the development of larger communities such as towns.

By late medieval times the town was an essential part of Britain's social and economic landscape and while the civic culture presented advantages in the shape of control of local revenues, shortcomings in planning placed towns under strain during the country's Industrial Revolution, when large numbers of people from rural locations migrated. Provision of accommodation for these workers led to the establishment of neighbourhoods from commercial and industrial necessity rather than as a result of any naturally occurring social phenomena (Chalkin & Kirby, 2001).

Understanding and responding to the deprivation, individual and social alienation that stemmed from this utilitarian residential development was an important feature of the social movements of the time, which arose to better the lives of the 'working poor' (Pugh, 1999). These moral and bio-social narratives about the behaviour of the poor merged into the mental hygiene movements of the late 19th century and so the idea of ordered, efficient, new towns, places where people could

be persuaded to feel and behave better, was born.

The development of the UK new town

In England the first concerted effort towards the establishment of entirely planned communities began with the town of Letchworth in 1903. Restlessness about the over-industrialisation of Britain's 'old' towns continued throughout the 1920s and 1930s through pressure from social medicine and a growing number of environmental and health charity groups, but it was the damage inflicted on the cities of Britain during the Second World War that provided the opportunity to replace housing on a town-sized scale.

By 1945, 27,600 homes were rendered uninhabitable in London alone, and so The Abercrombie Plan for London Housing Needs (1944) recommended the building of eight new towns to re-house this population. The New Towns Act (1946) was later passed in order to enable the planning and building of these new, replacement communities which happened in three main phases: the intensive building of new towns around bomb-damaged cities rapidly to replace lost housing; a second phase of building in the 1950s and early 1960s to relieve housing problems in rural locations followed by more commercially-based construction in the late 1960s and 1970s to take the total number of new towns in England and Scotland up to 32 by 1990.

The construction and development of new towns differed to other forms of post-war housing in that they were planned as relatively self-contained communities,

providing employment, recreational facilities and accommodation for the young couples and families moving in. The physical pattern of these cities was intended to promote communication, participation and to bring together different social classes at a neighbourhood level.

Despite the rapid growth of new towns, over the last decade, this initiative and its outcomes have suffered increasing disaffection. A parliamentary enquiry by the Select Committee on Transport, Local Government and the Regions (2002) recommended re-targeting deprivation monies, creative improvements to the architecture of town centres and services provided, transport planning and neighbourhood security so that the sustainability of the new towns could be enhanced and population shifts away from the less successful new towns could be reversed.

The development of new towns on the basis of socio-political ideology may be one of several factors underlying the difficulties associated with new towns in recent years. This prompts a number of questions for the Psychologist including whether moving to a new town did affect individuals' functioning in the way the social movements of the 19th and early 20th centuries had hoped. However, remarkably little work has been carried out evaluating the relationship between new towns and the mental health of their inhabitants. Clearly, this requires some further attention.

Review of the literature

This review is based on the available literature on mental health within new towns, published between 1950 and 2007, and an extensive search of MEDLINE, PsychINFO and Sociological databases. It examines relationships between these two concepts, discusses methodological limitations of the research to date and, on the basis of the existing literature and more recent socio-political objectives, proposes areas for future research.

Formal evaluation of the relationship between these projects of social engineering and residents' mental health stemmed from anecdotal reports that in adjusting to the move from larger cities such as London, people were experiencing significant levels of emotional distress or 'neurosis', more commonly referred to among health professionals and in the literature of the time as the 'new town blues' (Sainsbury & Collins, 1966).

An early study by Clout (1962) investigated the prevalence of psychiatric illness in a new town general practice by using the records of 1280 patients from Crawley new town and 616 patients from Crawley old town who had sought assistance for difficulties other than common physical ailments, over a 20-year period.

Clout's (1962) definition of psychiatric illness differed according to gender and used rather arbitrary criteria, however, results indicated that the prevalence of psychiatric illness (largely characterised by anxiety disorders) accounted for 28 per cent of all illness in Crawley new town and 24 per cent in Crawley old town, with higher rates observed among women aged between 30 and 40 years in both communities.

The next research on Britain's new towns was published by Chave (1966) who attempted to examine the assumed, but not yet proven notion, that there would be a reduced prevalence of mental health problems among residents of a new town and that this could be attributed to the social planning underlying the development of the community. Various criteria were used to determine the mental health status of a random sample of people living in the new town of Harlow and a control sample from a typical local housing estate where such planning was absent, ranging from admission to hospital for psychiatric problems to consultations with the general practitioner.

After adjusting data for variation in age and social class, it was found that, over a five-year period, the number of consultations by people living in the new town was around one-third higher than the national average,

but in line with the prevalence rates expected for the region of the country in which Harlow is situated. Further, these mental health difficulties appeared to be more prevalent among females, who had more recently moved to the area, were more socially isolated and who were, in turn, more likely to seek contact with their GP.

Alongside Clout's (1962) findings, these results appear to suggest that there is no association between the 'new town blues' and adjustment to life in these communities, but perhaps the presence of longstanding emotional vulnerabilities and/or distress that had been transferred to a new environment. A similar conclusion was drawn by Hare (1966) who, in a review of three published studies: Wilner *et al.* (1960), Taylor and Chave (1964), and Hare and Shaw (1965), acknowledged that although the social and physical conditions characterising older urban areas and new towns was vastly different, this appeared to have no measurable causal or mediating influence on the rates of mental health problems in the samples studied.

The methodology used in a study by Sainsbury and Collins (1966) allowed these assumptions to be tested. Using structured questionnaires the researchers took a sample of mental health and non-mental health service users who had been living in Crawley new town for less than four years.

Thirty per cent of the service users were found to have a history of psychiatric illness prior to this move, and in two thirds of cases this was characterised by anxiety disorders. Male and female service users differed markedly in the social problems they had encountered in the new town, with the former generally showing a more favourable attitude towards this move. By contrast, female service users found their new environment to be more lonely, they participated less in social activities, and were more likely to miss contact with relatives who had lived close by, prior to the move.

Results obtained in Sainsbury and Collins' (1966) study lend some support to

Chave's (1966) observation that some females living in new towns may be at greater risk of feeling socially isolated compared to their male counterparts, but do not appear to support Hare's (1966) assertions.

Like Clout (1962), Bain and Philip (1975) used notes taken in a general practice in Livingston, Scotland as the data source for further investigation of the new town/mental health relationship. Of 100 newly-registered families, 25 per cent of adults presented with psychiatric illness in their first year in the town; nearly double the consultation rate for psychiatric illness in the practice as a whole. However, up to 40 per cent of this group had presented with similar difficulties prior to the move to the new town and at two years follow-up the consultation rates for psychiatric illness and other physical health problems by new town residents had fallen in line with the practice average. These findings appear to suggest that mental health problems in early consultations might reflect the strain and process of adjustment following a move rather than difficulties with the experience of living in a new town. However, the presence of longstanding psychiatric problems in nearly half of the sample and the absence of an identified control group makes it difficult to draw firm conclusions.

Cobb, Miles and Limentani (1983) attempted to address these methodological issues by comparing rates of consultation at a health centre in Milton Keynes by people living in two new town housing estates with those living in surrounding villages. Analysis of the data indicated that those who resided in the new town were found to consult 10 to 15 per cent more frequently than those who lived in the older, surrounding areas. On the basis of these results, the authors concluded that patients who choose to move to the new town estates hold a more proactive attitude to seeking medical advice and support, and that this is more likely to be the underlying factor behind any evidence of raised rates of contact with services and/or measurable health problems than the social environment of a new town.

Discussion and conclusion

This review has aimed to examine one of a number of psychosocial assumptions underlying the creation of new towns and to open a discussion about the relevance of mental health among people living in these communities today.

One might imagine that the social movements who fought for and subsidised improved living conditions for the 'working poor' would have preferred research on new towns to begin by focusing on the anticipated improved physical and mental health of residents. However, in reality, the bulk of research conducted has been shaped by early anecdotal reports of emotional distress in individuals' adjustment to the transition from city to new town.

A number of methodological limitations were identified in the research conducted including: a lack of clarity around the aims, objectives and theory underpinning the research; and varying definitions of psychiatric illness and measures used to assess the presence and nature of mental health problems. One methodologically sound feature of the research reviewed has been the size of the samples investigated. However, this is balanced by the problematic and wide ranging ways in which samples are generated and, particularly with regard to control groups, relevance to the research questions raised.

Such methodological limitations make it difficult to interpret results, draw comparisons between the studies conducted, or for the literature to develop in a systematic way. The cross-sectional design and descriptive statistics used in the majority of the research adds to this problem, but does not discourage the authors of the research reviewed from making inferences about the causal direction of results. Any trends arising from this research are, at best, tentative. However, some key themes emerge.

Firstly, whether using contacts at primary or secondary health care services as the data source, there appears to be limited support for the notion of 'new town blues' or for the

association of new towns with enhanced mental health. Rather, the occurrence of mental health problems in new town residents was found to be either generally consistent with the wider population from which the samples were drawn, present prior to the move to the new town, and/or found to be a transitory experience.

Secondly, higher rates of psychiatric illness were observed among females compared to males, particularly among those of an age likely to be raising families. One explanation for this finding is that while their partners may have migrated to new towns for employment in their working groups, females were separated from their usual network of social support and became more socially isolated as a result. In this respect, it is perhaps unsurprising that some studies observed increased levels of contact between female participants and primary care services.

Lastly, much of the research has made reference to the prevalence of anxiety-based psychiatric disorders among samples studied, and in all new town and control samples, this type of symptomatology was found to be more common than other mental health problems. It is feasible that this finding may relate to the far-reaching psychological effects of the separation, crisis and loss involved in the Second World War and more specifically to the damaged attachments of children raised during this period (Foster, Davies & Steele, 2003).

While it is premature to draw firm conclusions about the nature of the relationship between mental health and new towns, early findings suggest that there may not be a direct association between the two, but a more complex interaction between mental health, environment and a number of other factors including gender, social support and attachment style.

It would appear that the socio-political ideology underpinning the development of new towns did not take into account how such variables might shape psychological and behavioural functioning or the short

and longer-term implications of moving people from a system with which they were familiar. Interestingly, recent investigations into the shortcomings of new towns (Select Committee on Transport, Local Government and the Regions, 2002) have followed a similar line, focusing on improvements to the infrastructure of these communities rather than considering the potential role of underlying psychosocial issues.

Additional research with methodological rigour is necessary further to explore the themes raised from this review. This should include longitudinal studies, based on testable hypotheses from which theories and interventions can be developed using internationally agreed definitions of mental health and psychiatric illness, with valid and reliable measures to assess these concepts.

The design of this research is an important area for consideration and should incorporate control groups from more established communities living alongside the new town developments, or individuals residing within the new towns who do not experience clinically significant mental health problems. Investigations that allow for the analysis of potential mediating factors should also be a priority.

The studies reviewed and published to date were largely conducted in the 1960s, involving young adults. If further research is to be carried out, and comparisons drawn between populations, it may be necessary to look towards recruiting participants of a similar age, who plan to move to recently proposed new towns in the southeast of England.

An alternative possibility is to revisit the original migrants to new towns; now into older adulthood and meeting challenges that in many ways reflect those faced earlier in life, particularly with regard to changes in social support and availability of attachment figures. It would be of interest to see if any of the issues raised from the research presented in this review continue to be of relevance for this group of people and influence individuals' understanding, experience and help-seeking behaviour with regard to mental health.

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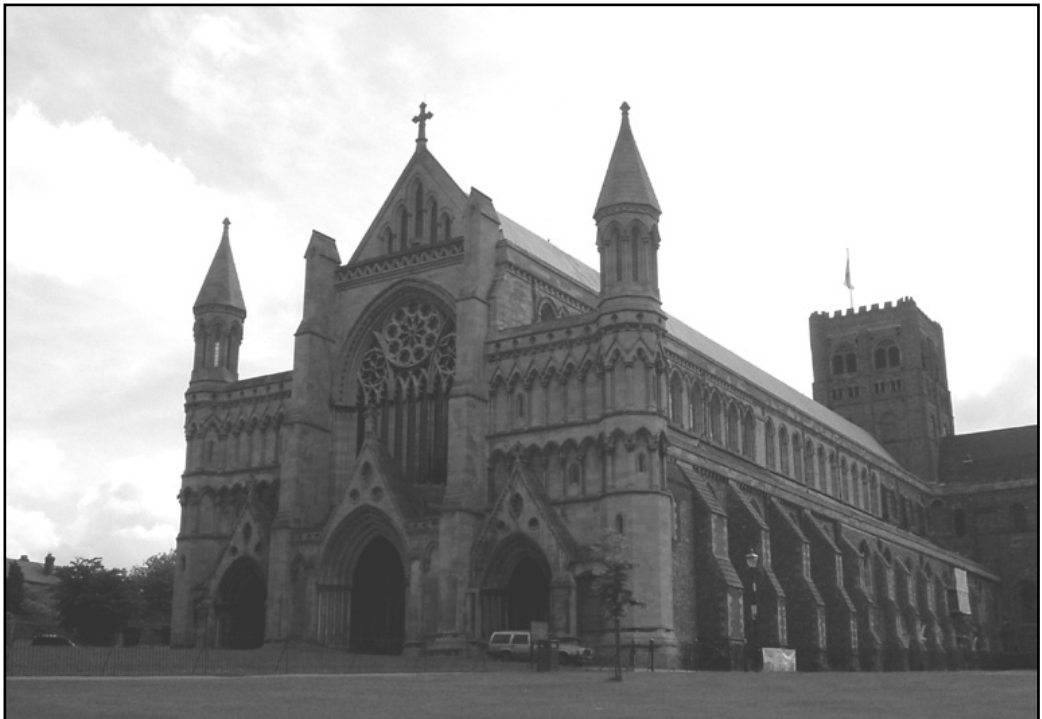
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Clinical case study informed by Psychodynamic ideas

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PSYCHODYNAMIC THEORY, in my experience, seems a less popular school of thought amongst clinical psychologists. For example, from attending a supervisor's workshop for one of the London based Doctoral Training Programmes in Clinical Psychology, I learned that only nine hours out of three years' of full-time study was spent teaching Psychodynamic ideas. I understand that more time is allocated for teaching Cognitive Behavioural theory. It also seems that the Government favours Cognitive Behavioural Therapy as opposed to Psychodynamic therapy. This is illustrated by a Governmental push of Cognitive Behavioural Therapy as the most effective form of psychological treatment when compared to other theoretical models (Layard, 2006). This is because an evidence base indicates that this theory is an effective one. Cognitive Behavioural Therapy may well be effective but this does not mean that other theoretical positions are not as effective in treating clients. One possible reason for the lack of equivalent evidence for Psychodynamic interventions is the view that it is more complex to evaluate Psychodynamic interventions than it is to evaluate Cognitive Behaviour Therapy.

I can see that this article could go in two directions. I could, in the first instance, continue to debate the effectiveness of psychodynamic therapy but I think this is fuel for another paper. What I would like to do is illustrate the usefulness of psychodynamic understanding when working with clients. I hope to illustrate this point using a case study. I also hope that other psychologists, who have a similar theoretical interest, will be motivated to write Psychodynamic case studies in support of Psychodynamic

theory and will therefore raise awareness of Psychodynamic thinking.

In this paper I will describe the treatment of a 76-year-old lady whom I shall call Sheila. A CPN (female) referred Sheila to me for 'bereavement counselling' following the death of her parents. Sheila's difficulty with mourning the loss of her parents was embedded in a long psychiatric history. This article describes the intervention from the assessment stage through to the end of treatment. It draws on the relevant literature from the Psychodynamic literature that helped me to understand the client's problems.

Background

Sheila was the first and only child of working-class parents. All that is known of her father is that he was a responsible but fragile man. She described him as fragile because she recalls him having a nervous breakdown when she was about six years old. This was because he was unable to obtain work. She developed agoraphobia after leaving school. As a result of this she had never been able to work or socialise with other people. Thus, she had to live with her parents. This was the first time she was living alone since her parents' deaths. She was also diagnosed with anorexia nervosa at 14 years and went into hospital at 21 years. She still has an eating difficulty in that she cannot keep any food in and uses laxatives excessively on a frequent basis.

She stated that her relationship with her mother was full of friction but was close. It was quite clear that her mother 'was her world'. She stated that she was 'All mother', that her mother was 'my God' and that she 'wanted my mother all for myself'. I was also given the impression that her mother was

unable to withstand her client's needs. This was illustrated when Sheila commented that her mother would often say in an exasperated manner, 'do what you like' and would let Sheila do what she wanted to do.

Her mother died 13 years ago, in 1994, of dementia of the Alzheimer's type and Sheila was the main carer. When her mother died, Sheila missed her mother terribly and berated and blamed her father for her mother's death. It seems that it was hard for Sheila to take responsibility for her anger and guilt over losing her mother.

Her father then became ill and died six years later (in August, 1999, of old age). He was 95 years old. It was around this time (when she was 73 years of age), that Sheila was referred to the team. She was admitted onto an acute mental health inpatient unit due to a feeling that 'her world had fallen apart' and she did not wish to live now that her father had died. She continuously blamed herself for his death and spoke about regretting taking out her anger over the loss of her mother on him. She also spoke about wanting to die. Her appetite and sleep were poor at the time. She was discharged back into the community with CPN support. However, she was re-referred by a rheumatologist involved in her care in 2003. This was because she was in a lot of pain due to 'her arthritis having galloped'. It is interesting to note that at this time her CPN had also retired, leaving her alone to cope on her own.

It is clear from her history that Sheila presented as a person with deep-seated problems. There was also the absence of close friendships in her life. It seems having no friends reflected an empty life. Her central difficulty in her current situation is her difficulty with facing life without her parents. Her wanting to die is her way of avoiding life without her parents.

I said I would meet with Sheila and carry out an assessment. We met for three weekly assessment sessions and five fortnightly treatment sessions. All sessions were based at Sheila's home.

Assessment phase

For the assessment and most of the treatment sessions, I met Sheila in her bedroom, situated on the ground floor. Despite there being daylight, the shutters on the bedroom window were closed. The room was dark and dreary. The overall impression was of being set back in time.

She literally lived in her bedroom. The impossibility of separating from her parents and living a life on her own forced Sheila to advertise for carers to live with her. The remaining bedrooms were taken over by the two live-in carers she had employed and a lodger who lived in the living room on the ground floor. She knew little about him. Thus, there was no living space in the house due to her substitute family filling the rooms. She lived, ate her meals and slept in her bedroom.

In stark contrast to the casual clothes she wore, Sheila often wore high-heeled, black, diamante shoes. She had a smooth complexion and long dark hair, looking much younger than her 74 years. This observation, in addition to reading her history, suggests that she had been indulged in her early childhood life and appears to have been treated in a grandiose and omnipotent manner by her parents. Now, in later life, Sheila is unable to manage being on her own and cope with making adult decisions.

I remember the deep dark circles under her vacant eyes, which gave her a frightened and empty look. She also spoke with a high, child-like shrill highlighting her immaturity.

In the first assessment session, I asked Sheila briefly about her background. She spoke fluently and was able to give an accurate account of her life. She was insightful as she stated she felt she hadn't 'grown-up'. She added that 'her parents were her life' and that she felt cheated and deprived of a life due to 'being indulged' by her parents. She stated that her goals of therapy were 'to get rid of the guilt she felt' and 'no longer grieve for her mother'. It was 'her father she now grieved for'. She also added 'her arthritis had galloped' since his death.

At the second assessment session Sheila informed me that she had received information from a neurosurgeon and had been advised to have a spinal operation that involved placing 'a metal-plate' in the back of her neck. The purpose of this operation was to straighten her neck. She was warned that if she did not have this operation there would be the possibility of her becoming paralysed. Sheila spent the rest of this session and the remaining assessment sessions speaking in an 'hysterical' manner of her fear of becoming paralysed and feeling terrified of the operation. Here is an extract from assessment session 2 to illustrate what I mean.

S: 'I haven't slept, I don't know what to do, I'd prefer to be paralysed than go into hospital. I can't go on like this, I really can't, I want to die. My father is out of my mind, this has taken over. I have no one, no-one will visit me, and what will I do. He'll (the surgeon) have to cut my throat and put his hand in...'

Review

I was struck by the intensity of the hysteria associated with having to have the operation. I felt overwhelmed by her incessant catastrophising and felt somewhat paralysed after meetings with Sheila. When she spoke in this manner I was reminded of Melanie Klein's paranoid-schizoid state:

'The paranoid-schizoid position describes the earlier position, that of the very young infant. This state of mind tends to be characterised by an exclusive concern with one's own interests, by a sense of persecution in the face of pain and emotional distress. A phantasy of self-directed aggression occurs leading to a fear of falling to pieces.'

(Hinshelwood, 1995)

It seems Sheila was operating from this unintegrated and incoherent state of mind. She perceived her situation as unrealistically bad and was unable to mix good and bad states of mind. Thus, as highlighted above, she feared an impending fragmentation of her self. From reading the assessment, it also seems

Sheila had a difficulty with being able to mourn the loss of her father and the loss of having had an adult life.

Freud's paper on Mourning and Melancholia (1917) illustrates the differences between a healthy state of mourning and a less healthy one. He called the not so healthy state 'melancholia'. He starts off by describing the differences between the two states of mind. One of the main differences is that in healthy mourning the presence of a 'good internal object' or self-esteem is required. It is this presence that allows the person to accept the reality of the loss of their loved one. In the not so healthy state of psychotic depression/melancholia, the mourning becomes complex. Instead of accepting the reality of the loss and experiencing the pain of the grief, he or she adopts a 'masochistic and perverse narcissistic state' where the person talks only of his/her misery and sadness over the lost one and keeps anything good, such as progress, quiet. Freud also describes how, in a psychotic depression, there is a hidden pleasure, a sort of autoerotic state in which the person goes over and over the pain of losing the person. From a theoretical stance it is known that in all masochistic states sadistic/aggressive feelings will also be present. It is this sadism that turns the goodness originally found in the relationship with the lost loved one into a sense of badness.

Freud's statement, 'And the shadow fell upon the ego' is a good illustration of what happens to the person when they come under the grip of a psychotic depression. It is the aggressive feelings towards the lost loved one that behave like 'a shadow' and inhibit successful mourning. I should also add that it is the guilt of having these feelings that represents Freud's term 'the shadow'. The individual also becomes very critical, confirming the notion that the superego has also become diseased by predominantly aggressive feelings and this results in self-torture.

I think the above illustrates Sheila's difficulties. It seems she had been unable to

mourn the loss of her parents by not being able to separate from them due to lacking a 'good internal object'. What set in place instead, was a melancholia that involved self-blame, auto-erotism and perverse narcissistic behaviours. To bear the loss of her parents meant having to take responsibility for the pain of the knowledge that the loved objects had been lost. This she could not do.

Assessment 2 gives an example of her low self-regard and self-blame that is symptomatic of a melancholia and not a mourning process.

'I'm so terrified, I've no-one, no-one will visit me in hospital.'

'Everything I did was wrong and nothing was right.'

'I know I am going to be paralysed, I know I will be.'

Sheila repeated these statements several times during the same session, illustrating the repeated self-attack and 'hidden pleasure' that Freud mentions in his 1917 paper.

Outcome

Due to the enormity of the arthritic pain and of her psychological distress, it was suggested by members of a supervision seminar, that initially I carry out liaison work designed to build links with the professions involved in the physical aspects of Sheila's care. The aim was to bring those professionals working with the physical and those working with the mental symptoms of her 'pain' together. In so doing it was hoped that support in working with Sheila would be achieved.

I recalled a paper by Arden (1999) on psychodynamic aspects of old age psychiatry in which he wrote about older adults 'wanting to go on being' or 'simply of the patient being borne in mind by his doctor'. He states that from a Kleinian perspective the consistency and reliability of the doctor can become introjected into the 'patient's unconscious as a good object'. I therefore felt that it would also be useful to meet with Sheila on a fortnightly basis for 30 minutes to provide a reliable and consistent pres-

ence. Initially I met with the care-co-ordinator to discuss a possible meeting with the physical health professionals. After a three-week gap I continued to meet with Sheila for six further fortnightly 'treatment' sessions.

Her fear of having the operation continued into the treatment sessions.

In the second treatment session, Sheila said that she was in 'so much pain and was certain she would become paralysed if she had the operation.' She continued speaking about how much pain she was in. She repeated her fear of becoming paralysed if she did not have the operation. This also illustrates going over and over the bad news, as outlined by Freud. She also spoke of an aggression that concerned me. The following example illustrates this:

Session 5

'I remember I had to tie-up my mother to a chair because she would slip and fall. I had to look after my mother. Do you know how it was to look after my mother for eight years? I did all the donkey-work, the carrying things up and down the stairs, the washing, the cleaning. My father just sat there. I tied my mother to a table because she kept walking off. Linda pointed out that it wasn't appropriate to do that.'

Sheila sounded sadistic and cruel when she said this again, highlighting the primitive nature of someone operating from the paranoid-schizoid position.

There was also a tendency to not want to apply the knowledge she had learnt with regards coping with her anxieties. In addition, there was also a difficulty in thinking constructively about her situation during the sessions with me. For example:

Session 1

M: 'It seems difficult to trust the doctor.'

S: 'Yes.'

M: 'You seem to feel unsure about having the operation.'

S: 'Yes, I want the operation but I can't have the operation; something awful will happen.'

M: 'What makes you think something awful will happen?'

S: 'I just know it will.'

M: 'What do you fear will happen if you have the operation?'

S: 'I don't know, I don't know.'

M: 'I'm wondering if it is difficult to think clearly due to the anxiety you feel...'

S: 'Yes I am anxious. I've read Claire Weekes' book and people have tried to teach me relaxation. I know all about physical symptoms of anxiety and the panic cycle.'

She also informed me at the end of the Session 4 that she had been taking laxatives. She said this was due to her appetite reducing and her feeling constipated.

I also attempted in the same session to challenge her comments but she was not able to think about what I had said, for example:

Session 4

S: 'You don't understand, I can't get out of bed, I can't move, I can't move my hands. I need that operation.'

She reaches to get a glass of water. I dispute her statement and comment on her managing to hold a glass of water.

S: 'How would I have got there? They would have had to get me a taxi.'

M: 'You have been there once before you could try again.'

The taking of the laxatives and the difficulty with using the knowledge she had been given as well her struggle with taking in my statements suggest a difficulty with thinking. Bion describes a similar state of mind called 'nameless dread' (Hinshelwood, 1995).

Hinshelwood (1995) describes Bion's concept :

'Nameless dread was described by Bion as a state of meaningless fear that comes about in the context of an infant with a mother incapable of 'reverie' – a concept that derives from Bion's theory of containing. When the mother fails to contain the infant's terrors and make them meaningful, this 'projective

identification-rejecting-object' is felt to strip the meaning from the experience and the baby; he therefore reintjects, not a fear of dying made tolerable, but a 'nameless dread' (Bion, 1962a, p.116).

Sheila could not allow anything in, due to being in this mindless state of dread. Her history of an eating disorder literally means a refusal to take things in. Her difficult but close relationship with her mother may be a contributory factor towards her current difficulty with being able to think.

However, I observed, through her behaviours only, some symbolic movement towards integration. By treatment Session 3, Sheila was finally able to make 'an adult decision' in that she decided to have the operation. It was at this session, that the curtains to her front window had been opened for the first time since I had known her. She had also managed to assert herself with the lodger and had told him to leave as he was not paying his rent. She had also cleared out his room and the living-room. For the first time in my contact with her we managed to meet in the living room. There was more space in her house and, possibly, this reflected more space in her mind.

She was also able to bring a dream to Session 3.

'Her parents are still alive. It is a weekday morning and they have got dressed and are leaving the house to go to work. They leave Sheila on her own in the home.'

Sheila stated she had no thoughts about this dream. I wondered if she felt that her parents had left her to get on with the business of living and that she had to do this on her own. Sheila did not comment on this statement, perhaps illustrating a continuing struggle with taking things in. As sessions progressed, Sheila appeared to talk more about her relationship with her parents. For example, at the fifth session she spent a substantial amount of time speaking about her stressful experience working as a carer for her mother. In addition to this she became more in touch with her physical frailty since she added that her parents

protected her from having to work but could not protect her from her deteriorating physical health.

After thoughts and conclusion

Sheila left me with strong counter-transference feelings because I, too, began to feel paralysed in the sessions. This was illustrated when my attempts at helping her think about her dilemmas were ignored by Sheila. She reminded me of a 'Queen Bee' in that sessions were spent with Sheila lying on her bed while she tried to draw me into her world by wanting me to get her things and do things for her. For example, Sheila wanted me to write to a neurosurgeon encouraging him to reconsider his decision with regards to her having an operation; she could not do this herself. Sheila also wanted more contact with me in that she wanted to meet weekly (Session 4) as opposed to fortnightly. She wanted me to sit and listen to her passively and not to encourage her to think and act constructively about her situation. Finally, despite being well enough to carry out household chores and make attempts to socialise, Sheila paid carers to do this. As already stated, her carers acted as a substitute family and not as real friends. She wanted me and the carers to be like her 'worker-bees' and do all the hard work while she lay on her bed and did very little.

I have described the clinical case of a 74-year-old lady suffering from a long history of somatic and mental health difficulties. Sheila is experiencing difficulty mourning the loss of her youth and the loss of her parents. With the use of illustrations from the clinical work I describe features that struck me during my work with Sheila and have applied psychoanalytic concepts to understand Sheila's clinical presentation.

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A Personal Construct Psychology exploration of dementia caregiving

Amanda Bingham

This article provides a brief overview of Personal Construct Psychology (PCP; Kelly, 1955) and elaborates its potential application to carers of people with dementia. A study was undertaken to explore carers' construing and its relationship with psychological adjustment (Bingham, 2006). The study used standardised questionnaires and repertory grids. A case study will be presented here in order to illustrate how an individual carer construed their situation and to highlight the implications for intervention from the perspective of Personal Construct Psychotherapy.

THE HIGH RATES OF mental health problems reported by family carers are well documented (e.g. Singleton *et al.*, 2002). Support for carers is integral to a comprehensive mental health service for older people (Department of Health, 2001; 2005). Recent guidance on dementia recommends carers who experience psychological distress should be offered psychological therapy (National Institute for Health and Clinical Excellence, 2006). There is an extensive literature on dementia care giving. Clinical Psychologists are considered to have an important role in promoting person-centred care (e.g. Boddington, 2001). Nevertheless, one theory of psychology and psychotherapy that has received relatively little attention in mainstream Clinical Psychology publications is Personal Construct Psychology (PCP; Kelly, 1955).

Personal Construct Psychology

Kelly (1955) described the philosophy underlying PCP as 'constructive alternativism'. He proposed that there are an infinite number of ways to construe the world and that 'all of our present interpretations of the universe are subject to revision or replacement' (Kelly, 1955, p.15). As with other constructivist approaches, there is a focus on meaning and people are viewed as actively creating their own realities (e.g. Mahoney, 1988).

PCP proposes that individuals construe the world in terms of their own unique set of personal constructs, which form an elaborate, hierarchically organised system (Kelly, 1955). A construct is a bipolar dimension of meaning that allows discrimination between elements of an individual's world. An element is anything that can be so compared and contrasted, such as a person. An example of a bipolar construct is happy-depressed. By saying that a person is happy, we are also stating that they are, for example, not depressed. Those constructs, which are concerned with how an individual construes oneself, form a person's core role structure and are central to identity (Kelly, 1955).

Personal construct systems function to help people to make sense of themselves and the world around them and to anticipate future events. If a person's hypotheses and constructs from which they were derived are disconfirmed, the person experiences invalidation and their hypotheses are generally revised. The process of hypothesis formulation, testing and reconstruction will normally present an individual with constant transitions in construing as they attempt to anticipate an ever-changing world.

Personal Construct Psychology and dementia

The application of PCP to understanding dementia has only been documented in recent years (Bender, 2003; Morris, 2000, 2004; Robbins, 2005). PCP has been promoted as an 'overarching theoretical approach' or a 'meta-theory' for describing person-centred care (Bender, 2003; Morris, 2000, 2004). It is proposed that PCP provides 'a model of the person that can be applied equally to the person with dementia at all stages of the disease; family and formal caregivers; and you and me' (Morris, 2004, p.70).

As with the onset of other illness or injury, the onset of dementia is likely to result in major invalidation, and demand considerable reconstruing for the person with dementia and the people around them (Viney, 1989).

The onset and progression of dementia is likely to lead to the disruption of the meanings that an individual holds about themselves and to invalidation of aspects of their core role structure. It has been proposed that people with dementia experience massive invalidation of the self (Bender, 2003).

Those who witness a loved one develop dementia are also likely to experience invalidation of aspects of their own core role structure. They are likely to need to revise meanings related to their role and identity and to that of their loved one.

Kellyan Threat, Guilt and Anxiety

Awareness of the prospect of transitions in an individual's construct system is associated with the experience of emotion, the particular emotion being determined by the particular transition with which the person is faced (Winter, 1992). The experience of threat, guilt and anxiety as defined by Kelly (1955) are likely to have particular relevance for family carers.

'Threat' is experienced when an individual becomes aware of an imminent and comprehensive change in their core role structure (Kelly, 1955). Following the onset of dementia, significant others are likely to experience threat as they become aware of a

need for change in the way that they construe themselves and their role, for example in terms of their independence and responsibilities.

'Guilt' is experienced when an individual perceives dislodgement from their core role structure (Kelly, 1955), for example, 'when we see ourselves behaving in a way that is not like me' (Fransella & Dalton, 1990, p.37). Following the onset of dementia, significant others are also likely to experience guilt as they become aware of themselves behaving differently, as their role within the relationship changes.

'Anxiety' is experienced when an individual has difficulties in anticipating events. It is the awareness that one's construct system does not apply to the events in hand (Kelly, 1955). Significant others may also experience anxiety, since the onset and progression of dementia is likely to be largely unfamiliar and unpredictable.

The experience of Kellyan threat, guilt and anxiety may help to explain the high rates of mental health problems that are found in family carers of people with dementia.

Personal Construct Psychotherapy

Personal Construct Psychotherapy (Kelly, 1955) is an exemplification of the application of PCP. Personal Construct Psychotherapy involves a process of reconstruction of a client's construct system. This may involve changes in both the structure and the content of the constructs.

The theory of PCP as applied to therapy with older people was elaborated by Viney (1993) in terms of a 'Life Stories' approach. The focus of Personal Construct Psychotherapy on anticipating the future is said to be of particular benefit in working with older people (Robbins, 1993, 2005). There is a growing evidence base for Personal Construct Psychotherapy with diverse client groups (Viney, Metcalfe & Winter, 2005; Winter, 2003), including older people (Botella & Feixas, 1989; Viney, Benjamin & Preston, 1989).

The case of Anne illustrates how one carer construes her situation and highlights the clinical implications from this perspective.

Case study

Anne was a 78-year-old White, British woman. She had been married to Bill for 52 years and they were living together at home. Bill had been given a diagnosis of Alzheimer’s disease one year prior to the interview reported here.

At the time of interview, Anne was the main carer for Bill. She was assisting him with personal care and was responsible for all cooking and domestic tasks. Anne completed the Hospital Anxiety and Depression Scale (HADS; Zigmund & Snaith, 1983). She scored in the severe range for anxiety (16/21) and in the mild range for depression (8/21).

Anne was interviewed in order to complete a repertory grid comprising 11 elements. Repertory grids allow the structure and content of an individual’s personal construct system systematically to be explored (Fransella, Bell & Bannister, 2004; Kelly, 1955). They were used here to gain insight into how carers construed themselves and their spouses before and after the diagnosis. Table 1 shows the titles of the 11 elements.

Table 1: Repertory grid element titles.

Key	Element title
A	Self now
B	Self five years before diagnosis
C	Self in five years time
D	Ideal self
E	Self as a carer
F	Typical carer
G	Spouse now
H	Spouse five years before diagnosis
I	Spouse in five years time
J	Ideal spouse
K	Typical person with dementia

Ten bipolar constructs were elicited from dyads of these elements. One pole was elicited by asking for an important way in which two of the elements differed, the other by asking for the opposite of this. Subsequently, the elements were rated on a seven-point scale on the elicited constructs.

The repertory grid was analysed using FLEXIGRID 6 (Tschudi, 1998). This was used to obtain a two-dimensional representation of constructs and elements, which shows the plot of the loadings of constructs and elements on the first two components from a principal components analysis. The plot derived from analysis of Anne’s repertory grid is presented in Figure 1. The elements are represented by letters (A–K) and the bipolar constructs are represented by numbers (1–10) with one pole shown above and the other below the horizontal axis. The closer together the elements are on the plot, the more similar that Anne construed them to be.

Figure 1 shows that Anne construes herself now (A) to be similar to herself in five years’ time (C), which is similar to herself as a carer (E). These elements were characterised by the construct poles: ‘frustrated’, ‘alone’ and ‘not much of a life’. It seemed that Anne was construing these elements in terms of what could be seen as the more negative pole of the bipolar constructs. Anne also construed herself now (A) as dissimilar from her ideal self (D). In the wider study, carers who construed themselves as further from their ideal selves reported higher levels of depression (Bingham, 2006). There is evidence that people with depression construe themselves and the future in more negative terms and construe themselves as dissimilar to how they would like to be (e.g. Neimeyer, 1985).

Kelly viewed depression in terms of constriction, described as reducing the number of elements attended to in order to minimise contradictions (Kelly, 1955). If the world of the person with dementia has become constricted (for example, through a reduced social network) it is not surprising that the relative occupying that same psycho-

logical and physical space also feels constricted (Bender, 2003). The similarity between Anne's construing of herself and herself as a carer suggests that she may have been experiencing strong feelings of role engulfment (Skaff & Pearlin, 1992).

Figure 1 shows that Anne views herself five years before the diagnosis (B) as similar to her ideal self (D) and her husband five years before the diagnosis (H) as almost identical to her ideal spouse (J). These elements were characterised by the opposite construct poles: 'going out and about', 'part of a couple' and 'happy'.

It can be seen that Anne construed herself to have changed considerably from how she viewed herself before Bill's diagnosis. It is hypothesised that Anne may have been experiencing Kellyan guilt, since she was aware of not being the sort of person that she had always seen herself as. In the wider study, carers who perceived themselves to have changed more since their spouse received the diagnosis of dementia were more likely to be depressed (Bingham, 2006).

When working with a carer experiencing Kellyan guilt, it may be beneficial to help them to elaborate their new role. Several therapeutic methods are available to aid this process. These include developing and enacting a 'fixed-role' both with the therapist and in social situations faced by the carer (Kelly, 1955).

Figure 1 shows that Anne construes her spouse now (G) to be somewhat similar to her spouse in five years' time (I), which itself was close to a typical person with dementia (K). These elements were characterised by the construct poles: 'forgetful', 'no understanding' and 'not caring'. Her spouse now was characterised by 'doing nothing'.

It was found that the majority of caregivers in the wider study, including Anne, used very few positive constructions in relation to their spouses and construed them to be very similar to a typical person with dementia (Bingham, 2006). It is possible that these carers did not have an elaborated theory of what it means to have dementia

and had little to inform their behaviour. This may have resulted in carers falling back on society's construing of the person with dementia as a helpless, dependent person (Morris, 2004). It might be important to help carers to elaborate their construing of their spouse. It seems that in order to maintain an individual's personhood it is important not to view them in terms of a stereotype (Bannister, 1981).

Conclusions

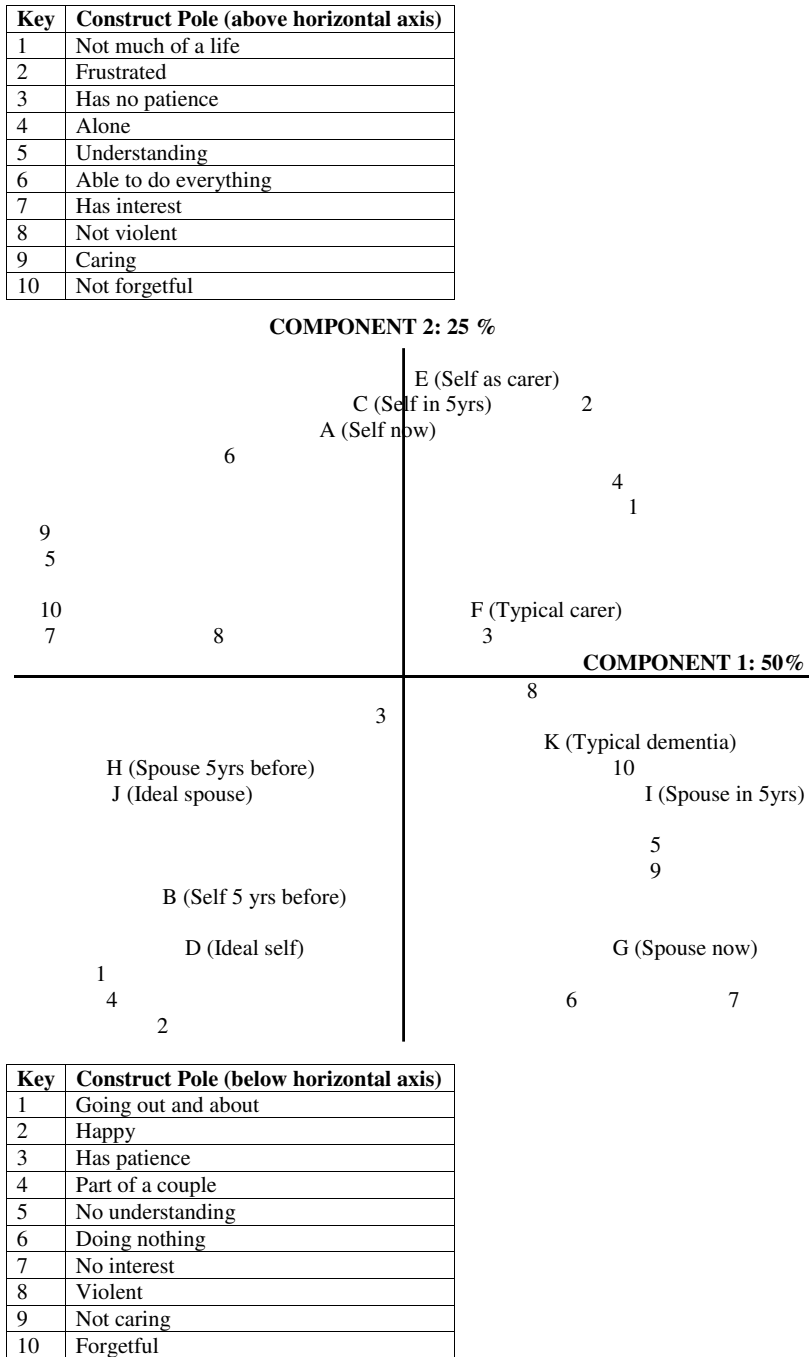
Repertory grids offer assessment tools that can elicit information on carers' constructions of their situation which may not be obtained through routine clinical interviews.

When it is identified that carers are faced with invalidation and the prospect of transitions in construing techniques from Personal Construct Psychotherapy may be applied to facilitate reconstruction and to reduce the experience of Kellyan threat, guilt and anxiety (Kelly, 1955). It is proposed that this will enhance carers' psychological adjustment and reduce their experience of mental health problems.

The transitions experienced by the older caregiver are likely to influence their life stories which may also benefit from being explored, elaborated and reconstructed (Viney, 1993). Personal Construct Psychotherapy is promoted as particularly appropriate for intervention with older people (Robbins, 2005; Viney, 1993). Furthermore, the theory of PCP may provide a framework for conceptualising the modes of action of the diverse range of psychological interventions for carers currently available (Morris, 2004).

Applying PCP theory to the area of dementia and caregiving has considerable benefits for people with dementia and their significant others. Since the theory of PCP is universal, it not only applies to clients but also to Clinical Psychologists working with this client group. For Clinical Psychologists, there is the need to be reflexive and at times, to elaborate and change their own construing.

Figure 1: Plot of constructs and elements from analysis of Anne's repertory grid.



A Personal Construct Psychology Exploration of Dementia Caregiving

Acknowledgements

This article reports on a study that was completed in partial fulfilment of the author's Doctorate in Clinical Psychology at the University of Hertfordshire. Thank you to David Winter and Steve Davies for their valuable supervision.

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Ward round conduct: A survey of staff attitudes to a code of conduct and observations on current practice

Helen Eracleous & Clare Lawson

WARD ROUNDS are held in a wide variety of mental health settings. Their primary function is to communicate and make decisions about the service user's care (Baker, 2005). Despite this, very little research has evaluated ward round practice and, to our knowledge, only one published study has looked specifically at ward rounds in older adult services. White and Karim (2005) state 'The way the ward round is conducted owes much to posterity and to institutional traditions that serve to reinforce unequal power relations between doctor and patient.' In 1997, Rogan Wolf sought to overturn these traditions with the publication of 'A code of conduct for ward rounds', which was 'a set of guidelines that protects a vulnerable individual from the insensitive treatment that traditional ward rounds have inflicted upon them.' The ward round code published by *Open Mind* (Wolf, 1997) and updated *Code of good practice for meetings with service users* (2000) was put together by service user groups based on their experiences. Central and North West London Mental Health NHS Trust used the code as the basis of their policy and the code was presented to the All-Parliamentary Group for Mental Health in October 2004 and following that was given Department of Health support, including promoting the code nationally. Wolf (2000) detailed the following standards as necessary for an atmosphere of care and respect between mental health service users and their multi-disciplinary support teams:

1. *Preparation for the meeting:* appropriate information given to the service user in advance, confidentiality explained, voluntary attendance explained, other settings in which to see professionals;
2. *People present:* the number of professionals should be kept to a minimum, they should be introduced and the reason for their attendance explained, the attendance of family, friends or advocates should be facilitated when the service user wishes;
3. *Appointment times:* times should be given and punctuality adhered to, a named person should be responsible for time keeping, all professionals should aim to be present from start to finish;
4. *Seating:* this should be arranged so that service user is part of the circle and as much a part of the discussions as possible;
5. *Refreshments:* when offered to staff they should be offered to service users;
6. *Questions:* should be asked in a respectful and dignified manner by the appropriate person, painful or intimate questions should not be asked unless absolutely necessary;
7. *Monitoring/evaluation:* advocates and teams should monitor adherence to best practice guidelines.

The limited number of studies looking at service user, carer and staff experiences of ward rounds report some positive experiences, some negative and ideas for change. Wagstaff and Solts (2003) carried out semi-structured interviews with eight service users. They reported overall satisfaction with the ward round process, but a number of people

expressed feeling fear and intimidation and not feeling involved in the decision making process.

Baker (2005) looked at how staff and service users viewed ward rounds in a forensic setting. Baker found that both service users and staff expressed negative feelings about ward rounds. Just under 40 per cent of service users felt anxious 16 per cent angry; 45 per cent of staff felt either frustrated, angry or bored. Feeling ignored, medical dominance and concern for the experience of the service user were cited as the reasons for the way staff felt. Service users recommended increasing their time, being given appointment times, being more involved in discussions, perhaps by being present throughout the meeting, and having the opportunity to meet with their consultant outside of the ward round. Moreover, inviting other people involved in their care, such as advocates, to be part of the meeting and being offered refreshments were also suggested. Staff suggested that there was a need to redefine ward round as a truly multidisciplinary rather than medically led. Interestingly, no study has looked specifically at whether colleagues from different professional groups hold different views about ward rounds.

White and Karim's (2005) study explored the views of 100 service users admitted to adult and older adult mental health wards in East Cornwall. They asked for preferences about where service users liked to be seen, about appointment times and about who attended. They also asked if service users felt anxious, able to express their feelings, or involved in the decisions made. Seventy-five people liked to have an exact appointment time, 54 people disliked having more than four people present and 37 disliked family and friends attending. Many people felt anxious before ward rounds and had difficulty expressing their feelings.

Bains *et al.* (1999) completed a questionnaire by phone with 67 carers, including 31 spouse carers of people with dementia. Most carers found attending the ward round was a

positive experience, but 23 said it had been stressful, and carers said they needed to know more about the purpose and composition of the ward round in advance.

Jamal *et al.* (2003) sent a postal questionnaire to consultant psychiatrists in the West Midlands to establish their current ward round practice. All 96 consultants reported that they introduced themselves and the team and 72 per cent said they explained the purpose of the ward round. They reported a median number of seven professionals attending, and additional comments mentioned that it could be daunting for service users.

Project aims

The aims of this project were to survey mental health professionals' views on the code of practice developed by service users, to explore any differences between staff working with older adults and younger adults, to explore any differences between different professional groups and to take a snap shot of current practice.

Participants

The participants were professionals working in adult and older adult inpatient wards and community teams in North Essex Mental Health Partnership Trust. The lead researcher visited three adult and three older adult ward rounds, and one adult and one older adult CMHT, introducing herself and the project. The 40 participants were asked their discipline, whether they worked in adult or older adult services and whether they were familiar with any code of practice for ward rounds. Of those 38 reporting their discipline, 15 were nurses, 10 psychiatrists, eight psychologists and five reported other specialties including social work and occupational therapy. Twenty people stated they worked in older adult and 17 in adult services.

Questionnaire

A questionnaire was devised for this study. The first section had 19 questions which mirrored the standards set out in the best

practice guidelines (Wolf, 2000). Participants were asked to rate these standards from 1 'not important' to 5 'very important' on a Likert scale. The second section had 21 questions asking the participants to answer 'yes', 'no' or 'don't know' about actual practice at the most recent ward round they had attended. These questions were also based on the standards from the best practice guidelines. There was also a section for additional comments.

Are professionals familiar with a Ward Round Code?

Most (75 per cent) of the professionals had not read any ward round best practice guidelines. This Trust does not have a code.

Do professionals rate the standards developed by the user groups as important?

As can be seen in Table 1 the vast majority (more than 70 per cent) of participants rated almost all of the standards drawn up by the user groups as 'very' or 'quite important'. The only three exceptions were that the service user should not be asked painful or intimate questions, that they should be present throughout the meeting and that they should be offered refreshments. Additional comments expressed concern about the service user being present throughout if they had cognitive impairments that limited their understanding of discussions.

Do professionals working within adult and older adult services rate standards differently?

Mean scores were calculated for each standard for the professionals working in adult or older adult services. For 16 of the standards, the mean ratings did not vary by more than 0.6 between the two groups, indicating a high level of agreement about how important they judged the standards to be for their client groups.

Do staff from different professional groups rate different standards as important?

Overall, there was a great deal of similarity in the views of different professional groups. All four groups (Nursing, Psychiatry, Psychology and 'Other') rated explaining confidentiality and encouraging family members to attend in their top five most important standards. That the service user understands the purpose of the meeting was rated in the top five by Psychiatry and Psychology. Having an appointment time was rated in the top five in importance by all professional groups except Psychology and having a structured agenda featured highest for Nursing and the 'Other' group. Spearman's rank correlation coefficients were calculated for the relationships between the different professions' rankings. These ranged from .91 to .98 (all $p < .01$) indicating a high level of agreement.

Do professionals observe the recommended standards in practice?

Table 2 shows that there are a number of standards professionals judged to be important, but that were not put into practice at the majority (50 per cent +) of the last ward rounds they attended. These were: service users having the opportunity to see professionals at another time; confidentiality; and voluntary attendance being explained; and, it being decided by all professionals who the most appropriate person is to ask questions. The other standards less frequently put into practice were: service users being present throughout; not being asked painful/intimate questions; and, being offered refreshments. Professionals rated these three standards as less important.

Discussion

Our key findings were threefold. Firstly, it was significant that most of our sample had read no guidelines. This highlighted our local need for policy and training. Wolf recommends a code enshrined in Trust policy, disseminated at inductions and CPA training, with its use promoted and audited at all levels.

Table 1: Summary of participants' ratings of the standards.

STANDARDS	Rated 5 (very important) or 4 (quite important)	Rated 3	Rated 2 (slightly important) or 1 (not important)
The patients and/or family attending are given an exact appointment time	97.5%	2.5%	0%
If a patient wishes to bring a family member, friend or advocate this should be facilitated and encouraged	97.5%	0%	2.5%
Each staff member introduces themselves and clarifies their reason for being there	95%	2.5%	2.5%
The patient understands what the meeting is for	95%	0%	2.5%
The purpose of the meeting is explained to the patient beforehand	90%	5%	5%
That confidentiality is explained to the patient beforehand	90%	10%	0%
Attendance by family is encouraged regularly	87.5%	10%	2.5%
For there to be a structured agenda based on an holistic care plan	85%	5%	7.5%
Thought is given to the most appropriate person to ask certain questions	85%	10%	5%
Patients are seen on time	82.5%	10%	5%
Service users have the opportunity to see the professionals at another time and setting	82.5%	2.5%	2.5%
The number of professionals is kept to a minimum	80%	12.5%	7.5%
There is a named person responsible for the smooth running of the ward round	80%	7.5%	10%
All professionals are present from the start	80%	5%	15%
That it is made clear to the patient that attendance at the ward round is voluntary	77.5%	17.5%	5%
The patient has the opportunity to see their consultant outside of the ward round	72.5%	10%	17.5%
Service users should not be asked questions that take them into painful or intimate areas of their lives	55%	20%	25%
The patient is present throughout the discussion of their care	45%	17.5%	37.5%
Patients are offered any present refreshments	27.5%	10%	57.5%

Missing values are not reported

Table 2: Participants' observations at their last ward round.

Questions:	Yes	No	Don't know
Are the family members attending given an appointment time?	80%	5%	5%
Is the attendance of family members, friends or advocates encouraged?	77%	8%	12.5%
Are the patients attending given an appointment time?	75%	8%	5%
Are family members invited on a regular basis?	75%	8%	15%
Do you think the length of the meeting is adequate?	75%	15%	7.5%
Does each staff member introduce themselves and clarify their reasons for being there?	72.5%	25%	2.5%
Do you feel the majority of patients understand the purpose of the meeting?	65%	23%	10%
Is the name of the meeting reflective of its function?	65%	18%	13%
Is there a structured agenda based on an holistic care plan drawn up?	57%	25%	15%
Is there a named person responsible for overseeing the smooth running of the ward round?	57%	23%	15%
Is the purpose of the meeting explained to the patient beforehand?	52%	23%	23%
Do you feel that every effort is made to keep ward round staff numbers to a minimum?	53%	33%	15%
Do patients have the opportunity to choose to see the professional at another time and setting?	48%	22%	30%
Do attendees of the ward rounds attend from the beginning and remain throughout?	43%	53%	2%
Are patients often asked questions that take them into painful or intimate areas of their life?	43%	43%	13%
Are patients and their family/friends seen within 15 minutes of their appointment?	40%	40%	15%
Is confidentiality explained to the patient beforehand?	35%	38%	27%
Is voluntary attendance at the ward specified to the patient?	33%	32%	25%
Is the patient present throughout the whole discussion of their care?	28%	70%	0%
Is it decided by all before the patient is called in about who the most appropriate person is to ask certain questions?	23%	65%	5%
Are patients offered any refreshments present?	13%	70%	10%

Missing values are not reported

Secondly, it was encouraging to find high levels of agreement about the importance of the standards. Most standards generated by service users were recognised as important by the professional groups surveyed, either working with adults or with older adults. This would support Wolf's view of the standards as 'plain common sense' and shows that the professionals' intention was not 'ward rounds run for professionals rather than for patients' (Palin, 2005, on Jamal *et al.*, 2005). It is of note that psychiatrists, who have been reported as dominant (Baker, 2005), reported similar attitudes to other professions, although they have 'more to lose' in the move towards service user-centred approaches.

In addition, in line with Robb *et al.* (2002) participants did not demonstrate ageism, seeing the standards as equally important for older and younger adults.

Thirdly, there was clearly a gap between professionals' good intentions and observed practice, with standards being rated as important more frequently than they were put into practice. Wolf expresses this ongoing challenge:

'The code is a useful step because, although it does not necessarily ensure good practice, it offers a yard-stick and reference point for what best practice entails, what to keep aiming for, despite the day to day pressures. Therefore, the most interesting study of all might be, what is it that makes this guidance to help members of the caring professions behave properly towards a person in trouble in a place of pressure necessary in the first place but so difficult to follow afterwards?' (Wolf, personal communication, 2007).

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An investigation into carer experiences of a Memory Clinic service: Satisfaction and identified needs

Joanna Coyle

This study aimed to investigate carers' experience of a memory clinic service. Sixty-three carers completed a questionnaire concerning their experiences of: (1) the overall service; (2) the assessment procedure; (3) the diagnostic feedback; and (4) staff manner. Resulting quantitative and qualitative data were analysed to identify areas of dissatisfaction or unmet need in current service provision. Findings and emerging recommendations are subsequently discussed.

MEMORY CLINICS were first established in the US in the 1970s with the aim of providing diagnosis, treatment and advice for people with memory impairment within an out-patient setting (Van der Cammen *et al.*, 1987). They are typically multi-disciplinary and concerned with early diagnosis and management of dementias (Sergent, 1995).

Memory clinic objectives coincide with patients' and carers' expectations (Hill *et al.*, 1995; Wald *et al.*, 2003). Hill *et al.* (1995) surveyed patients and carers before coming to a memory clinic and found that they were most commonly seeking: (1) diagnosis; (2) an explanation of the memory problems; and (3) some advice on how to cope with them. Their findings map onto the wider literature on carer needs of services. Nolan and Grant's (1989) extensive review of the literature reveals that carers seek: (1) information on dependent's illness; (2) treatment and services locally available; and (3) skills training in dealing with problems.

Memory clinics have been criticised for not meeting their aims in practice (Wright & Lindsay, 1995). Ambivalence towards sharing diagnosis is widely apparent and there is evidence of inadequate explanation of the illness and advice on dealing with memory problems (Hayley *et al.*, 1992; Hill *et al.*, 1995; Wald *et al.*, 2003). Hill *et al.* (1995), for example, surveyed patients and carers in

a London memory clinic and found that 30 per cent were unsure of the diagnosis or thought incorrectly that no diagnosis had been made. Only six per cent claimed to have received adequate information about the illness. Research to date, thus, illustrates a discrepancy between users' expectations and actual practice, alluding to areas of unmet need in service provision.

This study aimed to identify possible areas of unmet need in current service provision in a North Essex (NEMHPT) memory clinic in the hope that this would inform service development. In this service there are two teams, each comprising a Consultant Psychiatrist, a Clinical Psychologist and a CPN. The objectives of the clinic are to provide accurate diagnosis, treatment, information and advice to the person referred and their carer. Service protocol includes: (1) a 'one-stop' two- to three-hour assessment; (2) a clear open-disclosure policy; and (3) a 'no immediate discharge' policy, whereby clients and carers are offered a follow-up service comprising monitoring and co-ordination of services to meet arising needs. This study aimed to identify possible areas of unmet need by exploring the following questions:

1. What are the areas of relative dissatisfaction for carers with regard to current service provision in the domains of: (1) overall service; (2) assessment procedure; (3) diagnostic feedback; and (4) staff manner?
2. What are the unmet needs as identified by users?

Method

Measure

The study used a postal questionnaire design. The questionnaire comprised:

- The Client Satisfaction Questionnaire – four items (Larsen *et al.*, 1979) to assess overall service satisfaction.
- Items based on themes identified to be important for carers, both in the literature (Hill *et al.*, 1995; Nolan & Grant, 1987; Wald *et al.*, 2003; van Hout *et al.*, 2001) and by the Alzheimer's Society representative: (1) communication of test results; (2) provision of diagnostic information; (3) attitude of the clinician; (4) provision of information and advice. Some related items were drawn from the adapted 'Dementia Care Satisfaction Questionnaire' (van Hout *et al.*, 2001). Items were scored using a Likert scale.
- Open ended questions about 'most helpful' and 'least helpful' aspects of the service and 'recommendations'. These were included to allow users to set the agenda in terms of salient needs in service provision (Fitzpatrick & Bolton, 1994).

The questionnaire was piloted on memory clinic staff. The study was screened by NEMHPT audit and research committee who determined that ethics committee approval was not required as this was service evaluation.

Sample

The target population were nominated carers for people attending the clinic for an assessment of their memory problems prior to February 2004; 110 attendees were selected by reverse-consecutive sampling.

Procedure

The 110 sample participants were sent the questionnaire along with an information sheet about the research, a stamped-addressed-envelope and asked to respond within three weeks.

Results

Demographics

Sixty-three carers (57 per cent) responded. Mean age was 67.7 years (S.D. 14.8), 33 (53 per cent) were female, 63 (100 per cent) White British, 40 (64 per cent) partners, 20 (33 per cent) children and 1 (2 per cent) a friend of the person referred. The mean period of time since initial contact with the service was 18.1 weeks (S.D. 7.1), with a minimum contact time of four weeks. Of those attending a feedback appointment, 48 (77.4 per cent) reported receiving a diagnosis, 10 (16.1 per cent) no diagnosis, for 2 (3.2 per cent) the cause remained uncertain and 2 (3.2 per cent) did not know if they had received a diagnosis. Of those reporting receiving a diagnosis, 35 (72 per cent) reported a dementia, 3 (6 per cent) reported depression, 3 (6 per cent) reported other clinical conditions (anxiety, stroke, aphasia), 3 (6 per cent) reported 'all right', and 5 (9 per cent) did not know the diagnosis given.

Quantitative satisfaction data

Responses to quantitative items are shown in Table 1. Data were coded on a continuous four-point scale, where 1 signals the lowest level of satisfaction. Items within each domain were collapsed to obtain mean satisfaction scores for each domain shown in italics. Results in Tables 1 and 2 suggest a global pattern of carers being fairly satisfied with the service provided. In line with Firth-Cozens' (1993) recommendations to look for very small differences to show dissatisfaction in different situations, results suggest relative dissatisfaction in provision of diagnostic feedback and provision of dementia-specific feedback.

Table 1. Percentages of responses for each response option and mean scores per item.

	N	1	2	3	4	Mean (SD)
1. Overall Service (Valid N=63)						
Kind of service wanted?	61	2	10	69	20	3.1 (0.6)
Deal more effectively with the problems?	58	0	16	53	31	3.2 (0.7)
Overall, satisfied with service received?	60	5	7	52	37	3.2 (0.8)
Make contact with service again?	61	5	7	43	46	3.3 (0.8)
<i>Mean satisfaction score (CSQ) (1-4)</i>	61					3.2 (0.6)
2. Assessment Procedure (Valid N=63)						
Reasons for testing/interview explained?	63	0	6	73	20	3.1 (0.0)
Encouraged to offer my thoughts?	60	0	3	63	33	3.3 (0.5)
Asked how I was coping?	56	0	14	64	21	3.1 (0.6)
Overall satisfaction with assessment?	61	2	12	49	37	3.2 (0.7)
<i>Mean satisfaction score (8-11)</i>	63					3.2 (0.5)
3. Feedback Procedure (Valid N=59)						
Results of investigations – enough detail?	53	17	78	0		
Clinician knowledgeable about causes?	52	0	8	62	31	3.2 (0.6)
Diagnosis was vague?	50	8	24	52	16	2.8 (0.8)
Overall satisfaction with feedback?	53	0	17	50	32	3.2 (0.7)
<i>Mean satisfaction score (15-18)</i>	54					3.1 (0.6)
4. Dementia-Specific Feedback (Valid N=35)						
Told all I wanted to know re illness?	33	28	73	0		
I know about available treatments	33	0	9	88	3	2.9 (0.4)
I know about available care/support services	33	3	31	51	15	2.8 (0.7)
I know how to deal better with memory problems	32	0	32	56	13	2.8 (0.6)
<i>Mean satisfaction score (19-22)</i>	33					2.8 (0.6)
5. Staff Sensitivity and Understanding (Valid N=63)						
Felt what I was said was important	57	0	2	72	26	3.3 (0.5)
Felt free to ask questions & talk of concerns	56	0	5	63	32	3.3 (0.6)
Staff looked into all of my concerns	53	0	6	76	19	3.1 (0.5)
Overall satisfaction with staff sensitivity and understanding	57	0	4	51	45	3.4 (0.6)
<i>Mean satisfaction score (26-29)</i>	58					3.4 (0.4)

Mann Whitney-U (Exact) analyses revealed that mean, overall service satisfaction score was lower in carers who reported not receiving a diagnosis (M=2.8, S.D=0.8) compared with those who had (M=3.3, S.D=0.5), $U=159.0$, $z[-1.54]$ one-tailed, $p=.06$. Mean overall service satisfaction score was not significantly different according to the seriousness of the diagnosis and Spearman's Rank correlations revealed it was not significantly related to age or the number of carer-identified treatments or inputs provided.

Qualitative data

Qualitative items were analysed using thematic analysis. Bracketed numbers relate to participant number. Responses were scanned for information that related to carer need (met and unmet) in service provision and grouped into themes according to each domain of service provision. Salient themes are reported below for each domain.

1. Overall service

Provision of information: Unanimously, carers valued receiving information. 'Provision of information' fell into two categories:

- **Diagnosis:** Provision of a diagnosis emerged as the most helpful factor, allowing carers to move forward '*getting a diagnosis so can face up to what lies ahead*' (67), and to access treatment or services. Concurrent with this, delay in diagnostic feedback or no diagnosis emerged as the most salient unhelpful aspect.
- **Information on the illness and coping:** Lack of information about the illness emerged as a salient unhelpful factor and carers recommended provision of more information on the illness itself: '*Someone to explain what is happening, I know absolutely nothing except how my husband is acting*' (60), alongside advice on how to deal with the problems and information on support services.

Communication: 'Communication' fell into two categories:

- **Opportunity to talk:** Carers unanimously valued talking with staff: '*The most helpful aspect was] Being able to explain the family's worries, concerns and own problems with trying to help a parent who doesn't understand or remember who the family members are*' (44). Greater opportunity to talk to staff emerged as a salient recommendation, with some carers citing no opportunities: '*I did not have an opportunity to talk to the clinician. They did not want to know of my experiences or worries*' (57).
- **Follow-up contact:** Themes of frustration and confusion caused by communication breakdowns in the follow-up process were poignant. Carers cited difficulties in contacting their nominated person, and unreturned phone calls: '*It is very difficult to get in touch with a Dr [member of team]. If I ring I never get a call back, even though I have been told to ring if there are any problems*' (94). Others reported no communication regarding cancelled visits. Overall there was a sense that carer expectations

regarding follow-up were not adequately met.

2. Assessment procedure

Opportunity to participate: Overarching, was a sense that carers wanted to be active in the assessment: carers valued talking to staff and others wanted to sit in on the neuropsychological testing and not just 'wait outside'.

Talk alone: Carers unanimously valued opportunities to talk alone with a clinician due to difficulties in talking openly in front of the relative, and the belief that their account may better inform the assessment: '*Being able to give my point of view of the problems ... Often what the doctor sees at interview is the best side of the person, not the day-to-day problems, depression and frustrations*' (38). Inadequate provision emerged as a salient 'least helpful' factor with carers recommending better provision of this: '*To talk [about] someone who has a problem in front of them is very difficult. I feel there should be time allotted to talk to the carer on their own*' (94).

Clinician sensitivity: Clinician manner was a salient 'helpful' aspect of the assessment procedure, with carers valuing empathy, patience and relaxed style: '*...the casual way the assessment was carried out put my husband at ease. He had been worrying about going to the centre*' (48).

Provision of information: Lack of information about the assessment emerged as a salient 'least helpful' aspect: '*...we had not been told anything about the procedure before coming to the centre. I had not expected such a rigorous assessment and I was worried about my mother coping with it and about leaving her*' (21) and a salient recommendation was for the provision of information about the assessment process. A single but poignant comment suggests that some carers may not be aware of the potential outcome of the assessment: '*...tread carefully with the patient! I had no idea that the memory was as you found it, having regard for the dementia situation!*' (72).

3. Feedback procedure

Provision of information: Carers unanimously commented that information on the problem was important, exemplified by one respondent's comments that: *'feedback is crucial for both patient and carers' family'* (35). Concomitant with this, delays in receiving feedback or the provision of little information was the most salient 'least helpful' factor: *'I would have liked a more precise reason why the diagnostic test on my mother was not completed. I had the impression that my feelings were being spared. I... would have been grateful of any information'* (109). Some carers reported not receiving enough information on dementia: *'It was assumed we knew about Alzheimer's'* (60) and a salient recommendation was better provision of information regarding the illness and how to deal with the problems. Others experienced the absence of written information as unhelpful.

Clinician manner: Clinician manner emerged as a salient helpful factor, with carers valuing clinicians' use of layman's terms, thoroughness, and collaboration: *'...Comparisons were given with regard to previous memory tests to confirm and encourage positive nature of treatment it was in direct consultation with my father-in-law and we were able to share in process'* (56). Empathy and opportunities to ask questions or raise concerns were also noted as helpful aspects of the feedback procedure. A rarer but poignant theme to emerge as being least helpful, was the sense that the pace was rushed, preventing carers from asking questions or sharing concerns.

4. Clinician sensitivity and understanding

Common themes raised as being helpful were *friendliness*, *empathy*, and *being treated with dignity*: *'My father-in-law felt he had been treated with dignity and respect and courtesy and this greatly pleased him – as he is patronised for most of the time in his residential home'* (56). Further important aspects of the consultation seemed to be the sense of **being listened to** and **being able to talk and ask questions**: *'I found the doctor very easy to talk to. You felt you*

could ask any questions and he would answer you in a way that you would understand and not make you feel stupid' (94).

5. Overarching themes of need

To be active/collaborative in the process of care: Overarching was the sense that carers wanted to be collaborative both in the sense of: (1) gaining information to be better informed about the illness and ways of coping; and (2) wanting to communicate their experiences to the practitioner so that a common understanding of the problem and how to deal with it could be reached: *[I would recommend] to sit and talk about Alzheimer's and what can be done – not just being told this is what it is and how we will treat him* (67). Other overarching themes of need were **information provision** and **communication** (in terms of carers valuing opportunities to talk alone with a practitioner, particularly at the assessment, and valuing reliable follow-up communication) and 'clinician sensitivity'.

Discussion

This section looks at the quantitative satisfaction data and provides a summary and discussion of relative unmet needs as identified by analyses of both quantitative and qualitative data. It concludes with some recommendations.

Quantitative satisfaction data suggest a global pattern of carers being fairly satisfied with service-provision. This pattern falls in line with respondents typically scoring high on satisfaction measures (Firth-Cozens, 1993). Areas of relative dissatisfaction were apparent in provision of diagnostic feedback (32 per cent of respondents rated the diagnosis as 'vague'), and provision of dementia-related information, with around a third of carers reporting that they had not been told all they wanted to know about dementia, did not know about support services or how to cope better with the memory problems. Analysis revealed that overall satisfaction level was lower in carers who reported not receiving a diagnosis, suggesting the receipt of diagnosis as an important factor in satisfaction.

Trends of relative dissatisfaction found in the quantitative data broadly accord with qualitative data, whereby themes of 'least helpful' aspects related to the non-provision of diagnosis or diagnostic feedback and the inadequate provision of information regarding dementia. Qualitative and quantitative data, therefore, suggest relative unmet need for a substantial minority of carers in:

- Provision of clear diagnostic feedback;
- Provision of information on dementia and coping with the illness.

The unmet need of a clear diagnosis (at 32 per cent) is surprising given the clear open-disclosure policy of the clinic. These unmet needs concur with trends in other studies. With regards to diagnosis, for example, Hill *et al.* (1995) noted that 30 per cent of their sample of carers were 'unsure' of the diagnosis. With regards to provision of information, Van Hout *et al.* (2001) found that 37 per cent of their sample did not know about available care services and 50 per cent did not know how to deal better with the memory problems.

Given that the provision of diagnosis and information about dementia are prominent needs of carers attending the clinic and are also key objectives of the clinic, improved provision is an important priority. Further support for their consideration as key priorities comes from several studies which suggest the utility of information in helping carers to cope (Graham, Ballard & Sham, 1997; Nolan & Grant, 1989; Toner, 1987). Graham *et al.*, for example, found that more knowledgeable carers of people with dementia experienced significantly lower levels of depression. Why do carers report deficits in this provision? Is it due to unclear diagnostic feedback and information given at the time, or more due to carers subsequently forgetting what they were told? The latter would point to the utility of written, back-up information.

In addition to the above unmet needs, qualitative data suggest unmet needs in:

- Provision of *written* information regarding illness (confirmation of diagnosis and information about illness);

- Opportunity to talk alone with clinician, *per se*, but most saliently at assessment;
- Provision of information about the assessment procedure;
- Reliable follow-up communication;
- Sufficient time allocated for the diagnostic feedback.

Although the need to talk alone with the clinician at the assessment and reliable follow-up communication should be addressed by the current protocol of the clinic, there is evidently inadequate provision. Regarding the opportunity to talk alone to the practitioner at the assessment, it seems this need not be particularly resource-intensive – indeed, some carers requested only 'a little word' or 'a few minutes'. The follow-up service, however, is resource-intensive, demanding time in communicating with clients and other services. It seemed though, that carer complaints focused not on the *amount* of follow-up provision, but more about their expectations not being met (e.g. unreturned messages).

Recommendations

Overarching themes suggest that carers want to be active and collaborative in the care of the person, both in terms of: (1) gathering information; and (2) communicating their experiences to the service in order to reach a shared understanding of the problem. With this in mind, a broad recommendation is that procedures should be implemented to facilitate carers to: (1) request information; and (2) communicate openly. Although clinician sensitivity is indicated by carers to be necessary in the collaboration process, it does not seem to be sufficient. Indeed, although 95 per cent of respondents reported feeling that they could ask questions and talk of concerns and 93 per cent rated the clinician as knowledgeable, around one-third reported receiving inadequate information. Additional procedures, thus, seem necessary and could include:

- providing time for carers to speak alone with the clinician after the consultation;

- providing prior information about appointments and advising carers to note any information or questions they may wish to discuss;
 - clinicians being explicit that the carer can bring up any issues;
 - providing reading resource information.
- Specific recommendations for different stages of input include:

1. At assessment:

- Carers to be given the opportunity to talk alone with a practitioner.
- Prior information about the assessment procedure to be sent to the family, outlining duration, process, and rationale for testing.

2. At feedback:

- Diagnostic disclosure to be backed up with written confirmation.
- Overall, for practitioners to start with the premise that carers do or will want information. The *amount* and *pace* of delivery of the information to be based on the needs of the carer but to include greater provision of:
 - information on dementia (symptoms, severity and course) to be backed up with written information.
 - information on support services (i.e. Alzheimer's Society, respite care, etc.).
- To consider allowing more time for diagnostic disclosure.

3. During follow-up:

- Improved follow-up communication involving an open dialogue with carers to ensure that their expectations of follow-up match what can be reliably delivered by the service.

Acknowledgements

The author would like to thank the carers of clients at the memory clinic for giving their time to participate in this research and Dr Chris Barker and Dr Nancy Pistrang, University College London, for their advice in the process and write up of this research.

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Appendix A: Care Questionnaire

CARE QUESTIONNAIRE

This questionnaire is designed to help the (name of clinic) team to improve its service.

It should take about 15–20 minutes. You do not have to answer all the questions at once and you can come back to questions at a later time if you wish.

Please give your honest opinions, whether they are positive or negative, as accurate feedback will help the team to improve the service.

Please try to answer all of the questions. Please tick the box next to the reply that comes closest to your experience of the service. We also would like you to give your comments and suggestions in the spaces provided. Please give as much information as you can.

Thank you very much. We really appreciate your help.

(Please return your completed questionnaire before **Friday 5th March**)

Please fill in some details about you and the person with whom you attended the clinic:

You

Age:..... Sex: Male / Female Ethnicity:.....

Your relationship with the person attending for assessment:.....

The Person Referred For Memory Assessment

Age:..... Sex: Male / Female Ethnicity:.....

Did the person receive a diagnosis? Yes / No

What was the diagnosis?

What treatment and other input have been provided by the service?
.....

Overall experience with the Service

This section will ask about your experience of the service as a whole.

1. Did you get the kind of service you wanted?

No, definitely not No, I don't think so Yes, I think so Yes, definitely

2. Have the services you received helped you to deal more effectively with the problems?

Yes, they have helped a great deal Yes, they helped somewhat
 No, they really didn't help No, they seemed to make things worse

3. In an overall, general sense, how satisfied are you with the service you have received?

- Very satisfied Mostly satisfied Indifferent or mildly dissatisfied Quite dissatisfied

4. If you felt you needed more help, would you make contact with the service again?

- No, definitely not No, I don't think so Yes, I think so Yes, definitely

5. What things about the service have been most helpful?

.....

6. What things about the service have been least helpful?

.....

7. What recommendations would you make to improve the service?

.....

The Assessment Procedure (the interview and tests)

This section will ask you about **how you experienced the assessment procedure**, which included an interview about the memory problems and your relative/friend doing some tests (we will ask you separately about the feedback of the diagnosis on the next page).

NB: The word '*clinician*' refers to the staff member you spoke with (the doctor and/or psychologist).

8. The reasons for the detailed memory testing and interview were clearly explained.

- Strongly agree Agree Disagree Strongly disagree

9. The clinician encouraged me to offer my thoughts during the assessment interview.

- Strongly agree Agree Disagree Strongly disagree

10. The clinician asked me how I was coping with caring for my friend/relative.

- Strongly agree Agree Disagree Strongly disagree

11. Overall, how satisfied were you with the assessment procedure?

- Very satisfied Mostly satisfied Indifferent or mildly dissatisfied Quite dissatisfied

12. What things were most helpful about the assessment procedure?

.....

13. What things were least helpful about the assessment procedure?

.....

14. What recommendations would you make to improve the assessment procedure?

.....

The Feedback of Results and Diagnosis

This section will ask you about **how you experienced the feedback of the results from the assessment**, which would include being told the test results, a diagnosis (if applicable), and what this means for you and your family member/friend.

15. The results of the investigations were explained in enough detail.

- Not enough information given Just the right amount of information given
 Too much information given

16. The clinician seemed knowledgeable about the causes of the memory problem.

- Strongly agree Agree Disagree Strongly disagree

17. We received a diagnosis that was very vague.

- Strongly agree Agree Disagree Strongly disagree

18. Overall, how satisfied were you with the feedback procedure?

- Very satisfied Mostly satisfied Indifferent or mildly dissatisfied Quite dissatisfied

The questions in this box should only be answered if your family member/friend was diagnosed with a dementia (e.g. Alzheimer's, Vascular Dementia or other types of dementia):

19. The clinician told me all I wanted to know about the illness.

- Not enough information given Just the right amount of information given
 Too much information given

20. After talking with the clinician I know about available treatments.

- Strongly agree Agree Disagree Strongly disagree

21. After talking with the clinician I know about available care/support services.

- Strongly agree Agree Disagree Strongly disagree

22. After talking with the clinician I know how to deal better with the memory problems.

- Strongly agree Agree Disagree Strongly disagree

23. What things were most helpful about the feedback procedure?

.....

24. What things were least helpful about the feedback procedure?

.....

25. What recommendations would you make to improve the feedback procedure?

.....

Staff Sensitivity and Understanding

This section will ask you about **how you experienced the staff (the doctor and psychologist)** in both the assessment and feedback. Please rate them both together.

26. The staff made me feel that what I said was important.

Strongly agree Agree Disagree Strongly disagree

27. I felt free to ask questions and talk about my concerns.

Strongly agree Agree Disagree Strongly disagree

28. The staff looked into all my questions and concerns.

Strongly agree Agree Disagree Strongly disagree

29. Overall, how satisfied were you with the sensitivity and understanding of the staff?

Very satisfied Mostly satisfied Indifferent or mildly dissatisfied Quite dissatisfied

30. How do/did you feel about the attitude/behaviour of the staff.

What is/was most and least helpful?

.....

31. What recommendations would you make for how staff can improve their relationship with clients?

.....

32. Please comment on any other information or recommendations that you would like to add about the service you received.

.....

Thank you for taking the time to complete this questionnaire.

(Please return your questionnaire in the envelope provided before Friday 5th March)

Befriending and Costs of Caring (BECCA): Does service use by carers differ across two areas of England?

Xanthippe Tzimoula, Amy Bartlett & Georgina Charlesworth

In this paper we consider service use by carers of people with dementia. We present baseline measures for participants in the HTA funded 'Befriending and Costs of Caring' (BECCA) cost-effectiveness trial of befriending for carers. We recruited initially from the East Anglian counties of Norfolk and Suffolk, but needed to increase recruitment numbers. We, therefore, took an opportunity to extend recruitment into the London Borough of Havering, but had a concern that participants' service use may systematically differ due to variances in service configuration

Why might Havering be different?

(a) Tripartite model of service organisation

IN HAVERING, community services for people with dementia and their carers were organised in a tri-partite model where health, social and voluntary sector services were all based under one roof at The Petersfield Centre. The voluntary sector had played a significant role in the service planning and delivery. Age Concern personnel ran reception, were the first point of contact for self-referrals and provided carer support. The Petersfield Centre appeared as a Case Study (Case Study 13) in the Audit Commission's Forget-Me-Not report (2000, p.93), and received many visitors nationally and internationally as a model of good practice. At the time, this model was unique, and so unlike service provision in East Anglia.

(b) Population density

The counties of Norfolk and Suffolk are predominantly rural, with centres of population in the towns and cities of Norwich, King's Lynn and Great Yarmouth in Norfolk, and Bury St. Edmunds, Ipswich and Yarmouth in Suffolk. The Borough of Havering is in the far North East of Greater London and includes Romford and other areas formerly administered as part of Essex. The estimated number of people with dementia is just under 9000 for Norfolk and

Suffolk, compared to approximately 2000 in Havering. Given the area of Norfolk and Suffolk (over 9000km²) compared to Havering (just over 100km²), the 'density' of dementia varies greatly at approximately one person per km² in Norfolk and Suffolk compared to 20 people per km² in Havering.

(c) Recruitment differences

Recruitment for the BECCA trial began in Primary Care, but was extended to include recruitment through the voluntary sector and secondary services (Hooper *et al.*, 2004). In Havering, however, recruitment was only through the voluntary sector (that is, Age Concern).

Methods

Participants

Participants were family carers who provided 20 or more hours per week of care for a relative with progressive dementia living at home. A total of 236 carers were enrolled into the BECCA study.

Measures

Psychometric data were collected through interviews with researchers using a combination of validated measures and a resource-use questionnaire devised especially for this study. Data reported here are from the baseline (pre-randomisation) interview.

Demographic information included carer age, gender, kinship and age of person with dementia.

Carers' Assessment of Difficulties Index (CADI; Nolan & Grant, 1992; Nolan *et al.*, 1990). The CADI is a 30-item, multi-dimensional measure of burden. It can be used to assess both the frequency of experiences and the stressfulness of those experiences. The frequency of experiences scale can be used as a measure of objective burden (Charlesworth *et al.*, 2007) on which scores for each item range from 1 – 'never applies', to 3 – 'always applies'.

Service use

Carer service use was assessed by five dichotomous (yes/no) questions as part of the wider resource-use interview schedule carried out with carers at baseline:

- 'Has the person with dementia (PwD) stayed in residential or nursing home facilities?' (Respite care);
- 'Does PwD use day care/day hospital services?' (Day care);
- 'Is there anyone who comes to help PwD with personal care?' (Personal care);
- 'During the last six months of caring, have you used any services for carers (e.g. support groups, contact with advice and information workers/helplines)?' (Carer services);
- 'Use of any social clubs/ day centres yourself / jointly with PwD?' (Joint social events).

Analysis

Data were entered into SPSS version 12.0.1 for Windows (2003). Data were tabulated, and 2x2 Chi-square analyses were conducted for service use by location (Havering/East Anglia). T-tests were conducted for continuous measures of age and burden. As part of the *t*-test analysis, equality of variance was examined by Levene's test and adjusted degrees of freedom were reported where the equality of variance assumption was not met (significant Levene's test).

Results

Demographic information is shown in Table 1. The majority of carers were female in both areas. Carers in Havering were older (marginally significant, $t(234)=-1.9, p=.05$, and caring for older people with dementia, $t(57.4)=-2.0, p=.04$, but this was not due to a higher proportion of spouses. Levels of burden were similar in the two areas, $t(230)=-1.2, p=.25$.

Levels of service use, and chi-square results, are shown in Table 2. A greater percentage of carers were using respite care and day care in Havering, whereas a greater percentage of carers were using carers services in East Anglia. Results of the Chi-square analyses did not suggest any differences in service use for Respite care, Day care, Personal care and use of Carer services between areas. However, more carers in Havering reported participation in joint (with the person with dementia) social events than carers in East Anglia.

Table 1. Demographic information by location (Havering vs. Norfolk/Suffolk).

	Havering (N=30)	East Anglia (N=206)
Carer age (mean; SD)	71.8 (11.1)	67.5 (11.5)
Female carer (%)	20 (66.7%)	132 (64.1%)
Spouse carer (%)	21 (70.0%)	138 (67.0%)
PwD age (mean; SD)	80.3 (5.3)	77.9 (9.1)

Note: PwD = Person with Dementia

Table 2: Service use by location (Havering vs. Norfolk/Suffolk).

	Havering (N=30)	East Anglia (N=206)	²	p
Respite care	9 (30.0%)	47 (23.3%)	0.6	.42
Day care/hospital	18 (60.0%)	100 (49.0%)	1.3	.26
Personal care	12 (40.0%)	90 (43.9%)	0.2	.68
Carer services	16 (53.3%)	124 (61.7%)	0.8	.38
Joint social events	16 (53.3%)	60 (29.6%)	6.7	.01

Discussion

We examined the level of use of day care, respite, personal care and carer services by carers participating in the BECCA trial, comparing use by carers in Havering with carers in Norfolk and Suffolk. There was no evidence for any difference in levels of service use, except for participation in joint social events with the person with dementia. This was greater in Havering due to joint social events not being offered in all areas within Norfolk and Suffolk. Data from the main study and follow-up will be available in the coming months.

A limitation of this analysis is that we have only looked at the main services. Cost differences are likely to exist for carers in Havering compared to those in the counties of Norfolk and Suffolk, especially in terms of transport. It was assumed, but not checked, that respite and day care were available in all of the centres of population within Norfolk and Suffolk. Day Hospitals have been widely available nationally (Audini *et al.*, 2001).

Post Script

At the time of BECCA baseline data collection (April, 2002 to July, 2004), services in Havering were stable. Since then, however, there has been considerable re-organisation. The Community Dementia Service has been disbanded (in 2007) to make health service personnel available to create a CMHT for older people. The two Havering Day Hospitals, described by Brown *et al.* (2005) have been reduced to one, on the Petersfield site, and the rest of the Petersfield Centre has been re-designated as a psychological therapies centre for adults, including older people

Acknowledgements

The Befriending and Costs of Caring (BECCA) project (ISRCTN08130075) was funded by the Health Technology Assessment (HTA) Programme (project number 99/34/07) granted to Charlesworth (University College London), Mugford, Poland, Harvey, Price, Reynolds and Shepstone (University of East Anglia). Costs in Havering were covered by an AdHoc grant from the Department of Health to North East London Mental Health Trust. The views and opinions expressed in this paper are those of the authors and do not necessarily reflect those of the Department of Health. The BECCA trial was approved by the Eastern Multi Regional Ethics Committee (MREC), and by the five Local Ethical Research Committees (LRECs) in Norfolk and Suffolk, and by the Barking and Havering LREC. XT is currently funded by the ESRC (RES-000-22-2020 grantholders: Charlesworth, Higgs and Poland) to carry out a secondary analysis of BECCA data focussing on the inter-relationships between care sectors (family, voluntary and statutory services).

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Developing evidence-based practice - a Cognitive Stimulation Group for people with dementia

Louise Blurton

COGNITIVE STIMULATION is the term used to describe a programme of evidence-based psychological therapies, designed to bring about improvement in thinking, memory, reasoning, self-esteem and communication skills in people with dementia.

A cognitive stimulation therapy programme was set up, and methods devised in order to evaluate its effects on cognitive function and quality of life in people with dementia. It is an evidence-based programme developed from recent Cochrane reviews, suggesting cognitive stimulation has a positive impact on cognitive function (Spector *et al.*, 2003). Research was conducted at residential homes and day centres with 201 older adults, many of whom live in the NELMHT area. The results indicated that cognitive stimulation groups appear to improve communication, cognitive functioning and quality of life for people with dementia.

The therapy programme incorporates techniques that are commonly used in groups for people with dementia. Two examples are reality orientation and reminiscence therapy. Research suggests that reality orientation has a positive impact on cognitive function and behaviour (Spector *et al.*, 2003) and reminiscence therapy promotes communication and well-being (Pons, 2005, personal communication).

Following a review of local services and relevant research, it was felt that specific therapeutic interventions including cognitive stimulation would benefit clients attending Morland Day Hospital. The cognitive stimulation programme is run over a

seven-week period and includes 14 sessions. Each session begins with a warm-up activity, e.g. participants play catch with a soft ball and introduce themselves, which is designed to encourage group interaction and increase participants' alertness. Then, members of the group complete a reality orientation board, which aims to orientate members to time and place. The main activity of each session is based on different themes. These themes include:

1. Physical games;
2. Music, sound-effects;
3. Early memories;
4. Food;
5. Current affairs;
6. Faces/scenes;
7. Associated words;
8. Categorising objects;
9. Orientation – drawing maps;
10. Using money;
11. Number-related Activity;
12. Word-related Activity;
13. Using objects;
14. End of programme activity, quiz.

The programme can be adapted to suit the severity of the client's dementia. This means that we are able to run the group with individuals with both higher and lower levels of function. It can also be conducted in a variety of settings and facilitated by different professions, e.g. OT, nurse, psychologist, as long as they are trained in dementia care.

To date, the programme has been successful in that we have received positive feedback from group members. They have reported enjoying the groups, feeling pleasure in sharing their experiences and valuing the chance to offer help and advice

to others. They feel they have been given the chance to develop and relearn new skills, helping them to work with their illness. This intervention, developed from an evidence-base, enables us as practitioners to improve the quality of life for people with dementia, thus having a positive impact on their carers.

Louise Blurton works as an Assistant Psychologist at Morland Day Hospital, which caters for older adults in Barking and Dagenham. The day hospital provides support for people with dementia and clients are able to attend on a Monday and/or Wednesday.

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Colchester Castle and War Memorial, Colchester, Essex – Britain's oldest recorded town.

Development of a Therapeutic Day Hospital Drama as a powerful clinical tool – fun with a purpose

Lesley Benham

TURNING A VISION INTO REALITY commenced 5 July, 1999. The team faced the challenge of developing day care for older people with dementia in Weymouth/Portland, Dorset. A basic minding service that was not meeting its functions (Kitwood, 2002) was inherited. Commitment, time, effort and enthusiasm needed to be invested in the team to make them feel valued and motivated (Chapman, 2001). The major, developmental journey of a demoralised, change-opposing team was so vast that one element of innovation was focused upon: 'The use of drama/music'.

Making clinical work fun but purposeful captured the interest of a team who at the time disliked academic teaching styles. Naturally drama techniques were introduced quite by chance as a teaching tool empowering individuals to use their imagination, observe and communicate, while aiming to increase self-confidence, knowledge and skills. Concepts from the new culture of dementia care – 'viewing the person behind the disease' (Kitwood/Benson, 1995) were reinforced and supported by drama. The leader would role-play characters to emphasise the need to alter language, approaches and clinical practices.

This created new styles of working, promoted reflection (Gibbs, 1988) and evidence collection began. Drama is constructively used in teaching, presenting and most importantly in every day clinical work. It has influenced changes in attitudes, culture, practice and techniques providing quality care and service improvement to the people attending whilst building the team positively.

The team are now multi-skilled, managing challenging behaviour whilst

avoiding the use of medications. They are creative, person-centred, resourceful and continually responsive to change and challenges. The team are enthused, motivated and keen to share best practice. All team members have developed personally, and sometimes vacancies occur as individuals leave for jobs within the Trust having increased their skills and confidence. This is seen as a positive development as the work spreads wider to influence cultural change. Recruitment is no longer an issue and new team members are nurtured and encouraged to bring new ideas to the team.

Networking has been encouraged and numerous professionals both in and out of county have visited to share practice. We have strong links with a Team from Ebbw Vale, south Wales, and a Team from Moscow were extremely inspired by the work, environment and resources developed. Drama was very effectively tested to communicate as the group could not speak English and it proved a wonderful tool that resolved the problem. Community links have also been forged and strengthened with members of the public, health and social services.

Mental stimulation has increased as drama has been developed and expanded into activities with minimal budgetary implications.

The Day Hospital now fully meets its clinical functions of:

- Assessment;
- Mental Stimulation;
- Therapeutic Treatment.

The process for admission, assessment/care planning is now very structured and focused upon the individual. There is no rigid six- to eight-week assessment because if the person

only has one day per week attendance then the team feel they can not realistically build rapport and know the individual in-depth within six- to eight-days.

Assessments are completed depending upon the individual's responses to attendance and the availability of staffing/time resources. Referrals are accepted through the Community Mental Health Team for Older People. During introductory visits the assessment process is explained but it is stressed that permanent places are not guaranteed until after the assessment is completed. People are made aware that referral to a Social Care & Health Day Centre may be an alternative option as the Day Hospital is a specialised care area specifically for people who would find difficulty in coping in a social day care setting. As this is clearly explained, people appear to accept the decision made and are invited for discussion with their carers and key workers following the assessment process. The care plans have altered to identify not only problems/weaknesses and personal needs but also to identify people's strengths, and so are individualised. Techniques of how drama benefits individuals in clinical practice are identified in the actions and shared if there is a need for respite with alternative care areas and carers.

The team evidence their work in portfolios, reflective diaries and project files. The team have taken ownership and responsibility for driving developments forward and the Leader utilises a nurturing leadership style continually offering guidance and realistic support. All team members are valued and encouraged to share ideas and implement change.

Many Awards have been secured, evidencing positive development of the service/team:

- The Queen's Nursing Institute/ Alzheimer's Society Award for Excellence & Innovation in Dementia Care 2003;
- The Dorset & Somerset Modernisation Award for Team Innovation 2004;
- The Dorset & Somerset Modernisation Chairman's Award 2004;

- Finalist at The Nursing Foundation Studies Award – House of Lords, London;
- The North Dorset Primary Care NHS Trust Award for Team Innovation 2005;
- The Health & Social Care Nurse of the Year Award – Southern Region 2006;
- Finalist at The National Nurse of the Year Award – Excel Centre, London.

The Day Hospital has started to receive recognition for its work and is supported by the Dorset PCT with media coverage and by releasing the Leader to disseminate developments to influence alternative care areas. Other team members are encouraged to accompany her to develop their teaching skills and to experience networking opportunities whilst sharing their enthusiasm. The Leader has presented at The National Community Hospitals conference, York and at The UK Dementia Care Congress, Bournemouth. She also organises and runs workshops locally on Improving Dementia Care with funds won through the Awards to disseminate project work to a wider audience. Recently the team has 'buddied' a Social Care & Health Day Centre in Portland and influenced changes in culture, attitude, environments, activities and working practice.

Drama used in every day clinical work

A lady opposed nail care and objected to anyone cutting her nails, including her family. She experienced difficulties in maintaining daily living skills owing to the length of her nails. Creatively utilising personal profiling and after discovering the woman used to go dancing, the clinic room was altered. Flowers were introduced, plus a lacy tablecloth, a manicure set, colourful scarves and dance music. The leader approached the lady and communicated that she believed that she had a wonderful eye for colour and wished to have an opinion. The lady responded using 'posh' voice tones, quite spontaneously, which were totally out of character. 'Oh yes, my dear, I do, let me advise you.' She willingly followed the leader

into the clinical room and immediately stated what a wonderful room it was, with so much colour, and loved the manicure set with a bowl of soapy water carefully placed in her view. Without any prompt she turned 'Just look at these terrible nails, I wish you could cut them for me.' Having explained my nursing role and gained her consent she spent a relaxing time storytelling, reminiscing about her dance experiences and family life. On completion she immediately told everyone what a smashing beautician service there was available. Her well-being was maintained, risk of clinical infection was reduced and she was able to retain her daily living skills. After several sessions of repeating this procedure the room no longer required setting up as rapport was well established and she would willingly approach staff to complete the task.

A gentleman who required appointments in general hospital for physical health problems experienced severe behavioural problems and opposed interventions. Having accompanied him and occupied him with drama using voice tones, storytelling skills and diversion it was negotiated that his bloods, investigations and monitoring could be organised in partnership with the District Nurse visiting whilst he was at Day Care. The staff skilfully explained situations, gained his consent and occupied him having established rapport with puppets, dolls and storytelling techniques whilst the District Nurse completed her procedures. His well-being was maintained whilst having his clinical needs met and he no longer required the long journey to hospital for his health needs. It also reduced stress to his carer as clinical staff completed tasks in the familiar surroundings of the unit that he attended five days per week. This gentleman remained supported in the community for a long period before a hospital admission resulted in needing residential care.

Activities

The Day Hospital has developed a structured programme, which is planned in advance by all team members. People's strengths/weaknesses and abilities are identified, matched with topics and staff skills. There is choice available, flexibility, and everyone is focused whilst smaller group work is promoted. People are not pressurised to participate and there are no set rules. Staff members can be creative and imaginative during the sessions but each session has to have a beginning, middle and end and be purposeful. All activities are adapted to suit individuals; innovative board games have been designed and made by the team to incorporate long-term memories, drama and sensory work. Puppetry and dolls are also utilised and there is evidence of people's word finding and fluency difficulties improving. Examples of games developed are:

- Dorset Travel Game;
- Weymouth Bay Game;
- Woodland Game;
- Wild World Game;
- London Game;
- Day at the Races.

Hats are used for discussions and storytelling. They cost nothing as people donate them. They have been effectively used to entice individuals into toilet areas and to engage in clinical tasks or just to generate humour as needed.

The Dorset Memory Box service is utilised and staff creatively dress as characters to bring the box alive in order to encourage reminiscence and recall whilst generating humour. It is believed that often laughter is the best medicine. Various theme boxes have been developed and are well used in adult discussion groups and digital storytelling is being considered. Another example of drama is during Britain discussion groups. The staff member may dress appropriately in the costume of the county, thus encouraging communication through visual triggers. Singing around the world with hats is also a great favourite, as people recall familiar tunes.

Links with local schools promote life storytelling sessions, musical entertainment, drama and the youths frequently share their talents with older people. Members of the public, magicians, and vocalists also visit. Occasionally staff will put on a play or pantomime. Recently Tai Chi has been introduced and adapted with the use of a Seashore theme to incorporate music, drama, storytelling and sensory work. It has proved very effective for people with anxiety, and for people who experience varying levels of mental and physical impairment. People carefully explore the seashells and drift wood and mirror the actions of the staff member trained in delivering this relaxation exercise. Another exercise developed is chair-based. In another the staff member dresses as a police officer or refined lady with hat/umbrella and the group tell stories whilst completing exercises on a walk down Weymouth sea front. This adds another dimension to the session.



Arts and crafts are available but generally only utilised to produce an orientation seasonal corner. People specifically identified that they did not wish to have a day / date board as they felt this would be patronising, but decided on this corner instead to express themselves using alternative media.

The environment

The environment is continually aiming to promote well-being. There is a beautiful garden using colour, gazebos, arches, and seating areas.



The team have placed items such as an old bike, boat, gardeners' tools, water pump, statues, wind chimes and visual effects within the garden to stimulate conversation. An abundance of wild life is found and on a windy day the sea can be heard crashing against the shore. Despite being situated on a busy hospital site there is tranquillity and the garden atmosphere is just as important as the inside clinical area.

The inside of the unit is adorned with memorabilia to trigger long-term memories, and the walls are full of pictures reinforcing personal profiling.

Everything is aimed to promote communication and to promote normality. As budgets are low, the majority of items are obtained from car boots, charity shops or through donations. Surprisingly nothing has been broken but just gently explored by those who attend. A normal environment appears to promote normal behaviour and it also has the added benefit that the staff have a colourful, airy, positive environment in which to work.

Developing the Day Hospital has been an enormous challenge as the Leader has had no formal training in management or leadership and has utilised her own experiences to implement realistic changes. She is not an academic, having originally trained as an Enrolled Nurse who reluctantly completed her Open University Conversion Course. She was asked if she would like a challenge and has never looked back. The Dorset PCT has encouraged its Leaders to implement positive changes in clinical areas. The benefits of

this project are now evident most importantly to the people who attend, carers and the workforce. Award reports support the practice; there is now theory behind practice and Practice Development Unit Accreditation has been achieved and local and national awards prove that *'Drama as a powerful clinical tool – fun with a purpose'* has been effectively implemented.

The future challenge is to maintain the existing standards to continue promoting dignity in care and to maintain the balance of clinical work whilst disseminating clinical practice to alternative care areas.

This Leader believes that other Leaders need to invest in their teams, inspire them, gain their commitment and provide exciting challenges. They need to utilise budgets wisely and creatively whilst developing their negotiating skills. Teams need to have the same vision, be imaginative and creative while taking ownership and responsibility. The needs of the people receiving the service should always be considered and they should be involved in decision-making processes. Day Hospitals should be providing 'specialised' therapeutic day care as part of the person's active mental health treatment as opposed to minding services for carers. People with special needs that cannot be met within a normal Social Day Care setting should access such a service provision, as their clinical need is greater. There should be a clear Operational Policy and Vision.

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First published in *Signpost Journal*, 2007.

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Plaque on Colchester War Memorial, Colchester, Essex.

Statement of Equivalence – To Do or Not to Do

Michael Zivor

I ARRIVED IN THE UK approximately three years ago. I am originally from Israel, where I completed my BA in Behavioural Science and furthered my studies in Clinical Psychology in South Africa. I then decided to move to the UK to develop my knowledge, 'being closer' to Bowlby, Klein and Clark. I was somewhat surprised when asked to complete a variety of essays and placements, one of which was working with older people. I was genuinely not sure why a placement with 'older people' was necessary. In Israel, as far as I know, the clinical psychology training does not include this specialist placement. In our society, care of older people is the responsibility of the collective, particularly for Holocaust survivors.

During my training in South Africa, we spent several afternoons discussing older people. However, in the midst of poverty, HIV/AIDS, and extremely limited resources (I gave patients my lunch so they were able to take their medication), specialising in the area of older people seemed the privilege of prosperous, industrialised, Western societies.

This requirement from the British Psychological Society, therefore, resulted in ambivalent feelings. I decided to comply and began my placement. Reflecting back, it was an enriching experience. It was not just about learning the unique nature of older people's psychosocial and developmental issues, but it was a way of learning more about the British culture. I felt that my role was not only that of a clinical psychologist

but also a social agent, assisting older people to cope with social issues such as prejudice, discrimination, and neglect. In a way, this encouraged me to become more involved within the society I now live. I became significantly more mindful to the lifespan approach, which was neglected in my previous training. This assisted me in my work with younger adults, and helped me think more clearly and responsibly about prognosis and later life vulnerabilities.

Although completing the Statment of Equivalence requirements does take a significant amount of time, I found that with initiative, independence and valuable support from colleagues, completing the process may not always be pleasurable, but certainly achievable and worth the effort. So, for those who are still in the process, I would say that the opportunity of working with older people is not only about doing it but more about being here, adjusting, learning and integrating into British culture.

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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 romola.bucks@soton.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: romola.bucks@soton.ac.uk

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