



The  
British  
Psychological  
Society

Psychologists' Special Interest Group  
Working With Older People

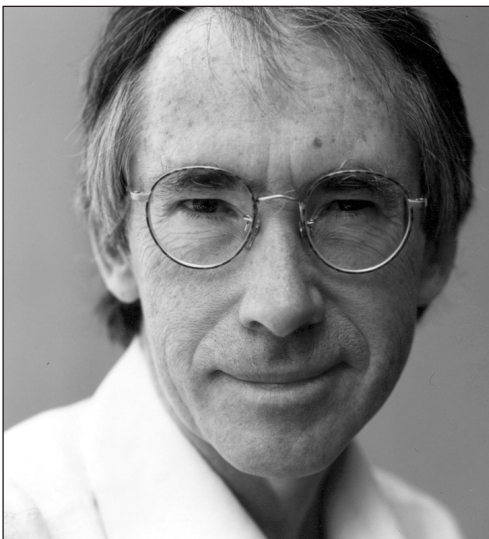
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**PSIGE**  
**Newsletter**



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**A novel approach:  
Ian McEwen writes  
about dementia**

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# **Psychologists' Special Interest Group Working With Older People**

## **AIMS**

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

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**Ian James & Sinclair Lough**

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# Letter from the Editors

Ian James & Sinclair Lough

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**W**ELCOME TO THE new look PSIGE *Newsletter*. The changes are in line with Society policy of a uniform corporate image. Please let us know what you think!!

Fronting this edition is an excerpt from Ian McEwan's new book *Saturday*. This is hot off the press and represents quite a coup by our National Secretary.

Thanks to our contributors. Please, please follow their example and send us articles. Enjoy this edition.

**Ian James & Sinclair Lough**  
*Co-Editors*

# Letter from the Chair

Nicky Bradbury

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**H**AVING HAD TWO of our quarterly meetings it feels like a good time to review our progress on this year's objectives as well as review the actions that have been carried forward from last year. (If you regard yourself as a good 'finisher' please consider standing for committee membership – we really need you!) I have been assured that the Early Onset Dementia paper is now complete and will shortly be available (free to members). We have agreed to delay the publication of the re-drafted briefing paper on commissioning Clinical Psychology services until the outcome of the Agenda for Change is clearer. This is to avoid producing a document that will become instantly outdated. Those of you who need the information urgently are invited to contact Steve Boddington who is happy to e-mail a copy of the final draft. Unfortunately the long awaited memory clinic document and test compendium still require further work but we do hope to be in the position to launch them at this year's conference.

The Training Sub-Committee has been working hard on our behalf to develop minimum expected standards for trainees to work effectively with older people. It now seems inevitable that these will be published by the DCP as 'aspirational' Good Practice Guidelines and, as such, carry a much reduced status within the training community. Nevertheless we sincerely hope that they will provide a useful tool for Geographical Groups in their negotiations with local courses.

A key task for the Website Task Group which was established this year is to advise on our future strategy. Currently we operate an independent site which has the advantage of autonomy but at a financial cost. The revamped Society website looks impressive and a decision must be made as to whether we continue to go it alone or be subsumed within the Society. It is our intention to bring a recommendation to the AGM in July. If you haven't done so already please take the opportunity to visit both sites and join in the debate.

**Nicky Bradbury**, *Chair*.

# Guest Editorial

Chris Allen

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**‘Sometimes you feel so happy you want to leap over the counter.’**

**W**HEN I ASKED Ian McEwan about his mother’s dementia and its influence on his new book, *Saturday*, he cited the above quote, which is one of his mother’s comments, as an example of her grammatically correct language that expressed nonsense. But does it? For me, whilst nonsense, it has a real sense of happiness and joy, perhaps the exhilaration of leaping a sweet counter. Certainly it communicates a sense of a personal history. So as an expression of joy it also summarised my feelings when he gave permission to re-print one of the most moving sections of the novel in the *Newsletter*. Ian has been described by *The Independent on Sunday* as ‘this country’s unrivalled literary giant’ and the day before I saw him at the Royal Festival Hall the publication of *Saturday* had prompted a feature on *News at Ten*.

It is great to have an extract from his new novel in the *Newsletter*, and better still to consider how many other people will be reading this extract when they read the novel. As the section we reprint addresses the issue of the experience of dementia and its impact, it will hopefully help draw attention to this issue amongst a wider public audience.

The section you will read details the visit of his main character, Henry Perowne, to his mother in an old people’s home. The character’s mother, like Ian’s own, has dementia and the account is based closely on his own visits.

The book as a whole covers a day in the life of Henry. He is a neurosurgeon and the novel is an extraordinary account of 24 hours in his life – the date being Saturday 15 February 2003 – the day of the huge anti-Iraq-war march in London. Henry’s visit to his mother is just one of the episodes in that

day. At many points in the account of this day it is impossible to forget that Henry is a neurosurgeon, even during a threatening encounter in the street Henry is aware of his potential assailants’ neurological condition. However, this is less evident during his visit to see Lily, which is much more the account of a son visiting his mother.

Henry is psychologically sophisticated in his interactions with his mother. He uses his knowledge of her history, humour and an ability to understand the world from her perspective as his aids for a successful visit. It would score well for well being on a dementia mapping exercise, and shows elements of life review and a sense, not unsurprisingly, of an individualistic narrative account of a person’s life – no crude reality orientation here.

Ian reports that when he went to see his own mother he took a notebook and would write down what she said. Using this device, they were able to write a poem together, much to Ian’s own amazement, but not if he had come across John Killick’s work (*Newsletter*, 84) who has also written stunning poems with people who have a dementia in this way. Ian has written about his mother’s dementia previously; he wrote an article about language called, ‘Mother Tongue’, when she first started to show the effects. He also plans to write a memoir as, ‘that’s the after-life I can give her’, about her early life in service and her devotion to housework. Her experience of dementia have made him more aware of his own mortality, death and the limited time we have available for life. Death is no longer a plot device in the novels and within this novel there is a real sense of larger questions being addressed. What is life for? What is the most we can hope to do

in the limited time we have available? What should guide our actions? These are fundamental questions that many people finally address, particularly when they have a realisation that their life is finite.

Given that Henry is a neurosurgeon, consciousness and the sense of self are also to the fore in the novel. Life and consciousness for Ian is beyond biological determinism, as

experience and living life is important as well. This novel successfully enters other states of mind; in particular in the section we have reprinted it demonstrates an acute sense of the experience of dementia from the perspective of a close relative.

**Chris Allen**

*National Secretary, PSIGE.*

*Thanks to: Hannah and Lucy at Rogers, Coleridge and White Ltd./Literary Agency for facilitating permission from Ian McEwan to publish this section of his novel, and access to see him at the Royal Festival Hall on 2 February 2005. Christine and Alexander from Jonathon Cape Publishers for help in obtaining Ian McEwan and Eamonn McCabe's permission for the extract and dust cover photograph to be used by the Newsletter, and Sarah for advice and support on how to do all this!*

# An excerpt from 'Saturday'

Ian McEwan

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CLEAN AND SCENTED, with a dull, near-pleasurable ache in his limbs, driving west in light traffic, Perowne finds he's feeling better about seeing his mother. He knows the routine well enough. Once they're established together, face to face, with their cups of dark brown tea, the tragedy of her situation will be obscured behind the banality of detail, of managing the suffocating minutes, of inattentive listening. Being with her isn't so difficult. The hard part is when he comes away, before this visit merges in memory with all the rest, when the woman she once was haunts him as he stands by the front door and leans down to kiss her goodbye. That's when he feels he's betraying her, leaving her behind in her shrunken life, sneaking away to the riches, the secret hoard of his own existence. Despite the guilt, he can't deny the little lift he feels, the lightness in his step when he turns his back and walks away from the old people's place and takes his car keys from his pocket and embraces the freedoms that can't be hers. Everything she has now fits into her tiny room. And she hardly possesses the room because she's incapable of finding it unaided, or even of knowing that she has one. And when she is in it, she doesn't recognise her things. It's no longer possible to bring her to the Square to stay, or take her on excursions; a small journey disorients or even terrifies her. She has to remain behind, and naturally she doesn't understand that either.

But the thought of the leave-taking ahead doesn't trouble him now. He's at last suffused by the mild euphoria that follows exercise. That blessed self-made opiate, beta-endorphin, smothering every kind of pain. There's a merry Scarlatti harpsichord on the radio tinkling through a progression of chords that never quite resolves, and seems

to lead him on towards a playfully receding destination. In the rear-view mirror, no red BMW. Along this stretch, where the Euston becomes the Marylebone Road, the traffic signals are phased, Manhattan-style, and he's wafted forwards on a leading edge of green lights, a surfer on a perfect wave of simple information: *go!* Or even, *yes!* The long line of tourists – teenagers mostly – outside Madame Tussaud's seems less futile than usual; a generation raised on thunderous Hollywood effects still longs to stand and gawp at waxworks, like 18th century peasants at a country fair. The reviled Westway, rearing on stained concrete piles and on which he rises swiftly to second-floor level, offers up a sudden horizon of tumbling cloud above a tumult of rooftops. It's one of those moments when to be a car owner in a city, the owner of this car, is sweet. For the first time in weeks, he's in fourth gear. Perhaps he'll make fifth. A sign on a gantry above the traffic lanes proclaims The West, The North, as though there lies, spread beyond the suburbs, a whole continent, and the promise of a six-day journey.

The traffic must be stalled somewhere else by the march. For almost half a mile he alone possesses this stretch of elevated road. For seconds on end he thinks he grasps the vision of its creators – a purer world that favours machines rather than people. A rectilinear curve sweeps him past recent office buildings of glass and steel where the lights are already on in the February early afternoon. He glimpses people as neat as architectural models, at their desks, before their screens, even on a Saturday. This is the tidy future of his childhood science fiction comics, of men and women with tight-fitting collarless jumpsuits – no pockets, trailing laces or untucked shirts – living a life beyond litter and confusion, free of clutter to fight evil.

But from a vantage point on the White City flyover, just before the road comes down to earth among rows of red-brick housing, he sees the tail lights massing ahead and begins to brake. His mother never minded traffic lights and long delays. Only a year ago she was still well enough – forgetful, vague, but not terrified – to enjoy being driven around the streets of west London. The lights gave her an opportunity to examine other drivers and their passengers. 'Look at him. He's got a spotty face.' Or simply to say companionably, 'Red again!'

She was a woman who gave her life to housework, to the kind of daily routines of polishing, dusting, vacuuming and tidying that were once common, and these days are only undertaken by patients with obsessive compulsive disorders. Every day, while Henry was at school, she spring-cleaned her house. She drew her deepest satisfactions from a tray of well-roasted beef, the sheen on a nest of tables, a pile of ironed candy-striped sheets folded in smooth slabs, a larder of neat provisions; or from one more knitted matinee jacket for one more baby in the remoter reaches of the family. The invisible sides, the obverse, the underneath and the insides of everything were clean. The oven and its racks were scrubbed after every use. Order and cleanliness were the outward expression of an unspoken ideal of love. A book he was reading would be back on the hallway shelf upstairs as soon as he put it aside. The morning paper could be in the dustbin by lunchtime. The empty milk bottles she put out for collection were as clean as her cutlery. To every item its drawer or shelf or hook, including her various aprons, and her yellow rubber gloves held by a clothes peg, hanging near the egg-shaped egg-times.

Surely it was because of her that Henry feels at home in an operating theatre. She too would have liked the waxed black floor, the instruments of surgical steel arrayed in parallel rows on a sterile tray, and the scrub room with its devotional routines – she would have admired the niceties, the clean

headwear, the short fingernails. He could have had her in while she was still capable. It never crossed his mind. It never occurred to him that his work, his 15 years' training, had anything to do with what she did.

Nor did it occur to her. He barely knew it at the time, but he grew up thinking her intelligence was limited. He used to think she was without curiosity. But that wasn't right. She liked a good exploratory heart-to-heart with her neighbours. The eight-year-old Henry liked to flop on the floor behind the furniture and listen in. Illness and operations were important subjects, especially those associated with childbirth. That was when he first heard the phrase 'under the knife' as well as 'under the doctor'. 'What the doctor said' was a powerful invocation. This eavesdropping may have set Henry on his career. This there were running accounts of infidelities, or rumours of them, and ungrateful children, and the unreasonableness of the old, and what someone's parent left in a will, and how a certain nice girl couldn't find a decent husband. Good people had to be sifted from the bad, and it wasn't always easy to tell at first which was which. Indifferently, illness struck the good as well as the bad. Later, when he made his dutiful attempts on Daisy's undergraduate course in the 19th century novel, he recognised all his mother's themes. There was nothing small-minded about her interests. Jane Austen and George Eliot shared them too. Lilian Perowne wasn't stupid or trivial, her life wasn't unfortunate, and he had no business as a young man being condescending towards her. But it's too late for apologies now. Unlike in Daisy's novels, moments of precise reckoning are rare in real life; questions of misinterpretation are not often resolved. Nor do they remain pressingly unresolved. They simply fade. People don't remember clearly, or they die, or the questions die and new ones take their place.

Besides, Lily had another life that no one could have predicted, or could remotely guess at now. She was a swimmer. On Sunday morning, 3 September 1939, while Chamberlain was announcing in his radio broad-

cast from Downing Street that the country was at war with Germany, the 14-year-old Lily was at a municipal pool near Wembley, having her first lesson with a 60-year-old international athlete who had swum for Britain in the Stockholm Olympics in 1912 – the first ever women’s swimming event. She had spotted Lily in the pool and offered to give her lessons for free, and coached her in the crawl, a most unladylike stroke. Lily went in for local matches in the late 40s. In 1954 she swam for Middlesex in the county championships. She came second, and her tiny silver medal, set on a wooden shield made of oak, always stood on the mantelpiece while Henry was growing up. It’s on a shelf in her room now. That silver was as far, or as high, as she got, but she always swam beautifully, fast enough to push out in front of her a deep and sinuous bow wave.

She taught Henry, of course, but his treasured memory of her swimming was of when he was 10, on a school visit one morning to the local pool. He and his friends were changed and ready, had been through the shower and footbath, and had to wait on the tiles for the adult session to end. Two teachers stood by, shushing and fussing, trying to contain the children’s excitement. Soon there was only one figure remaining in the pool, one in a white rubber cap with a frieze of petals he should have recognised earlier. His whole class was admiring her speed as she surged up the lane, the furrow in the water she left behind, just at the small of her back, and the way she turned her head to breathe without breaking her line in the water. When he knew it was her, he convinced himself he’d known from the beginning. To add to his exultation, he didn’t even have to claim her out loud. Someone called out ‘That’s Mrs. Perowne!’ In silence they watched as she reached the end of her lane right at their feet and performed a flashy underwater turn that was novel at the time. This was no mere duster of sideboards. He’d seen her swim often enough, but this was entirely different; all his friends were there to witness her super human nature, in which he

shared. Surely she knew, and put on in the last half-length a show of demonic speed just for him. Her feet churned, her slender white arms rose and chopped at the water, her bow wave swelled, the furrow deepened. Her body shaped itself round her own wave in a shallow undulating S. You would have had to sprint along the pool to keep up with her. She stopped at the far end and stood, and put her hands on the edge and flipped herself out of the water. She would have been about forty then. She sat there, feet still immersed, pulled off her cap and, tilting her head, smiled shyly in their direction. One of the teachers led the kids into solemn applause. Thought it was 1996 – the boys’ hair was growing thickly over their ears, the girls wore jeans to class – a degree of 50s formality still prevailed. Henry clapped with the rest, but when his friends gathered round, he was too choked with pride, too exhilarated to answer their questions, and was relieved to get in the pool where he could conceal his feelings.

In the 20s and 30s, great tracts of agricultural land to the west of London disappeared before an onslaught of high-speed housing development, and even now the streets of frowning, respectable two-storey houses haven’t quite shaken off their air of suddenness. Each near-identical house has an uneasy, provisional look, as if it knows how readily the land would revert to cereal crops and grazing. Lily now lives only a few minutes away from the old Perivale family home. Henry likes to think that in the misty landscape of her dementia, a sense of familiarity breaks through occasionally and reassures her. By the standards of old people’s homes, Suffolk Place is minute – three houses have been knocked through to make one, and an annexe has been added. Out front, two privet hedges still mark the old garden boundaries and two laburnum trees survive. One of the three front gardens has been cemented over to make parking space for two cars. The oversized dustbins behind a lattice fence are the only institutional clues.

Perowne parks and takes the potted plant from the back seat. He pauses a moment



before ringing the bell – there's a taste in the air, sweet and vaguely antiseptic, that reminds him of his teenage years in these streets, and of a general state of longing, a hunger for life to begin that from this distance seems like happiness. As usual, Jenny opens the door. She's a large, cheerful Irish girl in a blue gingham tabard who's due to start nurse's training in September. Henry receives special consideration on account of his medical connection – an extra three tea bags in the brew she'll bring soon to his mother's room, and perhaps a plate of chocolate fingers. Without knowing much at all about each other, they've settled on teasing forms of address.

'If it isn't the good doctor!'

'How's my fair colleen?'

Off the narrow space of the suburban hallway, tinted yellow by the front door's leaded glass, is a kitchen of fluorescent light and stainless steel. From there comes a clammy aroma of the lunch the residents ate two hours earlier. After a life-time's exposure, Perowne has a mild fondness, or at least a complete lack of disgust, for institutional food. On the other side of the entrance hall is a narrower door that leads through into the three interconnecting sitting rooms of three houses. He can hear the bottled sound of televisions in other rooms.

'She's waiting for you,' Jenny says. They both know this to be a neurological impossibility. Even boredom is beyond his mother's reach.

He pushes the door open and goes through. She is right in front of him, sitting on a wooden chair at a round table covered with a chenille cloth. There's a window at her back, and beyond it, a window of the house next door, 10 feet away. There are other women ranged around the edges of the room sitting in high-backed chairs with curved wooden arms. Some are watching, or looking in the direction of, the television mounted on the wall, out of reach. Others are staring at the floor. They stir or seem to sway as he enters, as if gently buffeted by the air the door displaces. There's a general,

cheery response to his 'Good afternoon, ladies' and they watch him with interest. At this stage they can't be sure he isn't one of their own close relatives. To his right, in the farthest of the connecting sitting rooms, is Annie, a woman with wild grey hair which radiates from her head in fluffy spokes. She's shuffling unsupported towards him at speed. When she reaches the end of the third sitting room she'll turn back, and keep moving back and forwards all day until she's guided towards a meal, or bed.

His mother is watching him closely, pleased and anxious all at once. She thinks she knows his face – he might be the doctor, or the odd-job man. She's waiting for a cue. He kneels by her chair and takes her hand, which is smooth and dry and very light.

'Hello Mum, Lily. It's Henry, your son Henry.'

'Hello darling. Where are you going?'

'I've come to see you. We'll go and sit in your room.'

'I'm sorry dear. I don't have a room. I'm waiting to go home. I'm getting the bus.'

It pains him whenever she says that, even though he knows she's referring to her childhood home where she thinks her mother is waiting for her. He kisses her cheek and helps her out of her chair, feeling the tremors of effort or nervousness in her arms. As always, in the first dismaying moment of seeing her again, his eyes prick.

She protests feebly. 'I don't know where we can go.'

He dislikes speaking with the forced cheerfulness nurses use on the wards, even on adult patients with no mental impairment. *Just pop this in your mouth for me.* But he does it anyway, partly to disguise his feelings. 'You've got a lovely little room. As soon as you see it, you'll remember. This way now.'

Arm in arm, they walk slowly through the other sitting rooms, standing aside to let Annie pass. It's reassuring that Lily is decently dressed. The helpers knew he was coming. She wears a deep red skirt with a matching brushed-cotton blouse, black tights and black leather shoes. She always dressed well.

Hers must have been the last generation to care as a matter of course about hats. There used to be dark rows of them, almost identical, on the top shelf of her wardrobe, cocooned in a whiff of mothball.

When they step out into a corridor, she turns away to her left and he has to put his hand on her narrow shoulder to guide her back. 'Here it is. Do you recognise your door?'

'I've never been out this way before.'

He opens her door and hands her in. The room is about eight feet by 10, with a glazed door giving on to a small back garden. The single bed is covered by a floral eiderdown and various soft toys that were part of her life long before her illness. Some of her remaining ornaments – a robin on a log, two comically exaggerated glass squirrels – are in a glazed corner cupboard. Others are ranged about a sideboard close to the door. On the wall near the handbasin is a framed photograph of Lily and Jack, Henry's father, standing on a lawn. Just in shot is the handle of a pram, presumably in which lies the oblivious Henry. She's pretty in a white summer dress and has her head cocked in that shy, quizzical way he remembers well. The young man is smoking a cigarette and wears a blazer and open-necked white shirt. He's tall, with a stoop, and has big hands like his son. His grin is wide and untroubled. It's always useful to have solid proof that the old have had their go at being young. But there is also an element of derision in photography. The couple appear vulnerable, easily mocked for appearing not to know that their youth is merely an episode, or that the tasty smouldering item in Jack's right hand will contribute – Henry's theory – later that same year to his sudden death.

Having failed to remember its existence, Lily isn't surprised to find herself in her room. She instantly forgets that she didn't now about it. However, she dithers, uncertain of where she should sit. Henry shows her into her high-backed chair by the French window, and sits facing her on the edge of the bed. It's ferociously hot, even hotter than

his own bedroom. Perhaps his blood is still stirred by the game, and the hot shower and the warmth of the car. He'd be content to stretch out on the oversprung bed and start to think about the day, and perhaps doze a little. How interesting his life suddenly appears from the confines of this room. At that moment, with the eiderdown beneath him, and the heat, he feels a heaviness in his eyes and can't stop them closing. And his visit has hardly begun. To revive himself, he pulls off his sweater, then he shows Lily the plant he has brought.

'Look,' he says. 'It's an orchid for your room.'

As he holds it out towards her, and the frail white flower bobs between them, she recoils.

'Why have you got that?'

'It's yours. It'll keep flowering through the winter. Isn't it pretty? It's for you.'

'It's not mine,' Lily says firmly. 'I've never seen it before.'

He had the same baffling conversation last time. The disease proceeds by tiny unnoticed strokes in small blood vessels in the brain. Cumulatively, the infarcts cause cognitive decline by disrupting the neural nets. She unravels in little steps. How she's lost her grasp of the concept of a gift, and with it, the pleasure. Adopting again the tone of the cheerful nurse, he says, 'I'll put it up here where you can see it.'

She's about to protest, but her attention wanders. She has seen some decorative china pieces on a display shelf above her bed, right behind her son. Her mood is suddenly conciliatory.

'I've got plenty of them cups and saucers. So I can always go out with one of them. But the thing is, the space between people is so tiny' – she brings up two wavering hands to show him a gap – 'that there's hardly enough space to squeeze through. There's too much binding.'

'I agree,' Henry says as he settles back on the bed. 'There's far too much binding.'

Damage from the small-vessel clotting tends to accumulate in the white matter and

destroy the mind's connectivity. Along the way, well before the process is complete, Lily is able to deliver her rambling treatises, her nonsense monologues with touching seriousness. She doesn't doubt herself at all. Nor does she think that he's unable to follow her. The structure of her sentences is intact, and the moods which inflect her various descriptions make sense. It pleases her if he nods and smiles, and chimes in from time to time.

She isn't looking at him as she gathers her thoughts, but past him, concentrating on an elusive matter, starting as though through a window at an unbounded view. She goes to speak, but remains silent. Her pale green eyes, sunk deep in bowls of finely folded light brown skin, have a flat, dulled quality, like dusty stones under glass. They give an accurate impression of understanding nothing. He can't bring her news of the family – the mention of strange names, any names, can alarm her. So although she won't understand, he often talks to her about work. What she warms to is the sound, the emotional tone of a friendly conversation.

He is about to describe to her the Chapman girl, and how well she's come through, when Lily suddenly speaks up. Her mood is anxious, even a little querulous. 'And you know that this ... you know, Aunt, what people put on their shoes to make them ... you know?'

'Shoe polish?' He never understands why she calls him Aunt, or which of her many aunts is haunting her.

'No, no. They put it all over their shoes and rub it with a cloth. Well, anyway, it's a bit like shoe polish. It's that sort of thing. We had side plates and God knows what, all along the street. We had everything but the right thing because we were in the wrong place.'

Then she suddenly laughs. It's become clearer to her.

'If you turn the picture round and take the back off like I did you get such a lot of pleasure out of it. It's all what it meant. And the laugh we had out of it!'

And she laughs gaily, just like she used to, and he laughs too. It's all what it meant.

Now she's away, describing what might be a disintegrated memory of a street party, and a little watercolour she once bought in a jumble sale.

Some time later, when Jenny arrives with the refreshments, Lily stares at her without recognition. Perowne stands and clears space on a low table. He notices the suspicion Lily is showing towards what she takes to be a complete stranger, and so, as soon as Jenny leaves, and before Lily can speak, he says, 'What a lovely girl she is. Always helpful.'

'She's marvellous,' Lily agrees.

The memory of whoever was in the room is already fading.

His emotional cue is irresistible and she immediately smiles and begins to elaborate while he spoons all six tea bags out of the metal pot.

'She always comes running, even if it's narrow all the way down. She wants to come on one of them long things but she doesn't have the fare. I sent her the money, but she doesn't have it in her hand. She wants some music, and I said you might as well make up a little band and play it yourself. I worry about her though. I said to her, why do you put all the slices in one bowl when no one's standing up? You can't do it yourself.'

He knows who she's talking about, and waits for more. Then he says, 'You should go and see her.'

It's a long time since he last tried to explain to her that her mother died in 1970. It is easier now to support the delusion and keep the conversation moving along. Everything belongs in the present. His immediate concern is to prevent her eating a tea bag, the way she almost did last time. He piles them onto a saucer which he places on the floor by his foot. He puts a half-filled cup within her reach and offers her a biscuit and a napkin. She spreads it over her lap and carefully places the biscuit in its centre. She raises the cup to her lips and drinks. At moments like these, when she's skillful in the long-established routines, and looks demure in her colour-matched clothes, a perfectly

well-looking 77-year-old with amazing legs for her age, athlete's legs, he can imagine that it's all been a mistake, a bad dream, and that she'll leave her tiny room and come away with him into the heart of the city and eat fish stew with her daughter-in-law and grandchildren and stay a while.

Lily says, 'I was there last week, Auntie, on the bus and my mum was in the garden. I said to her, You can walk down there, see what you're going to get, and the next thing is the balancing of everything you've got. She's not well. Her feet. I'll go there in a minute and I can't help losing her a jersey.'

How strange it would have been for Lily's mother, an aloof, unmaternal woman, to have known that the little girl at her skirts would one day, in a remote future, a science fiction date in the next century, talk of her all the time and long to be home with her. Would that have softened her?

Now Lily is set, she'll talk on for as long as he sits there. It's hard to tell if she's actually happy. Sometimes she laughs, at others she describes shadowy disputes and grievances, and her voice becomes indignant. In many of the situations she conjures, she's remonstrating with a man who won't see sense.

'I told him anything that's going for a liberty and he said, I don't care. You can give it away, and I said don't let it waste in the fire. And all the new stuff that's going to be picked up.'

If she becomes too agitated by the story she's telling, Henry will cut in and laugh loudly and say, 'Mum, that's really very funny!' Being suggestible, she'll laugh too and her mood will shift, and the story she tells then will be happier. For now, she's in neutral mode – there's a clock, and a jersey again, and again, a space too narrow to pass through – and Henry, sipping the thick brown tea, half listening, half asleep in the small room's airless warmth, thinks how in 35 years or less it could be him, stripped of everything he does and owns, a shrivelled figure meandering in front of Theo or Daisy, while they wait to leave and return to a life of which he'll have no comprehension. High

blood pressure is one good predictor of strokes. One-hundred-and-twenty-two over 65 last time. The systolic could be lower. Total cholesterol, five point two. Not good enough. Elevated levels of lipoprotein-a are said to have a robust association with multi-infarct dementia. He'll eat no more eggs, and have only semi-skimmed milk in his coffee, and coffee too will have to go one day. He isn't ready to die, and not is he ready to half die. He wants his prodigiously connected myelin-rich white matter intact, like an unsullied snowfield. No cheese then. He'll be ruthless with himself in his pursuit of boundless health to avoid his mother's fate. Mental death.

'I put sap in the clock,' she's telling him, 'to make it moist.'

An hour passes, and then Henry forces himself fully awake and stands up, too quickly perhaps, because he feels a sudden dizziness. Not a good sign. He extends both hands towards her, feeling immense and unstable as he looms over her tiny form.

'Come on now, Mum,' he says gently. 'It's time for me to go. And I'd like you to see me to the door.'

Childlike in her obedience, she takes his hands and he helps her from her chair. He piles up the tray and puts it outside the room, then remembers the tea bags, half concealed under the bed, and puts them out too. She might have feasted on them. He guides her into the corridor, reassuring her all the while, aware that she's stepping into an alien world. She has no idea which way to turn as they leave her room. She doesn't comment on the unfamiliar surroundings, but she grips his hand tighter. In the first of the sitting rooms two women, one with snowy hair in braids, the other completely bald, are watching television with the sound off. Approaching from the middle room is Cyril, as always in cravat and sport jacket, and today carrying a cane and wearing a deer-stalker. He's the home's resident gent, sweet-mannered, marooned in one particular, well-defined fantasy: he believes he owns a large estate and is obliged to go around

visiting his tenants and be scrupulously polite. Perowne has never seen him unhappy.

Cyril raises his hat to Lily and calls, 'Good morning, my dear. Everything well? Any complaints?'

Her face tightens and she looks away. On the screen above her head Perowne sees the march – Hyde Park still, a vast crowd before a temporary stage, and in the far distance a tiny figure at a microphone, then the aerial shot of the same, and then the marchers in columns with their banners, still arriving through the park gates. He and Lily stop to let Cyril pass. There's a shot of the newsreader at her space-age desk, then the aeroplane as he saw it in the early hours, the blackened fuselage vivid in a lake of foam, like a tasteless ornament on an iced cake. Now, Paddington police station – said to be secure against terrorist attack. A reporter is standing outside, speaking into a microphone. There's a development. Are the Russian pilots really radical Muslims? Perowne is reaching up for the volume control, but Lily is suddenly agitated and trying to tell him something important.

'If it gets too dry it will curl up again. I told him, and I told him you have to water it, but he wouldn't put it down.'

'It's all right,' he tells her. 'He will put it down. I'll tell him to. I promise you.'

He decides against the television and they come away. He needs to concentrate on his leave taking, for he knows that she'll think she's coming with him. He'll be standing once more at the front door, with his meaningless explanation that he'll return soon. Jenny or one of the other girls will have to distract her as he steps outside.

Together they walk back through the first sitting room. Tea and crustless sandwiches are being served to the ladies at the round table with the chenille cloth. He calls a greeting to them, but they seem too distracted to reply. Lily is happier now, and leans her head against his arm. As they come into the hall they sense Jenny Lavin by the door, already raising her hand to the high double-security lock and smiling in their direction. Just then his mother pats his hand with a feathery touch and says, 'Out here it only looks like a garden, Aunty, but it's the countryside really and you can go for miles. When you walk here you feel lifted up, right high across the counter. I can't manage all them plates without a brush, but God will take care of you and see what you're going to get because it's a swimming race. You'll squeeze through somehow.'

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# Using referencing objects with older adults – a brief clinical note

Stéphane Duckett

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Home is so sad. It stays as it was left,  
Shaped to the comfort of the last to go  
As if to win them back. Instead, bereft  
Of anyone to please, it withers so,  
Having no heart to put aside the theft.

And turn again to what it started as,  
A joyous shot at how things ought to be,  
Long fallen wide. You can see how it was:  
Look at the pictures and the cutlery,  
The music in the piano stool. That vase.

*Home is so Sad*, Philip Larkin  
(Courtesy of Philip Larkin and Faber & Faber)

THE POIGNANCY OF Larkin's poem rests on that acknowledgement that objects, particularly those accumulated over a lifetime can be imbued with enormous significance. They may serve as windows onto their owners or, as Larkin suggests, silent witnesses onto a lifetime. The *Oxford English Dictionary* would appear to acknowledge this fact in its definition of the word 'object': 'that to which action, thought or feeling is directed'. Within Older Adult Psychology we have long recognised the importance of objects as biographical tokens, particularly within the context of reminiscence work (Hepworth, 2000; Kamptner, 1998 and Paterniti, 2003, Bryant & Foster, 2002).

The following article attempts to briefly summarise some of the ways with which I have utilised 'referencing' objects in the context of my work with older adults. It obviously assumes that your clients are being seen in their home or living environment. I have deliberately avoided the term objects of reference since the expression already has

a specific connotation within the field of rehabilitation and educational psychology, namely utilising objects to facilitate communication with subjects who have, for a variety of reasons, no or little receptive language. Referencing objects refers to the action of utilising an object, to access thoughts, feelings, values or recollection with the idea of promoting engagement in the therapeutic process.

In a world where older adults frequently become steadily more isolated culturally historical events, fashions, values gradually evolve, change and transform. Where originally they may have been emblematic expressions they may lose all meaning and recognition except within living memory and to an extent decontextualised within novels and plays, etc. Objects within this context may serve as islands of meaning; reference points to a subject's past and as a consequence may serve as powerful tools during the course of a therapeutic intervention on several levels:

1. Therapists acknowledging the object validates its worth and, therefore, importance and by extension as an expression of what has been important to the client, those values that define the client's self-worth itself. For instance, one client who through his dementia found that he was losing his ability to communicate fluently still found that his aesthetic sense remained very much intact. He gained immense pleasure from a collection of watercolours. The fact that I was able to identify a particular artist and did not hide the pleasure that I took from this unknown (to me) piece, clearly gave the client an enormous sense of pride at his astuteness and keen eye in having acquired this piece.
2. Referencing objects 'anchors' them and hence their meaning or the values they may express whether purely aesthetic or moral, i.e. a war memento, in a world where they may be adrift or decontextualised. For instance, a military-issued compass which was on a desk and saw service along with its owner in Burma for six years for the client was symbolic of the fact that he had been willing to give his life for his country, but that what he perceived to be the general public's ignorance about the privations and sacrifices made by soldiers in that particular theatre of war. My acknowledging it and listening to the history linked to this compass allowed the client to identify much about what he regards as important in life.
3. Within the process of therapy itself referencing objects may serve as an excellent way of 'bridging' (Lazarus, 1976) with a client, i.e. starting the intervention on a non-pathologising and hence less threatening way of engaging the client. For instance, I have noted particular books, framed photographs, flowers, furnishings or even the residence itself. I once commented on how sunny and agreeable a client's flat was; this led into an account of how this client had bought the flat from her landlady who had taken her (my client) in as a war refugee. The sunniness of the flat she saw as an expression of the warmth with which she had been sheltered by her elderly landlady. This ultimately led on to her now more fully appreciating the isolation that her landlady had experienced and my client's own feelings of vulnerability at this juncture in her life.
4. In terms of content, hearing the stories unfold about the objects themselves may yield invaluable information about the client's past, past accomplishments, past issues and experience that may go far in explaining current concerns, motivation and behaviour. By contrast sometimes the complete absence of objects may also suggest much about the subject's alienation and current state of mind. An elderly, former refugee who had served as an administrator in his country of origin's erstwhile government had a photograph of the Head of State for whom he had worked. A reference to this led to a discussion highlighting the pain over the loss of his country of origin as well as family members. His recent retirement, and the fact that he was in the early stages of a dementia, re-invoked painful memories of the trauma of that early loss.

However, referencing objects needs to be done with considerable care and may alienate the client.

1. Revealing your ignorance about important historical and cultural events may alienate you from the client. By contrast the client may not expect you to know and therefore may take pleasure in informing you (an expression of their expertise and hence validating to them).
2. Knowing more than your client may intimidate them or underscore their lack of expertise and hence devalue them therefore one needs to be measured in what you reveal of what you know. Allow the client to tell their story.

3. Referencing specific objects within the client's own environment can be misunderstood as a request for that object (Duckett, 2004) and create tensions for both the therapist and/or client without the other necessarily being fully aware of that fact.

The word object has been used within a wide variety of settings in psychology. In an attempt to distinguish its use here the term 'referencing object' has been coined. It denotes an artifact which is utilised within the context of a therapeutic intervention to access ideas, thoughts, values, memories or emotions. There are no hard and fast rules on the use of referencing objects however, they may represent a useful tool to both validate as well as access important therapeutic

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material within the context of your work. Increasingly, as our clients are surviving to greater ages the necessity of seeing the client within their own home arises. Whilst this represents considerable logistic and therapeutic challenges for us as older adult psychologists it undeniably represents opportunities in contextualising the client and ultimately their 'presenting problem'. Central within this work will be thinking through using the client's environment and specifically the artefacts within that environment as a therapeutic voice.

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# The need for psychotherapeutic services for people with Parkinson's disease

Michael Bender & Tony Wainwright

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*'- is it not what we expect in men, that they should have numerous strands of experience lying side by side and never compare them one with the other?'* George Eliot (1872/1994), *Middlemarch*, p.560.

ONE OF THE puzzling features of the present mental health scene for older adults is that, while there is much interest and concern about providing psychotherapeutic services for one chronic, degenerative disease, namely the dementias, people with another, equally terrible and overlapping condition, namely Parkinson's, have not been seen as requiring such services: *'Although the medical model is well suited to acute illness, in chronic illnesses, like PD, the long-term social and psychological effects of the illness have not been addressed adequately within it.'* (Parry, 1990.)

G.S. Charlton & C.J.Barrow (2002, p.472).

This paper aims to highlight the frequent occurrence of significant indicators of emotional distress experienced by people with Parkinson's disease; and, therefore, the need that they and their support networks have for ready access to a wide range of psychological services. We will then suggest a model for such service delivery.

## Demonstrating the need

A good place to start would be the collection of accounts of what it is like to have Parkinson's, presented in a book called *Injured Brains in Medical Minds*, edited by Narinder Kapur (pp.167–215). Some 17 accounts make for painful reading.

Congruent with the lack of psychological services nationally for people with Parkinson's, is a relative paucity of research into its psychological aspects. We will, therefore, on occasion, draw on the much more extensive literature concerning the psycho-

logical effects of dementia. Ellgring *et al.* (1993), using 'a representative sample of 325 patients (200 men, 125 women)' found that five types of stress were reported by 80 per cent or more. These were: 1. Psychological stress from bodily symptoms; 2. Lack of efficiency; 3. Anxiety and psychological distress; 4. Social Interaction; and 5. Partnership and family. We will focus on five areas for which there is research evidence: social difficulties, anxiety, depression, dementia and psychosis.

1. **Social difficulties** can arise for a number of reasons, which include: **decreased mobility**, resulting in seeing fewer people, and fewer social interactions; **facial rigidity**, causing difficulties in communication, and which may lead to avoidance by some of the person's network; and **excess salivation and difficulty eating food**, increasing the likelihood of embarrassment and of social withdrawal (MacCarthy & Brown, 1989; Ellgring *et al.*, 1993.) Ellgring *et al.* reported that, in their sample, 84 per cent reported difficulties in social interaction.

2. **Anxiety** is more frequent in people with Parkinson's disease than in the elderly population generally (15 to five per cent). Across various studies, clinical anxiety in people with Parkinson's is put at 40 per cent. This is higher than in other chronic medical conditions, such as multiple sclerosis (Menza, Robertson-Hoffman & Bonapace, 1993).

Marsden and Parkes (1976) estimate that 'after two to three years of L-dopa treatment, 15 to 40 per cent of sufferers experience on-off fluctuations and warn that the prevalence

may increase with longer periods of treatment.' (Matson, 2002, p.94). If the person has off periods, Matson reports that seven per cent experience no anxiety, 27 per cent experience anxiety sometimes, and 67 per cent experience anxiety very often.

It appears that anxiety can be experienced by the person before there are clear motor signs and before diagnosis (Mayeux *et al.*, 1981; Santamaria, Tolosa & Valles, 1986; Stein *et al.*, 1990). Henderson *et al.* (1992) 'surveyed 164 PD patients and found that 78 experienced symptoms of panic or anxiety. Of these, 21 per cent had symptoms of panic/anxiety before the onset of motor symptoms.' (Zesiewicz *et al.*, 1999, p.111).

The amount of anxiety experienced does not correlate with the severity of Parkinson's (Stein *et al.*, 1990.) Probably, anxiety fluctuates with each new problem that is encountered, and, therefore, is cyclical, rather than linear.

**3. Depression.** The figure usually given for depression in the general elderly population is 15 per cent. Rodin and Voshart (1986) give a figure of 18 per cent for the medically ill in hospital.

By contrast, Laidlaw *et al.* (2003) and Poewe and Luginger (1999), reviewing the literature, give the prevalence rate of depression for people with Parkinson's disease as between 50 and 60 per cent (Cummings & Masterman, 1999; Zesiewicz *et al.*, 1999).

Again, there is little evidence that severity of Parkinson's is a predictor of depression (Schrag *et al.*, 2001; Zesiewicz *et al.*, 1999; MacCarthy & Brown, 1989); however, it may correlate with rate of progression of the illness (Mayeux *et al.*, 1981; Troster *et al.*, 1995; Schrag, Jahanshahi & Quinn, 2001).

We will look at dementia in a moment. Here all we need to note is that people with Parkinson's IF they get dementia, usually get Lewy Body's, rather than Alzheimer's. This form of dementia is associated with much higher rates of depression than is found in Alzheimer's (McKeith *et al.*, 1992: 38 per cent to 15 per cent; Ballard, Bannister & Oyebode, 1996: 43 per cent to 16 per cent).

Concerning co-morbidity of anxiety and depression, Menza *et al.* (1993) 'found 12 out of 42 PD patients met DSM criteria for anxiety disorder. Eleven (92 per cent) of these patients had a comorbid depressive disorder' (Zesiewicz *et al.*, 1999, p.111)

We have not found studies of rates of depression among **carers or relatives**. Carers of people with dementia have been extensively studied, and Ballard *et al.* (1996), surveying the literature, reports a consensus that 40 to 60 per cent are depressed.

Staying in the field of dementia, Waite *et al.* (2004) found the most powerful predictor of whether the caring relative was depressed was the presence of depression in the person with dementia. They found that 14 out of 18 carers living with a dementia sufferer were depressed when the person was depressed (78 per cent), compared to 13 out of 28 (46 per cent) of carers who were depressed when living with a non-depressed person.

**4. Dementia.** If a person with Parkinson's disease has dementia, this is likely to be the more rapid deteriorating Lewy Body variety.

Gibb (1989) gives a figure of 10 to 20 per cent of dementia in Parkinson's. First and Tasman (2004) quote Kaplan, Sadock and Grebb (1994) that dementia 'is found in nearly 40 per cent of such individuals [persons with Parkinson's] older than 70 years of age (p.295)'. Aarsland *et al.* (1996), based on a community survey, gives a figure of 27 per cent. The latter authors also found that, if a person with Parkinson's has dementia, they were much more likely to be depressed than PD patients without dementia (23 per cent compared to 2.3 per cent).

**5. Psychosis.** The frequency of psychotic behaviours in the later stages needs noting. Hallucinations, paranoid accusations and sexualised behaviours can occur and be very distressing to both the person and their relatives.

We should note that both confusion and disturbed behaviour can be the side-effect of

the powerful anti-Parkinson's medication, especially as dosages are increased in an attempt to control the latter stages of the disease (Gibb, 1989).

We hope we have demonstrated the high rates of emotional distress and cognitive loss suffered by people with Parkinson's to justify the case for the provision of adequate psychological services for them. The question of how we should frame these services is addressed in the next section.

### A framework for services to people with Parkinson's disease

There is evidence that antidepressants worsen motor symptoms (Zesiewicz *et al.*, 1999). Therefore, there is a particular need with this client group to develop effective psychological methods of treating emotional distress.

When considering psychological interventions, we require a holistic perspective. This is provided by Bender (2002), who proposed that six perspectives are needed to understand any person, so the model is normative, not pathological (Figure 1)

Having given some meaning to these perspectives (for a fuller exposition, see Bender, 2002), we need to relate these perspectives to some indicator of the severity or stage the disease has reached. MacMahon and Thomas (1998) have provided a Four Stage management pathway, which is suitable for our purposes, and we can, therefore, combine the two.

MacMahon and Thomas' stages are fairly self-explanatory. Diagnosis is not so much a stage, as an event that the person must come to terms with. Then follows a quiet period, when the medication is effective, often referred to as 'the honeymoon' period. As the medication becomes less effective, and symptomatology increases, so the patient has entered the complex phase; and as the medication fails to be effective, so it is switched towards the relief of pain and distress.

The grid presented in Figure 2 (overleaf):

- allows for an holistic assessment, rather than a purely diagnostic one;
- places the person with Parkinson's in a social context;
- allows the rational planning of services on an individual basis;
- encourages the monitoring and providing for changing need.

Such an approach contrasts with an 'assess-treat-discharge' model. This model is not helpful for any chronic deteriorative condition. We would counsel against closing cases. Rather, we should be permanently available to provide support as and when it is needed.

In terms of services, **we must not assume that the patient and the relative(s) have the same agendas.** In the field of cognitive losses, this assumption has resulted in collusive liaisons between mental health professionals and relatives, excluding the actual patient. We need to be providing services to both as individuals.

Figure 1: The Six Perspectives for Understanding the Individual (Bender, 2002).

1. Contextual	The meanings and implications the person gives to situations and interactions they are currently within.
2. Difficulties	What skills have been damaged?
3. Intrapsychic	The affective response(s) of the individual to their situation.
4. Interpersonal	The effect on their position and relationship with close others.
5. Effects of the past	The effect of past crises and experiences on present behaviour.
6. Societal	Society's valuation of the person.

Figure 2: Framework for Developing Psychological Perspectives for Understanding Parkinson's: Bender's (2002) Six perspectives x MacMahon & Thomas' (1998) Parkinson's Care Pathway Stages.

Bender's Six perspectives	Diagnosis	Maintenance	Complex	Palliative
1. Contextual				
2. Disability				
3. Intrapsychic				
4. Interpersonal				
5. Effects of the past				
6. Societal				

We should be offering a variety of services that can be accessed as the need arises (Wright, 1999). It is government policy to encourage patient self-management and consumer choice, and the approach advocated here is congruent with these values. So, after diagnosis, we might offer information and education sessions to the patient and their network; and then, in the maintenance phase, availability to professional advice, as and when requested, may suffice. As the condition worsens, so there might be individual or group therapy support for the patient, carer support groups for the network, and family work to resolve tensions inside the home. We should also have good links with palliative care and end of life counselling.

To give this some theoretical and research background, we can use the stress buffering concepts, first introduced by Brown and Harris (1978). As is well known, they proposed three types of predictive factors: vulnerability, support and life events.

We will not discuss vulnerability, except to say that any service will need to have access to practitioners who have the relevant skills to handle early traumatic damage. The occurrence of stressful life events might trigger requests for assistance, which would be readily available under in an open case/open access service.

In terms of social support, Russell and Cutrona (1991) showed a significant negative correlation between depression and social support in non-psychiatric older people. Haslam *et al.* (in press) has shown that social support in patients undergoing heart surgery decreases their level of stress. Waite *et al.* (2004) show this effect nicely in their study of carers of people with dementia. Carers with a confidant they saw daily had a Geriatric Depression Scale of 3.29; those who saw a confidant weekly had a mean GDS score of 5.23 and those without a confidant 8.67, differences which are highly statistically significant ( $p=0.007$ ). Similarly, Seiler *et al.* (1992), reported the highest level of depression in patients with difficult relationships, then by single patients, and least for those in a stable relationship.

Haslam (2004) has theorised concerning how we are most likely to activate such support. He argues that **we give and get help as a function of our social identity**. That is to say, we should not see support as a property of the individual but rather that it is channelled into and from groups which we identify with.. This issue is explored in relation to PD in Charlton and Barrow (2002).

This approach suggests clinically useful strategies, that we might call *identity tasks* for us to work on with our clients:

- to retain their pre-diagnosis group memberships;

- to relate to new relevant groups, such as fellow sufferers (hence the value of group, rather than individual, therapy);
- to see the team and the patients as a common group with a united purpose, that they can identify with (Haslam, 2004).

This in turn informs us about the kind of team that need to be created. Crucially, such teams need to have control over their environment, so that they can readily modify the services they offer to clients according to current need.

The likely benefit of such interventions is increased by the fact that people with Parkinson's score as less apathetic than do people with Alzheimer's and are more in agreement with relatives' ratings, suggesting that denial is somewhat less important in this condition (Robert *et al.*, 2002).

We have suggested that a range of types of clinical expertise should be available. Ellgring *et al.* (1993) report positive results with five to eight two-hour seminars of psychological training over a period of two to three months; and also, in a small sample, benefits from individual counselling. With regard to CBT, the reader may wish to consult Kemp, Corgiat and Gill (1991/1992 – groupwork); for individual work, Dreisig *et al.* (1999); and the successful treatment of depression in a person with Parkinson's described in the excellent *Cognitive Behaviour Therapy with Older People*, by Laidlaw *et al.* (2003). This man had had a course of antidepressants, which had not been effective. A close friend, also a Parkinson's sufferer, had died quickly from the disease. Treatment started with the keeping a weekly baseline of his activities which allowed him and the therapist to highlight his withdrawal from social activities, such as visiting music shops, cycling, hill-walking.

He and the therapist agreed on three goals: symptomatic relief of the depression; increasing his activity level; and targeting his assumptions and beliefs about the meaning of Parkinson's.

Treatment consisted of 14 one-hour sessions, on a monthly basis, plus a routine three-month follow-up. The main work was done by having him record negative thoughts and then challenging them. For example, not being able to undertake the fine finger movements required to check the tyre pressures on his car resulted in worsening of his tremor and a loss of his confidence. While he could not help Mr. P unscrew valve caps, the therapist helped him avoid catastrophisation of the event and create a more benevolent cycle

Post-treatment assessment showed that activity outside the house went up from 12 hours a week to 29. Where previously he had always been accompanied by his wife, he could now go out by himself; and while before treatment he had not been able to go further than the local shops, he could now once again go to the city centre music shops, and go for walks by himself. His anxiety and depression had decreased. Previously, he had suffered from disturbed nights. These had now stopped. His sense of confidence and independence had increased.

Of course, this man still had Parkinson's; but it was now something he was able to face. What the psychologist had done was to help decrease **excess disability** (Lawton, 1980) and, rather than lose energy to lowered mood, helped him break down his problems into a manageable size and develop skills to minimise their effect.

## **Conclusions**

We have outlined the needs of people with Parkinson's, the kind of therapeutic services they might benefit from, and a framework for service delivery.

We have moved away from the therapist as an expert on the soul or psyche towards being an engineer, collaborating with the client to create positive changes in their relationship with their physical and social environment. This decentring of the therapist is necessary because the person cannot get day to day support from a service; nor can they get identity-maintenance, since the only role

we can provide for them is as a service user. Rather, we must work with them to make their environment as nourishing, stimulating and supportive as possible.

We hope that our colleague clinical psychologists can help remedy this indefensible shortfall in services to a highly at risk group.

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# Talking therapy as a psychological intervention for people with dementia: A literature review

Sophie Heason

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SINCE THE INCREASE of awareness of dementia in the health care professions, and the wider accessibility to early assessment of cognitive deterioration, there has been an expanding cohort of people with a diagnosis of dementia in the early stages. Psychological services for older adults have seen an increase in referrals of people with early-stage dementia. Also, assessment of cognitive ability, and subsequent diagnosis of dementia may raise issues of loss, change and life-review.

## Method

The search strategy for this review involved searching *The Web of Science*, *PsychInfo*, and *OVID* for articles dated from 1981 to 2004, with the keywords *psychological therapy*, *counselling*, and *psychological intervention* in the title or abstract alongside the keyword *dementia*. Online databases were searched for items that had quoted previous important articles in the field. Items that were selected for review concerned any type of dementia and the provision of any style of individual psychological therapy. Items concerning group therapy or systemic approaches to intervention were excluded from the review, as were those that addressed therapy for care-givers to people with dementia.

## Literature review

Despite displaying flexibility of thought in his own later years, Freud stated that psychoanalysis with people over 50 years old would not work as they are unable to learn and develop. However, research has shown that older people can benefit from talking therapies (Knight, 1996). The main topics of therapy that arise in the literature are coping

with chronic illness and disability, death and life review, loss and bereavement, loss of control, and trauma in past life (Knight, 1986, 1996; Goudie, 2002a). People with dementia are as likely, if not more, to need to address some of these issues. The prevalence of symptoms of depression in people with dementia is cited as 30.9 per cent, and of depressive syndrome as 19 per cent (Alan & Burns, 1995, cited in Cheston & Bender, 1991). Links between psychological problems, such as depression, and dementia could either be a result of organic changes in the central nervous system, or of secondary processes, such as adjustment to loss or response to environment. The fact that a person with dementia and depression can improve in mood, indicates that secondary processes, which also change, contribute to depression. Verhey *et al.* (1993) examined 170 outpatients with dementia, and found no significant relationship between insight into cognitive impairments and depression, which indicates that increasing insight during therapy will not increase levels of depression. Additionally, treatment for depression may improve memory, thus enabling the client to maintain their cognitive ability at its optimum.

Cheston (1998) compiled a literature review of psychotherapeutic work with people with dementia to address meeting the needs of this client group. He argued that there is a moral call to therapists to provide care for people in this cohort who are isolated and have unmet needs, and that this overrides the lack of evidence for efficacy of therapy that he found. However, this conclusion leaves questions concerning which methods and therapy tools are the



most useful to people with dementia. This review is more extensive than Cheston's, will contain more critique of the methodology of the research, and discuss more recent publications. Firstly, I plan to discuss suitability for therapy. I will then separate the literature concerning provision and efficacy of therapies into groups, according to the theoretical frameworks they use. I shall then summarise the literature concerning adaptations to therapy for people with dementia, and then conclude on how the findings of this review may influence my clinical work.

Before addressing the different approaches to therapy in the literature, it is necessary to review discussion of suitability for therapy in clients with dementia. Hausman (1992) stated that efficacy of therapy is dependent on the degree to which the dementia has progressed, the stage in progression of the dementia in which the therapist and client first begin work, and the degree of psychological sophistication the client had prior to the dementia. Some researchers state the need for sufficient cognitive ability to have insight, ability for new learning and to monitor their own thoughts and beliefs (Thompson *et al.*, 1989), whereas the approach of resolution therapy can be used with people at all stages of dementia (Goudie, 2002b). There are also issues of ability to give consent to therapy, which are not within the scope of this review. Bryden (2002) outlines a useful guide to assessment before therapy, and considering the likely deterioration of the client, throughout therapy. She states that it is important to know levels of physical health and cognitive competence, current and past levels of psychological well-being, spirituality, and use of medication. She also suggests completing a genogram and a lifeline to understand biography, social context, past and current issues, and personality. Woods (2003) made the strong argument that a clinician should adapt their intervention to every client, regardless of age. This point is in line with most of the literature reviewed here concerning formulation and intervention in talking therapies.

### **Exploratory therapies**

People with dementia may find it difficult to maintain memories of attachment relationships, which paradoxically are so important in a time of uncertainty and stress. Therapeutic intervention may focus on attachment and providing a secure relationship for exploring difficult issues. Cheston and Bender (1991) state that people with dementia are able to establish new attachments, as long as the level of communication is appropriate. Kitwood (1997) proposed that the 'social psychology' of the environment around a person with dementia is vital to their well-being; this includes relationships in which the person is treated as such, and not as a set of symptoms. The therapeutic relationship can enhance sense of personhood, improve sense of self and self esteem, and give the client space to resolve internal conflicts. In psychotherapeutic work the presence of the therapist may allow for projection and transference so that the client may work through issues of unresolved emotions and of loss. Hausman (1992) explains that even at times when the therapist is not remembered, there will be recognition that this person, or office, is associated with being cared about and understood.

Sinason (1992) wrote a case study of year-long psychotherapy with a professor who had dementia in which their secure relationship was a major agent of intervention. She described the changes in him, the losses of words, memory and identity that he went through and her emotional reaction to witnessing these. She described the metaphors that he used to express his emotions, his need for her reflection and containment of his emotions, and his need for her to act as his proxy memory, remembering between sessions for him and maintaining the existence of the information, and thus himself, in his world for a little longer. Hausman (1992) pointed out that holding of information may help the client to feel understood and not need to repeat them self. In the later stages of dementia in cases

when a therapeutic relationship is already established, Hausman describes how the therapist can help the client to recall important stories and people which will integrate the self of the past with the present self.

The social constructionist perspective is that through narrative and others' response and validation of narrative, the person can maintain a sense of self (Bond, 2001). Sutton (2003) discussed her use of Cognitive Analytic Therapy (CAT) as a framework for intervention with two people with a diagnosis of dementia and trauma in early life. She described the process by which the therapeutic relationship, and the joint writing of a personal narrative, enabled the clients to integrate the dis-associated parts of themselves so that they would have a greater sense of self. The two case studies illustrated how CAT could be used with this client group, particularly with an emphasis of integrating a sense of self for people whose world may feel as if it is becoming fragmented. Sutton describes the processes of change in the clients; one client's quotes indicate the significance of therapy and the changes that occurred in him. *'Andrew said it was like opening a door of a room you've never been in' ... and that the therapy was like having a 'surrogate parent', 'you get to make mistakes and you don't get thrashed for it.'* (pp.159–160)

The process of negotiating a narrative with the client in this therapeutic approach adds to the strength of these case studies. The opportunity for the client to confirm the therapist's findings adds to the paper's validity and reliability. Sutton and Cheston (1997) wrote a short chapter on the use of story-telling with people with dementia to allow them space to use narrative and metaphor to process past and present experiences and to express emotions that are subsequently listened to and valued.

Most of the research concerning the exploratory therapies has used case studies to illustrate methods of intervention, and to describe the process of change. Evidence that Hausman (1992) provides for value of psychotherapy in a case study was that the

client, who had been in denial to all of his family about his dementia, admitted and discussed the diagnosis with his therapist, thus protecting his family yet being able to explore the implications. Sutton (2003), Hausman (1992) and Sinason (1992) all provided evidence for change in their clients, such as becoming more relaxed and relieved during therapy, and joint reports of carers about improved cognitive ability and mood after sessions. While in such case studies such evaluation is relevant, it is important to remember that the therapist's counter-transference, and the families' need for hope and resolution may bias their evaluation of therapy. Another report of change in such case studies concerns change in content of thought and discussion in the client. This can be a subtle change, again vulnerable to interpretation, but may indicate that goals of intervention have been achieved. Such change is difficult to measure in a concrete way, and may not be immediately reflected in a measure of well-being. This illustrates how complicated it is to measure efficacy of therapy with this group.

### **Directive therapies**

Thompson *et al.* (1989) argued that the strengths of CBT with people with dementia are that it is short term, structured so that the therapist can be directive; it focuses on current problems, focuses on the relearning of existing but potentially declining problem solving skills, and uses different media of communication which can maximise the learning process. In my opinion most talking therapies can use different media to communicate, can be related to current problems in the client's life and can build on the relearning of existing skills, thus leaving the strengths of CBT that Thompson *et al.* (1989) outline that it is short term and more directive. Another strength is that there has been more evaluation of the efficacy of CBT and that it has been indicated that it is useful.

Thompson *et al.* (1989) emphasises that CBT is focussed on cognitive distortions, and clients may have accurate negative evalua-

tions about their life and losses which have to be accepted. They recommend supportive relationships from therapist and others, a need to develop problem solving skills to maintain ability to function, and an increased need for positive activities to balance the negative experiences in the clients' life. Some of the cognitions that are focussed on in CBT are over generalisation and negative bias, which contribute to a downward spiral of thought and mood. Such thoughts may be more prevalent in people with dementia as they lose problem solving skills, abilities in abstract thinking, and may forget alternative and more positive thoughts. It is also likely that this client may catastrophise, in view of specific memory problems, feelings of lack of control and insight into deterioration. For example a chain of thoughts may develop from the client not being able to balance a cheque book, will worry about money, feel out of control, be uncertain about looking after them self and then think that they will have to go into a home. Carrying flash cards that give alternatives to common catastrophic chains of thought would be a cognitive behavioural intervention. While Thompson *et al.*'s (1991) paper is useful in outlining this rationale to therapy, and suggesting modifications for this client, the only evaluations of efficacy are a comment from clinical experience that it is 'effective' (p.394). A paper by Teri and Gallagher-Thompson (1991) outlines similar interventions, and reports that when depression rating scales are used before and after measures, depression has been shown to decrease. However they give no further details.

Goudie (2002b) described the use of CBT to treat depression in a man with dementia. The trigger for depression was the introduction of a home carer to assist with activities of daily living. Mr Walker's consequent thoughts were about his lack of control, that he must now be useless, and worries about the future. Practical changes were made with his home carer to enhance feelings of control and the therapist and

client discussed alternative ways of thinking about his abilities. Goudie reported changes in his thought patterns and an improvement in his score on a mood scale. Although the scale is not stated, this is an improvement on the purely subjective assessments of efficacy of therapy.

Scholey and Woods (2003) described the techniques used and common themes during eight individual cognitive therapy sessions with seven people with dementia and depression. The participants were referred to the authors by a consultant psychiatrist in a memory clinic for cognitive therapy. Inclusion criteria were clinically significant cognitive deficits on standardised psychometric tests, and a score of 11 or above on the Geriatric Depression Scale (GDS). There was a difference in actual cognitive ability of the participants, as shown by a difference of 10 points in the Mini Mental State Examination at the beginning of the intervention. The therapy sessions followed a similar outline to those described by Thompson *et al.* (1989). The issues raised by the clients were ideas about the cause of the dementia, a loss of control and feelings of insecurity, and previous trauma. Scholey and Woods (2003) reported a significant difference in score on the GDS before and after intervention for the group, and clinically reliable change, as measured by the Reliable Change Index, in two clients. They argue that this result is comparable to those of other studies of efficacy of psychotherapies. This study is important, as it one of few that systematically evaluates the effectiveness of a psychological therapy with this client group.

While Scholey and Woods' (2003) paper is a good step towards establishing evidence-based practice, there are flaws in the research. There was a variety of use of psychotropic medication between participants. The study findings are not easily generalised, due to the small sample size, and that the participants were selected for their suitability for intervention. However, the findings that two participants show reliable clinical change is good considering the use of

the GDS, which is a widely established assessment tool, but not a particularly sensitive tool to measure change by degrees. Strengths of the study are the use of the Competency Checklist for Cognitive Therapists to ensure adherence to the cognitive behavioural model, and the use of valid and reliable measures of mood and cognitive ability.

### **Therapies that aim to reinforce personhood**

The distinction between explorative, cognitive behavioural therapies, and those that focus on personhood and relationships is restricted, in that issues of relationships and personhood are most likely to be considered in all therapies. However, there is a body of theory and practice in dementia care that specifically focuses on reinforcing the personhood of the client and the value of their experiences, emotions and well-being.

Reality orientation has been used as a 24 hour approach to care, and to therapy sessions, in which the carer is constantly reminding the client of the facts about where they are and what they are doing. There is evidence that the therapy is effective in improving verbal ability and behaviour in a ward setting (Holden & Woods, 1995). However, there remain questions as to whether such changes result in actual improvement in well-being in people with dementia. This was a pioneering therapy when it was first introduced, and represents a philosophical shift towards addressing the client with dementia as a person. It seems that the philosophy has moved on since the introduction of reality orientation to person-centred approaches that address emotion and self in addition to verbal understanding of surroundings.

Validation Therapy, pioneered by Naomi Feil (2003) focuses on the emotion behind the action of a person who is disoriented, and was developed in response to dissatisfaction with reality orientation. She argues that there are links between past and present emotions, disoriented people retreat into past memories, and that painful feelings

need to be acknowledged to resolve past conflicts. The role of a carer in validation therapy is to use words, touch, and eye contact to validate the emotional message the client is trying to convey. While validation theory has intuitive resonance, there is little published research to provide evidence for the theory or the efficacy of the therapy. There are testimonials as to how the approach has improved the quality of care in services for people with dementia, and brief vignettes but very little evidence for change. There is also a lack of distinction between dementia, and disorientation. However, the therapy does acknowledge the personhood of a client, and their need to be seen beyond their symptom presentation; it is training in this that may be improving the services described in testimonials, and not the attempt to validate past unresolved conflicts.

Resolution therapy (Goudie, 2002b) applies Rogerian counselling skills to find and empathise with the hidden meanings which are thought to be in the seemingly incoherent language and behaviour of people with dementia. The difference between resolution therapy and validation therapy is that the former is less interpretative, and is focussed on present situations and emotions. This is described as having a cathartic effect on the client, in that their emotions are expressed and acknowledged, and that some sense about the causes of an individual's distress might be made. The emphasis seems to be more on attitude of communication, than on progressing someone through stages of development. It seems that resolution therapy is the application of skills that a therapist might use in talking therapy, such as reflection, empathy and good non-verbal communication, but it has also can be used in providing therapy for people with dementia in the later stages. There is little research to evaluate the value of this approach in dementia care

Reality orientation, validation therapy and resolution therapy are presented in most of the literature as psychotherapeutic approaches to working with people with

dementia. These therapies can be used as approaches in individual therapy, initially as talking therapies in the early stages of dementia, and in later with adaptations to type of communication. These approaches seem to have been evaluated even less than the psychodynamic and cognitive-behavioural approaches, so judgements about their use are based on reports of clinical judgement, and on their value when working with people without dementia.

### **Adaptations to therapy for people with dementia**

While particular frameworks may be used to provide therapy for people with dementia there has been agreement across the literature for the need for the therapist to be flexible. Hausman (1992) suggested that being able to establish rapport with the client is paramount, and boundaries may be different to allow for that. For example, she recommended going for a walk during therapy, if that would make the client more comfortable, or meeting in a café. She also suggested the use of phone calls between sessions to remind the client of the therapist's existence and to look at notes from last session.

There is a general acceptance of the need to involve carers in the therapy, either by their presence in session (Sutton, 2003), involvement in establishing therapy aims (Sinason, 1992), or by asking them to prompt with homework, and in planning positive experiences (Teri & Gallagher-Thompson, 1991). Counter-transference and the emotional impact of working with people whose skills may be deteriorating may have an impact on the therapist and dynamics between client and therapist (Miesen, 1999). Thompson *et al.* (1989) suggest that therapists might deal with the emotional impact of the work and the consequent impact on therapy by consulting and receiving support from colleagues, setting small goals and acknowledging their achievement, and monitoring their own cognitive distortions about therapy and the client.

Sinason (1992) described a change in

style of communication as an adaptation. To provide a safe space in therapy, the person's deficiencies should not be emphasised by asking closed questions or correcting language or memory problems. Thompson *et al.* (1989) emphasised the need to monitor comprehension during sessions, that the pace should be slower and more repetitive. Goals also need to be realistic in light of the client's cognitive impairment. There is also the issue of length of therapy, which may change according to model of therapy used, client need and the stage of dementia that the client is at. In relation to attachment and loss it has been argued that the therapist should work with the client long term until the client dies or chooses to stop therapy (Sinason, 1992). Thompson *et al.* (1989) argue that short-term therapy is more appropriate with someone whose cognitive ability will deteriorate, and possible as long as termination issues are addressed.

### **Summary**

The literature on provision of talking therapies with people with dementia is still in the early stages of development. Different approaches to providing psychotherapy for this group have shown that some people with dementia can form an attachment with a therapist and, with flexibility on behalf of the therapist, discuss, explore and deal with issues related to their well-being. Therapists who have used explorative methods with this group have presented their work in case study format, which provides insight into the process of therapy, and allows for subjective evaluation of the usefulness of the intervention. Research reporting a cognitive behavioural therapy has provided a limited amount of evidence for the value of the intervention for people with dementia. This research has also used case studies to illustrate method and efficacy, with the same argument that CBT is of value in therapy. Other approaches to providing care to people with dementia, based on supporting the personhood of the individual with dementia, have been developed and can be integrated with other

talking therapies, or used on their own as an intervention. However, these have not been formally evaluated.

### **Conclusion**

The limitations to research in the efficacy of psychotherapy with people with dementia is that there is so little of it to draw conclusions from, and there is certainly not enough to argue the strengths of one therapeutic approach over another in this field. The more evaluative research, which focussed on change in well-being as a result of intervention, was a useful step towards further quantitative research. Scholey and Woods' (2003) study indicated the usefulness of CBT, but the size of the sample makes it difficult to draw any concrete conclusions from the results. Concerning the use of case studies, Cantley and Smith (2001) state: 'In an important sense the case study approach systemises the way in which we learn from innovation as a regular part of professional life. But we need not be apologetic about that.' (p.302)

To further understanding of talking therapy as a psychological intervention with people with dementia, the body of research needs to become more diverse by building on case studies and non-specific reports of decrease in psychological distress. Future research should build on studies such as Scholes and Woods' (2003), using established methods of assessing clinical change and exploring the experience of therapy for people with dementia. I see the value in both qualitative and quantitative methodologies in this process. There are a range of issues that make research on this topic difficult. The lack of verbal ability in the client group makes it difficult to verbally evaluate changes in mood as a result of intervention. Brooker (2001) describes measures of well-being devised by Bradford Dementia Group that consider a collection of behaviours as a profile of well-being, such as signs of self respect, showing affection, and creative self-expression. This approach is far more time-consuming than presenting a Geriatric Depression Scale. Another difficulty is that

people's cognitive skills may deteriorate during therapy. Such changes make it difficult to evaluate the client's comprehension of the content of therapy.

This literature review informed how I worked with the two clients who had dementia. The case studies of both explorative and directive therapies provided me with details about how other people have worked with this client group in individual therapy, and how different approaches may influence the work of a therapist. To evaluate the value of my intervention, I monitored signs of well-being in my clients who had dementia to evaluate efficacy of the therapy, as well as presenting a GDS. Evaluating comprehension by my two clients was not a great problem, as they were both in the early stages of dementia, and the use of reflection and monitoring made sure that they understood what we were discussing. The literature on adaptations to therapy was useful, and keeping in mind the need to go slowly, to monitor comprehension, and to be flexible in my approach made it easier for me to communicate with the clients. Flexibility was also important in trying to understand process issues when clients were repetitive or forgot their appointment.

The literature also provided me with positive, but conservative, expectations of therapy. Both the literature and my own clinical work showed me how at specific moments the client is able to understand and integrate different aspects of their self, despite all that is fragmenting in their life. If a therapy is able to lower levels of distress for a moment in session, there may be longer term effects, but even if the moment of resolution is just within therapy, surely that is of value.

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# Accepting gifts from clients: When is it appropriate?

Stéphane Duckett

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**U**NDER WHAT CIRCUMSTANCES do we accept gifts from clients and is it ever appropriate to do so? The Society's guidelines (see Appendix) simply enjoin us not to exploit our patients. It has been our experience with working with the older adult population that this issue has come up far more frequently than in any other specialty. A recent brief survey within this Trust (see Table 1) would appear to support the suspicion.

The present article touches on some of these issues with the aim of raising awareness and highlighting the potential ethical and clinical vulnerabilities for both patient and therapist alike. Whilst in practice it may be impossible to distinguish between ethical and clinical considerations, for the purposes of this article it may be important to make this distinction.

## The ethical implications

Defining the term 'ethical' is notoriously difficult (Elford, 1987, p.20) even for professional philosophers, however, the *Oxford English Dictionary* defines it quite simply as 'the science of morals'. 'Morals' in turn are described as the 'conduct, which follows from an understanding of right and wrong' (refer to R. Gillon, 1990, for a more detailed discussion), which in turn is defined by the fundamental tenets we abide by. When Nye Bevan first formulated the concept of a National Health Service at the very heart of his formulation was the tenet that good health care should be an entitlement for every citizen (Campbell, 1997). Therefore, it is not left to the individual to purchase their care but rather that we recognise as part of a civilised society that we all assume responsibility for the care of all alike. To achieve this

goal the remuneration of health care workers as with other services, is independent of the recipient of those services.

Gift-giving may carry the implication of reciprocity. In the giving and the receiving there may be a subtext whether explicit or not, which may seek to influence or circumvent the notion of universal access irrespective of means. Given the complexity of our social communication the possibility of misinterpretation exists. The following two vignettes illustrate this point.

*Example 1.* On a rehab ward where due to staffing problems therapy sessions are having to be 'rationalised', family members of a patient purchase and donate a valuable piece of equipment for the ward. Family are angry when the ill relative is not shown preferential treatment on the ward. Staff feel caught in a bind.

*Example 2.* An elderly, cognitively compromised client who is socially isolated and without living family feels, unbeknownst to the clinician, obliged to 'buy' services from the therapists through small gifts he can nevertheless ill afford. The issue is not addressed by the clinician, therefore, the client continues to feel obliged to gift to the point that it impacts on their modest household budget.

I have selected two examples in which the clinicians involved were not explicitly attempting to exploit their client but rather, quite innocently, found themselves in an ethically and clinically compromised situation without, in the last example, this clinician even being aware of the fact.



Table1: Gifting Questionnaire.

		Adult Psychology Service N=32	Older Adult Psychology Service N=10
1. Over the past 12 months have you received any gift?	No = Yes =	4 16	3 24
2. Was there any overt reason for the gifting i.e. Christmas, thank you for service, etc.?	Yes =	6	6
3. What was the gift?	Food/Drink = Non-food item = Published material =	4 10 12	10 11 3
4. What was the approximate monetary value of the gift?	< £15 = > £15 =	16 0	19 5
5. Did you accept the gift?	Yes =	13	20
6. Were there any clinical considerations that played a part in your accepting or not accepting the gift?	Yes =	5	20
7. Did you discuss this with a colleague or supervisor?	Yes =	4	19

### Clinical dimension

All of human behaviour carries meaning in one form or another. It behoves us therefore as clinicians to consider contact with our clients in the context of the services we provide them with and this would therefore include gifting and accepting gifts.

*Example 1.* A 76-year-old depressed client is gifting items to her therapist because her depression and low-esteem which follows from this makes her feel unworthy to receive her attention. She, therefore, feels the need to recompense the therapist for her time over and above the remuneration she receives from her employers.

*Example 2.* An 88-year-old gentleman in a nursing home is mistakenly convinced that he has an irreversible life-threatening illness, which has remained undiagnosed and which will claim his life within a matter of months if not weeks. He is gifting away to carers and

other patients his most treasured possessions based on this delusion. A visiting clinician, unaware of the gifting finds himself on the receiving end of a gift of a valuable item. The client's delusions are encapsulated and therefore not evident unless explicitly addressed however, the client is not acknowledging the issue since he has 'resigned himself to his fate'.

In both these instances gifting whilst appearing innocently carries a significant implication with respect of a client's pathology.

### Gifting and older adults

There are factors, which make the clinical and ethical issues of gifting particularly salient for the older adult population. Some of these issues might include:

- a. Poor self-esteem and lack of sense of entitlement to services due to internalisation of ageism (Bytheway, 1995).

- b. A failure to understand the fact of universal entitlement to health care irrespective of means. This may seem surprising to us as post-war children but for many of our elderly clients they will have been born into a world where the NHS did not yet exist.
- c. A failure to understand the nature of our roles as psychologists. Whilst we take for granted the notion of psychotherapy that is discussing our intimate problems with a stranger this development is still historically a recent event. Many of our clients may have boundary issues around the intimacy of the communication that takes place within therapy (Duckett, 2004). This may be exacerbated by their being cognitively compromised. Not fully understanding the professional nature of our work they may indeed feel obliged to reciprocate in some form.
- d. For many of our clients they may, quite rightly, in some instances perceive a foreshortened future and therefore they may wish to 'put their house in order', i.e. divest themselves of material items.
- e. Many of our clients are surviving to a much greater age. Whilst some may welcome this development for some it may mean that they are becoming increasingly isolated in outliving not merely friends but their own children and family generally (Gibson, 1999). Clinicians may unwittingly find themselves playing a far more central role from the client's point of view than they would be suspected on casual review.
- f. Lastly, unfortunately we as a society have not universally recognised the role that potentially all ages can offer towards promoting the well being of our society as a whole. Being older therefore for many adults does entail their being devalued as members of society. If you are part of a group of people who are not valued for what you do you may find value in what you possess and gifting is a means to express that 'value'.

There are potentially many other factors, which may make the issue of gifting particularly salient to the population we serve. I have touched upon some of the most obvious. The emphasis in this article has been on the meaning of gifting from the point of view of the client and rightfully the focus of our clinical attention on this issue should be from the client's point of view. However, the need to address this issue also resides in our need as clinicians not to render ourselves vulnerable to misconstruing our actions as exploitation vis a vis our vulnerable clients. Are there circumstances in which accepting a gift may not simply be appropriate but indeed desirable? Most certainly however, given the complexity of the issue, hopefully highlighted in this article, clinicians may be well advised to consider the acceptance of a gift carefully and review each instance within the context of their supervision and not rely on following a simple policy to the letter.

### **Appendix**

The Professional Practise Guidelines (1995). 2.1.4 Gifts. Psychologists need to take care they do not exploit clients for personal gain in the form of gifts and financial endowments.

### **Acknowledgement**

I would like to thank Dr Sarah Johnson for her helpful comments.

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# Annual Conference – Durham, July 2004 – A review

A. Spencer

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**A**FTER THE PSIGE Annual Conference had ended, I reflected on what this Conference had meant to me as an assistant psychologist.

Firstly I attended the workshop on 'Mindfulness', a technique based on Buddhism and Yoga that aims to raise consciousness of automatic actions such as walking by, 'anchoring awareness in the present' thereby creating choices and enhancing self-control.

Mindfulness appears to embrace benchmarks of many therapies. For example, being non-judgmental, patient and establishing trust, etc., and Smith's critical analysis of it's limitations alongside its value impressed me the most, where research so far suggests (when combined with cognitive therapy) this is most successful treating older people with recurring depression.

I then attended a series of lectures on a vast range of subjects leading to many more questions than answers. For example, Ian James, when presenting models of memory in therapy, challenged current practice by issuing caution for therapists working with older people when delving into schemas

because these can be poorly defined, easy to elicit but more importantly can change over time. Life is dynamic and people are subject to self-review under different environmental conditions, therefore therapists should be 'mindful' of their power because information may not be true and can even be harmful.

Finally at the risk of sounding naive it was both challenging and refreshing to hear Tom Kirkwood's keynote address on positive ageing. Put simply people are not programmed to die but programmed for survival. This erroneous belief underpins many negative presumptions within society about ageing. By understanding environmental factors that affect successful ageing, such as inactivity and isolation psychologists (through research and practice) can do much to influence the 'value' of ageing within society and improve the quality of life for many.

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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 (January, April, July, October).

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Language should be inherently respectful to older people and consistent with the British Psychological Society's guidelines.

## Letters to the Editors

The Editors welcome correspondence which combines brevity with rational argument. Letters may be edited if more than 250 words in length.

*All contributions should be sent to:*

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