



Division of  
Clinical Psychology  
Faculty of Old Age Psychology



The  
British  
Psychological  
Society

Psychology Specialists  
Working With Older People

# PSIGE Newsletter

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# Psychology Specialists Working With Older People

## AIMS

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

## EDITOR

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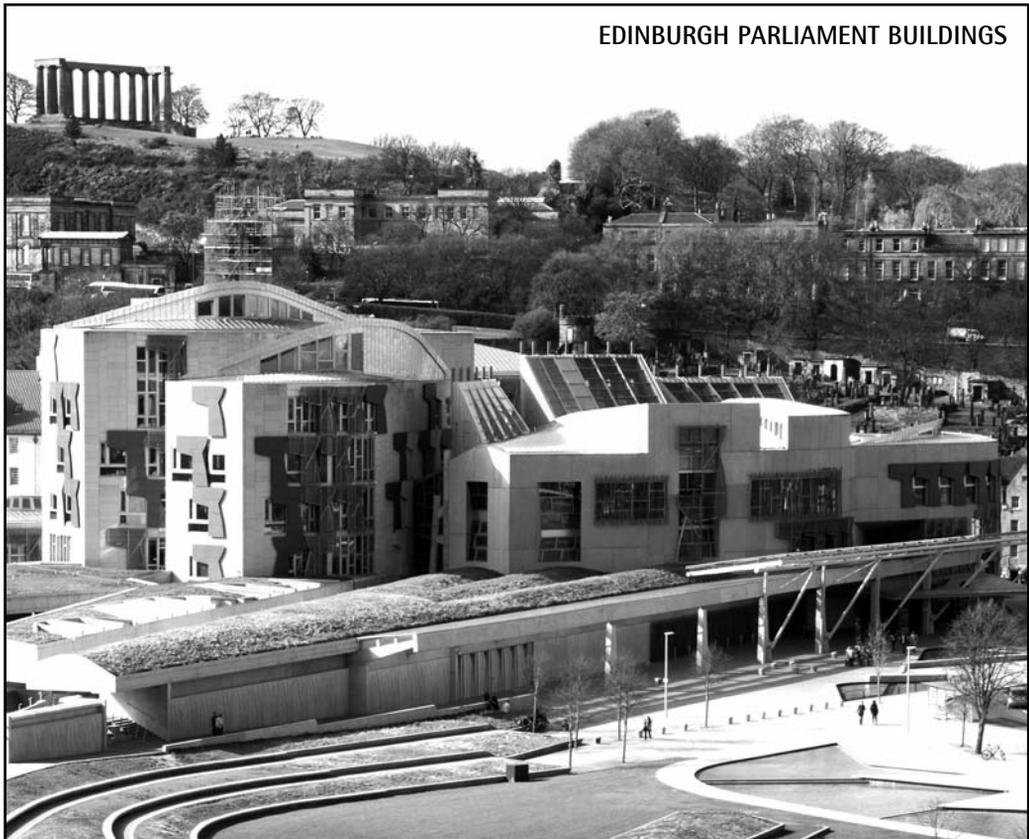
# Letter from the Editor

Louisa Jackman

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**A**S USUAL when a geographical group collate the *Newsletter*, the group have undertaken most of the work toward its production. I would like to say a huge thanks to the Scottish group for hosting the conference, and providing the written version of the rich pickings emerging from the speakers and poster presentations. As one of the unfortunates who was unable to attend the conference, I was especially pleased to be able to have access to information and thinking that I had missed, some of which has turned out to be especially timely in a new post (thanks Daniel et al!).

As Cath tells us in her 'Letter from the Chair', at the recent National Committee meeting at Parcevall Hall, there have been continued discussions about how to carry forward the special workstreams on dementia and IAPT. I am looking forward to letting you know more about special editions of the *Newsletter* to reflect these themes. In the meantime, I am continuing to receive high quality submissions toward next April's general *Newsletter* and am collating the Wessex Geographical Group papers ready for January. Please continue to send in submissions or contact me if you have an idea you would like to consider.



# Letter from the Chair

Cath Burley

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**T**HIS IS MY FIRST 'Letter from the Chair' and I would like to say how much I am enjoying the role and trying to represent PSIGE and Older People as DCP Older Adult Lead. However, as with any role when you 'step up' you are unaware of quite the extent of the work that others have been doing and I would like to thank Don Brechin for his excellent work as Chair for the last two years – he made it look so easy!

I would also like to register my thanks to Sandy, Cerys and the Scottish GG for all their hard work in hosting not only an excellent conference but also a superb edition of the newsletter which highlights the excellent workshops and presentations which took place there. It makes very good reading so I hope you will enjoy the enclosed articles.

## **So what has been happening since the conference?**

At our Strategy meeting at the end of September we confirmed the plans for the two work streams on IAPT and dementia for the rest of the year. These will include engaging with you as PSIGE members in working groups to write commissioning papers, produce a newsletter of evidence-based practice linked to the work in all four nations on each topic, prepare parallel workshops for 14 June (the day before the 2012 PSIGE Conference in Bristol) as an update on both topics, and send out updates via a monthly lyrics mailing list. The IAPT one already has in excess of 150 members from a variety of professional groups and organisations. The committee leads, Julia Boot (IAPT) and Liz Baikie (Dementia) look forward to hearing from you with ideas, case studies and examples of evidence based practice to populate the PSIGE website and to inform the Department of Health about our work.

I attended the IAPT Workforce planning meeting at the Department of Health on 4 October and the meeting about the work of the four new therapeutic modalities later that day: IAPT is broadening out from CBT to establish training places for IAPT workers in Couples Therapy for Depression, DIT, Counselling for Depression and IPT. It would be very useful if we could encourage locally High Intensity Therapists with an interest in older people to take advantage of this training and supervision. Both meetings were useful fora to raise the flag for psychology and older people.

On Tuesday 11 October, PSIGE and the DH hosted a multi professional event for 40+ people at the British Psychological Society's London office on IAPT for older people. Kevin Mullins and others of the DH IAPT team attended including Professor Andre Tylee as the new Long Term Conditions Lead. Other speakers included Jeremy Clarke (National IAPT Advisor) and Alistair Burns (National Dementia Advisor). There were four working groups on Commissioning, Workforce Issues, Long Term Conditions, and Dementia. These working groups will continue to meet throughout the year to produce case studies and examples of good practice. It was good to meet up with many of you there and to hear the excited buzz of conversation throughout the day.

Sue Watts from Salford and I will be presenting at the New Savoy Partnerships conference in November, working hard to raise older adult issues under the equality agenda.

Recently, Becci Dow and Mhairi Donaldson had a teleconference with GG chairs and Treasurers to summarise the final parts of the transfer of the PSIGE accounts and membership lists to the Society. This meeting was an opportunity to make closer

links between the work of the national committee and GGs. We hope to develop a more accurate and lively website and to share GG events more widely across the membership.

The Committee continues other work on the Guidelines for Neuropsychological Supervision which is with the Professional Governance Panel prior to printing. The Neuropsychological Test Compendium Group has reformed under the chair of Neil Watson and the remainder of the tests in that document will be reviewed this year.

The Training and Development Subcommittee are beginning to plan a new round of training events including one hosted by South Thames on 'Choosing and Delivering Evidence Based Psychological Interventions across the Dementia care pathway' on 11 November and Couples Work on 9 March with one on Long Term Conditions later in the year. Ideas for further events or speakers for the latter two are most welcome.

You will have noted that South West PSIGE will be hosting the PSIGE 2012 conference at Wills Hall Bristol on 15 June 2012. The theme is 'Systemic Issues' and further details will be out shortly – please keep the event in your diaries. The following year Essex and Herts GG will be our hosts.

In a radical departure from usual events, PSIGE has been invited to co-host the 2012 DCP conference in Oxford (5–7 December). Although early in the planning stage it is envisaged that the Wednesday will be a day free to all DCP members with speakers from all the faculties on a cross cutting theme. The DCP will then support PSIGE to invite renowned international speakers as keynotes for an event which will highlight current research and academic practise. Please let us know if there is anyone at all you would particularly like to hear speak and we will try to invite them. The DCP will run their conference in parallel and this will offer PSIGE members the option of attending their sessions or vice versa. In future years it is likely that other Faculties will co-host the conference. This is a tremendously exciting opportunity for PSIGE to create a noteworthy event.

PSIGE is what we each make of it – please help with any or all the activities above and help to make 2011/2012 a very dynamic PSIGE year.

Best wishes.

**Cath Burley**

Keep up-to-date by visiting our website:

**[www.psiges.org](http://www.psiges.org)**

# Letter from the Guest Editor

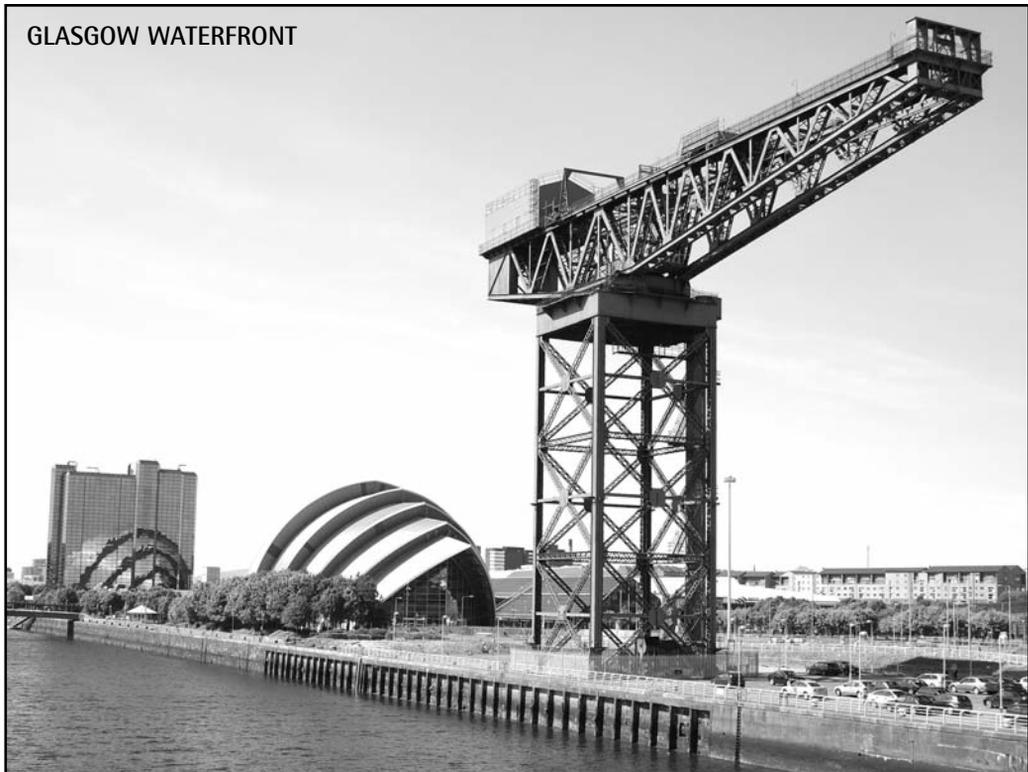
Claire Donaghey

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**T**HIS ISSUE of the *PSIGE Newsletter* is the product of the PSIGE National Conference which was held in Glasgow in June of this year. Unfortunately, I was unable to attend the conference as I was on my honeymoon! I was very disappointed to be missing the conference and the workshops as it all looked so interesting and relevant to my clinical work – however, I don't think my new husband would have been very pleased with me if I delayed our honeymoon for the conference! So, having the opportunity to

be Guest Editor has been fantastic. All the papers are very thought-provoking and contribute greatly to our clinical practice working with a diverse population. I hope you enjoy reading the articles and abstracts just as much as I did. I also want to thank all those who contributed to this issue of the *PSIGE Newsletter* and for making it such an interesting read.

**Claire Donaghey**  
*PSIGE Scotland member*



# Letter from Convenor of PSIGE Scotland and Chair of Conference Organising Committee

Sandy McAfee & Cerys MacGillivray

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**W**ELCOME to the National Conference Edition of the *PSIGE Newsletter*. We were delighted to host the 2011 National Conference in Scotland's *other capital city* – Glasgow! While the June weather was typically unpredictable, the ambiance of the workshop and conference days was warm and welcoming.

It has been a rollercoaster ride organising the 2011 Conference. We began planning it in 2009 which was, unfortunately, the year the National Conference had to be cancelled. The impact of the changing economic climate and NHS culture could no longer be ignored, and the realisation that the conference needed to adapt to this was agreed by both PSIGE National Committee and the Conference Organising Committee. We were grateful to the National Committee for listening to our plans for change and supporting our vision of a combination of workshops and one day conference which would offer the high quality of information that members expect from PSIGE, but with flexibility in cost and attendance to accommodate NHS budget and time issues.

We were fortunate to have two excellent half-day workshops to offer delegates. Deborah Lee ran a very successful and well-received event, looking at using compassion focused therapy to work with shame and self-attack. Professors Maria Marquez-Gonzalez and Andres Losada Baltar from Madrid ran another cutting edge workshop on CBT and ACT for dementia caregivers.

We decided to focus on 'home grown' talent for our conference day as we have a wealth of internationally-renowned researchers and clinicians within the UK.

Professor Linda Clare came from Wales to give a keynote speech about her work on cognitive rehabilitation for people with early-stage Alzheimer's disease, and the obvious choice for our other keynote speech was Scotland's own Ken Laidlaw. His speech was entitled 'CBT with older people: Can we enhance outcome by enhancing its 'fit' with older people?' This provided an excellent link to Donna Gilroy's presentation about an Edinburgh-based research project which is exploring the use of a dyadic CBT approach to treat depression in dementia. Both Ken and Donna are hoping to publish their findings later in the year, so we were very grateful for the sneak preview of their project.

Professor Keith Millar first spoke at a PSIGE Scotland Study Day a number of years ago, and we were delighted when he agreed to present at the PSIGE National Conference. His work looking at the effects of general anaesthetic on cognitive function in older adults is both fascinating and thought provoking. Professor Kate Davidson's work looking at personality disorders within adult populations has led her to question why these disorders appear to be less prevalent within the older adult population. It was a great opportunity to remind ourselves to be open to understanding interpersonal issues in therapy with people who have long-standing problems. She also highlighted the gaps in research into personality disorders and the older adult population.

Daniel Collerton and Arlene Astell have both been active members of PSIGE, taking on committee and sub-committee roles. Daniel's presentation on working psychologically with hallucinations in later life

focussed on the importance of looking at the emotions evoked by hallucinations and using this as a medium for developing coping skills. The work is on-going, and again we were fortunate to have a preview. We will look forward to seeing it published in the fullness of time.

Arlene Astell's presentation was the last of the day, but without doubt the most moving. Her video clips showing the impact of a new skills-based approach to helping staff communicate with people with advanced dementia will stay in the memory of many of the audience. Arlene has given workshops on the training she uses, and her 25 minute presentation will have whetted the appetite of many to learn more about it.

Stephanie Crawford is a newly-qualified clinical psychologist working in Glasgow, and her thesis project investigated the reliability of the ACE-R when used by community psychiatric nurses. There has been a co-ordinated approach to help staff move away from measures such as the MMSE, and the ACE-R has been widely introduced in Scotland within older adult services. It was, therefore, very appropriate to hear about Stephanie's research findings, and to consider how such tools are introduced and supported within older adult settings.

In addition to our workshops and conference day, we had a poster display area. This was well utilised by a variety of people working within older adult settings, and generated interesting discussions during the coffee breaks. It was also an opportunity for people to publicise their hard work without having the daunting task of formally presenting it.

We have had positive feedback regarding this year's conference. Some of the comments include:

*'A worthwhile event with excellent speakers chosen, very informative and clinically relevant. Thank-you to the organisers!'*

*'Very much enjoyed the conference...thank-you for a very successful event.'*

*'Really enjoyed the day and all the presentations – took a lot of useful learning away to help with my clinical work'.*

Our thanks go out to all to all of the presenters, leaders of our workshops, and our keynote speakers, who made the two days so successful and stimulating. We would also like to take this opportunity to thank all of the members who supported the conference. There is clearly still an appetite for the PSIGE National Conference and it is one of the few CPD events where we can network with a large number of Older Adult specialists in a relatively short time. If you were unable to make it this year, we hope you enjoy reading some of the articles from the conference – PSIGE would love to see you at the 2012 event (no, not the Olympics, the PSIGE Conference!).

And finally, a huge thank you to our colleagues in PSIGE Scottish Branch for all of their efforts to make the two days run so smoothly with very few hiccups!

**Sandy McAfee**

*Convenor of PSIGE Scotland*

**Cerys MacGillivray**

*Chair of Conference Organising Committee*

# An introduction from the Convenor for PSIGE Scotland

Sandy McAfee

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ONE OF THE tasks for the Conference Organising Committee was to put together a programme that would not only be intellectually stimulating but also clinically relevant, as we know that getting agreement for CPD time is becoming more and more difficult in many places within the NHS. The context for this conference, of course, is the changing NHS, and the changing demography of the UK.

We're not yet quite sure what the Conservative/Lib Dem Government is going to do with the NHS in the other 'Devolved Nations', and whether or not this will be of any particular benefit to older people or our ability as a profession to help them with their health and mental health problems. Here in Scotland, we know that the SNP Government has pretty much exactly the same challenges ahead of it, such as:

- increasing demand for health care across all ages;
- unprecedented demographic change – from a pyramid to a supertanker;
- the ageing population, particularly a large projected increase in people living beyond the age of 75;
- a relative reduction in the number of people of working age;
- an increase in the number of people managing long term conditions;
- tighter financial budgets;
- needing to do more for less for a larger number of people;
- needing to do more to address social deprivation, as deprivation and wealth inequality has been repeatedly linked to health inequality – such as variations in mortality, life expectancy and healthy life expectancy.

My own recent research in West Lothian, assisted by Rosie Ashworth, has also shown that social deprivation is a major factor in understanding patterns of referral, patterns of attendance and drop out from therapy.

Just to throw some figures at you, we are now entering the era when the 'baby boomers' are starting to retire.

- If you were born in 1945 or 1946 you are now 65 years old.
  - In 2009 there were 5.194 million people in Scotland, 883,000 of whom were over 60.
  - By 2033 there will be a 50 per cent increase in the over-60s, and the population will rise to 5.54 million.
  - There is a higher proportion of older people living in rural areas than was the case historically – so equity of access to services is an issue.
  - Since 2003, the over-60s have outnumbered the under-16s.
  - There is a projected rise in the number of people over 75 of more than 80 per cent, by 2033.
  - In 2010 there were 71,000 people living in Scotland with dementia. This is projected to increase to 127,000 by 2031.
- There are, of course, many potential benefits for society of a healthy ageing population, and no doubt older people themselves will play a key part in maintaining and supporting the health and well-being of other people in their communities, families, and in the work place over the next few decades. I can think of several retired psychologists who just couldn't keep away from the office and returned to work part-time following retirement!

As a profession we need to think about how we can modify what we do, and the way

we work, in order to meet these challenges. For example:

- Developing and disseminating the evidence base of what works for older people.
- Developing effective models of training and supporting others to deliver psychological therapies.
- Understanding the systemic issues that affect service delivery.
- Working with Government and policy 'winks' to help shape health strategy – something we are getting more successful at here in Scotland.

You may be familiar with the curse:

*'May you live in interesting times'*

...which is often attributed to the Chinese, although according to the BBC website it may in fact be an old Scottish curse!

This is supposedly one of three curses – followed by

*'May you come to the attention of powerful people'*

... and

*'May your wishes be granted'.*

So we live in challenging times in the NHS, but also in 'interesting' times!

**Sandy McAfee**

*Convenor of PSIGE Scotland*

GLASGOW CATHEDRAL



# Cognitive Behavioural Therapy and Acceptance and Commitment Therapy for dementia caregivers

Andrés Losada & María Márquez-González

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**D**EMENTIA caregiving is known to be associated with negative consequences for caregivers' both psychological (high levels of anxiety, depression, guilt and anger) (Pinquart & Sörensen, 2003; Losada et al., 2010) and physical health (e.g. impairment in immune function and cardiovascular health; Mausbach et al., 2010). Furthermore, caregivers' distress seems to remain stable during long periods of time, suggesting that adaptation or natural adjustment to care is not a common phenomenon (Clay et al., 2008; Schulz & Williamson, 1991). Dementia caregiving involve many different demands to caregivers, who devote a great amount of time to care activities (70 hours a week, approximately), and this situation usually lasts for several years. These circumstances explain why dementia caregiving has been considered to be a prototypical chronic stress situation (Vitaliano, Young & Zhang, 2004). In order to provide a plausible explanation of caregivers' stress, the stress and coping model adapted to caregiving has been used (see, for example, Knight & Sayegh, 2010), among other models such as the diathesis-stress one (Russo et al., 1995). Taken together, these models allow the understanding of why dementia care is not associated with the same negative psychological or physical consequences in all the caregivers, as they differ from each other in, among other variables, the way in which they appraise the care situation and their resources to manage it, as well as in the specific coping strategies they use. During the last decade, these frameworks have boosted the development and implementation of diverse interventions

aimed at helping caregivers to cope better with their situation.

Despite that many studies have been conducted with the aim of testing the efficacy of interventions with dementia caregivers, the mainstream research from the 1990s shows that it is, at best, only moderate, with individual interventions being more efficacious than group interventions (Knight, Lutzky & Macofsky-Urban, 1993; Pinquart & Sörensen, 2006). Some potential reasons which have been proposed (e.g. Knight & Losada, 2011) to explain why interventions have not been as efficacious as they were expected to be are the following: (a) they are not usually grounded on sound theoretical models which allow to understand its mechanisms of action, that is, the way in which they have influenced the outcome variables; (b) standardised interventions have been applied to different profiles of caregivers, some of who might not match the interventions' ideal target profile (e.g. non-depressed caregivers participating in programmes aimed at reducing depression); and (c), in most cases, the assessment of the implementation of the interventions has not been included in the analysis of its efficacy (Burgio et al., 2001), even when it has proven to provide important cues for optimising the interventions (e.g. Márquez-González et al., 2007).

## **CBT interventions with caregivers**

Besides the psychological and health consequences of dementia caregiving already commented, it is also very common to find dramatic reductions on caregivers' chances to get involved in pleasant activities and to

enjoy their social relationships. In order to be able to maintain their leisure and social activities, it is usually necessary for caregivers to delegate and ask for help in caring for their loved ones. However, many caregivers do not ask for any kind of help, and even refuse it when it is offered to them. Furthermore, many of them believe that they do not need help, as they are able to assume care by themselves and they do not mind to renounce social life and pleasant activities during the time they have the caring responsibility. This frequent style of coping with the caregiving situation often leads to the development of higher levels of arousal, anxiety and depressive symptoms which are difficult to manage for many caregivers. Closely related with this dysfunctional coping style, there are many irrational beliefs (rigid verbal rules) regarding how care should be conducted. Examples of these beliefs are 'a caregiver should only seek help from others or find other alternatives when the caregiving situation is at its worst or when he/she can no longer handle it' or 'it is logical for caregivers to give up their own needs, setting aside their own life satisfaction, in favour of their relative's needs.

These considerations may explain the empirical data showing that, among all the analysed interventions on caregivers' distress, the highest effect sizes have been found for the cognitive-behavioural interventions (CBT) (Pinquart & Sörensen, 2006), which specifically address these dysfunctional beliefs that leads to maladaptive coping behaviours. CBT with caregivers is currently considered to be an evidence-based therapy for reducing distress in this population (Gallagher-Thompson & Coon, 2007), leading to significant reductions in caregivers' depression, anxiety and burden scores (Gallagher-Thompson & Coon, 2007; Pinquart & Sörensen, 2006), and to an increase in the degree of involvement in pleasant activities (Losada, Márquez-González & Romero-Moreno, in press). Many different interventions have been developed from the CBT perspective, with

some of them focusing on increasing the frequency of caregivers' engagement in everyday pleasant activities and problem solving ability (Coon et al., 2003), and other interventions which also include the cognitive restructuring of caregivers' dysfunctional thoughts, training them to think about caregiving in more flexible ways (Burgio et al., 2003; Losada et al., in press). Although there are different versions of CBT interventions with caregivers, most of them share the objective of helping caregivers to cope with their situation in more adaptive ways, via changing their thoughts or making more flexible their ways of thinking, which eventually would facilitate the development of more adaptive behavioural patterns. Other shared characteristics are their psychoeducational style and their frequent standardised structure, which usually includes one or more of the following components: (a) training in the identification, challenge and modification of dysfunctional thoughts; (b) programming and performing pleasant activities, aimed at self-care; (c) training in central skills such as asking for help or general communication skills; and d) arousal reduction techniques, usually relaxation training.

The CBT objectives and components already listed were included in a CBT group intervention which was conducted by our research team (Losada et al., 2004; Márquez-González et al., 2007). It consisted of eight weekly sessions (two hours of duration each), which were attended by as much as eight caregivers in each of the groups. This intervention proved to be effective for reducing caregivers' depressive symptomatology and increase the frequency of leisure activities. Furthermore, the modification of dysfunctional thoughts and the increase in the frequency of pleasant activities seemed to mediate the effects on the intervention on caregiver's depressive symptomatology (Losada et al. in press).

### **Change or Acceptance? Bringing acceptance into focus in interventions with dementia caregivers**

In our clinical experience with CBT interventions with caregivers, it has become evident that while many caregivers obtain many benefits from these interventions, many others do not welcome it nor benefit from it in the expected degree. On one hand, the message 'take care of yourself', which is implicit in this interventions from the very beginning, and its strong emphasis on change (of thoughts and behaviours), does not seem to fit well with caregivers who are focused almost exclusively on their loved ones, in a role (caregiving) that gives meaning to their lives, and who do not understand quite well that professionals keep on telling them to care for themselves, and providing them with a list of tasks to do in order to achieve that self-care (as if they did not have enough tasks to do in their lives...).

On the other hand, CBT has a clinical perspective, with the most usual outcome variables (objectives of the intervention) being variables related with a hedonic perspective of well-being, namely: depression, anxiety, stress, etc. This is something to be reflected upon, as caregiving is a life context which strongly impacts caregivers' values and life purpose and self-realisation, variables clearly representing the eudemonic type of well-being.

With regards to CBT strong emphasis on change, it sharply contrasts with the fact that, in the caregiving context, there are many situations and internal experiences (thoughts, emotions and sensations) which are very difficult, when not impossible, to be changed. For example, the dementia diagnosis and its associated cognitive decline, emotions such as sadness of grief for the loved one who is progressively leaving, or uncomfortable thoughts related to the cared person or other relatives, are inherent to the dementia caregiving situation and present little likelihood of being changed directly by the caregiver.

When focusing on caregiver's aversive emotions and thoughts, it is not unusual to find caregivers who reject these experiences or try to delete them through diverse methods (compulsive behaviour, suppression, denial, etc.). The tendency or desire to control and/or avoid the occurrence of uncomfortable emotions, sensations and thoughts has been called experiential avoidance (EA; Hayes et al., 1996), and has been proposed as a core dimension underlying many different forms of emotional and behavioral disorders. EA is currently the focus of great clinical interest due to its significant associations with negative psychological consequences in the general population (e.g. Hayes et al., 1996). People with high levels of EA engage in different strategies with the aim to get rid of aversive internal experiences which they consider to be the cause of their suffering. The struggle to fight those aversive experiences can be exhausting, as the 'boomerang effect' usually appears when efforts are made to exert direct control on thoughts and emotions (Campbell-Sills et al., 2006; Wegner, 1989). In the context of caregiving, Spira et al. (2007) found a significant association between caregivers' level of EA and their degree of psychological distress.

Taking all these considerations into account, our research team decided to analyse more deeply the potential role of EA in caregivers' well-being. As the instrument which is usually used to assess EA, namely, the Acceptance and Action Questionnaire (Hayes et al., 2004) is rather unspecific, and does not address the particularities of the caregiving context, we decided to develop a questionnaire which specifically covered caregivers' EA (Experiential Avoidance in Caregiving Questionnaire; EACQ; Márquez-González et al., 2010). Some of the items which compose the EACQ are 'A caregiver should not have bad thoughts about the person cared for' or 'I can't bear getting angry with my sick relative'. Although the EACQ is currently in a review process, preliminary data confirm the direct associa-

tion between the tendency to avoid care-related aversive thoughts and emotions (and the situations which arise them) and caregivers' distress. Significant and positive correlations have been found between this scale and depressive symptomatology and rumination, and negative with vitality and satisfaction with personal self-care related values.

### **Proposal on an acceptance-based intervention with dementia caregivers**

Given the relevant role found for EA in caregivers, we decided to develop an intervention programme to address this dimension, and thus help caregivers to disengage from this dysfunctional tendency. Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999), one of the 'third wave' behavioural therapies which are generating considerable excitement in the fields of clinical and health psychology, is the frame in which the clinical relevance of the EA has been proposed and developed, and, consistently, it was designed for helping people with psychological problems which involved experiential avoidance. The main objective of ACT is not to reduce the person's distress, but, to help people live the lives they want to live, striving to act according to their values, and accepting the unavoidable pain which comes along in every person's life. As it is evident, ACT clearly holds an eudemonic perspective of well-being, focused on the person's values and goals which give directions and sense to their lives. We found this perspective to be especially interesting for the understanding and intervening on dementia caregivers' well-being, as it is well reflected in McCurry's (2006) analysis of the caregiving situation. Hence, drawing on ACT, we developed a pilot intervention for dementia caregivers, which was first applied in a group format. Promising results were obtained with this pilot intervention, which is described in detail in Márquez-González et al. (2010).

After this first experience with an acceptance-based psychological intervention, our

research team decided to focus on the refinement of this intervention, and is currently involved in the application and testing of an acceptance-based intervention programme in an individual format, which will be compared to a CBT intervention and a control condition (minimal support) in order to analyse their differential efficacy. In this study, which is being conducted with the support of the Spanish Ministry of Science and Innovation, only depressed caregivers participate (>16 score in the CES-D), whose level of experiential avoidance is assessed and controlled (through random assignment to one of the three experimental conditions: CBT, ACT and control) in order to analyse its potential role as a moderator of the efficacy of the interventions. The main hypothesis of the study is that the ACT intervention will be more effective for caregivers with higher scores in EA. The programme structure and the contents of its eight sessions are displayed in Table 1.

The enhancement of caregivers' ability to accept the unchangeable aspects of caregiving (real situations and aversive internal experiences) is one of the central modules of the Acceptance-based intervention. As mentioned above, it is not infrequent to find that caregivers who refuse to accept a dementia diagnosis or the dementia-related changes and behaviours of their relatives. Many other caregivers also fight against their aversive internal experiences, such as anger, frustration, rage, shame, hopelessness, etc. Still other caregivers have difficulties accepting negative thoughts about their relatives, or their situation, and some have trouble accepting their vulnerabilities, needs or weaknesses. The therapeutic work on acceptance in our intervention programme involves helping caregivers to understand the concept of 'experiential avoidance' and identify it in their own experience, to discover the trap of control (the negative consequences of trying to avoid the unavoidable), and to engage in the alternative to EA: willingness or openness to experiencing aversive emotions and thoughts (and the

**Table 1: Structure of the acceptance-based individual intervention for dementia caregivers.**

SESSION	CONTENTS
1	Establishment of the therapeutic alliance Validation and fostering emotional disclosure Identification of experiential avoidance patterns First approach to work on caregiver's values
2	To increase caregiver's emotional awareness and his/her understanding of the importance of it To understand the disadvantages of avoidance (experiential and behavioural) and the importance of acceptance To contact with caregiver's values
3	To learn acceptance strategies To work on the value/s and objectives related to caregiving To explore other values and objectives related to self-care and the own life project To work on committed actions related to the value/s of caregiving To learn mindfulness skills
4	To learn acceptance strategies To work on the value/s and objectives related to caregiving To work on other values and objectives related to self-care and the own life project: Analysis of potential incompatibilities To work on committed actions related to caregiver's central values To learn mindfulness skills
5	To learn acceptance strategies To work cognitive defusion To work on caregivers' values, objectives and committed actions, analysing barriers and difficulties To learn mindfulness skills
6	To learn acceptance strategies To work cognitive defusion To start working the 'self as context' To work on caregivers' values, objectives and committed actions, analysing barriers and difficulties To learn mindfulness skills
7	To work the 'self as context' To work on caregivers' values, objectives and committed actions, analysing barriers and difficulties To learn mindfulness skills
8	Review of previous work Integration of the learned skills, and continue walking in the desired life directions Assessment of knowledge/skills acquired throughout the intervention

unchangeable situations associated with their occurrence) without trying to modify them, avoid them or change them. It is important to highlight that acceptance, from this point of view, is not resignation. It is more like being flexible, and able to disengage from unfruitful attempts to control or avoid situations or internal experiences that can not be directly controlled nor avoided, while continuing pursuing one's personal values.

The specific techniques that we use in order to foster acceptance include some of the proposed by Hayes et al. (1999) and Wilson and Luciano (2002) (e.g. *the rule of private events* or *the pink elephants*), and some new ones which we have developed specifically to help caregivers understand the concept of experiential avoidance ('Isabel, the super caregiver'), or to bolster their acceptance of their vulnerabilities and their need for rest, nurturance, support and care ('My best friend and me') (see Márquez-González et al., 2010). Some cognitive defusion exercises are also included in the programme with the aim of helping caregivers to reduce the 'believability and behavioural impact of aversive thoughts', not by confronting nor challenging them, but by developing the attitude of seeing them as what they are: only thoughts (Luoma & Hayes, 2003). In this regard, we are finding important obstacles to the successful understanding and learning of the demineralisation exercises aimed at defusing language and thought. It seems to us that these exercises require abilities for abstract thinking and metacognition on the part of the client, and these abilities are lacking in many of the caregivers who attend in our clinical practice, for reasons related to their low level of formal education.

The other central module of the Acceptance-based intervention is represented by the work on caregivers' values, which constitute the frame of the programme, as values give sense and meaning to acceptance. Consistently, significant efforts are made throughout the whole intervention to clarify

and analyse them and to help caregivers to figure out and perform actions to get closer to them. In order to assess caregivers' values we use an adaptation of the instrument developed by Hayes et al. (1999), namely, the values assessment rating form, which is also as a tool for enhancing values clarity and analyzing the consistency between them and the caregiver's behaviour. This tool involves asking caregivers to generate brief values narratives with regard to several different life domains: their role as caregivers and/or the relationship with the person they care for, their couple/marriage/intimate relations, family relations, social relations (friends and social activities), their work/professional life, personal growth and development, leisure time/hobbies, spirituality, citizenship/community life/volunteering, their own health (physical and mental) and any other area which they consider important in their lives. For each area they have to answer the following questions: (a) What would you like to get or to work toward in this life domain? (value narrative); (b) How important is this value for you? (value importance; scale from 1: low importance, to 10: high importance); and (c) How successfully have you adhered to this value in your life over the past month? (consistency with value; How consistent have you been with it?) (scale from 1: not at all successfully, to 10: very successfully). This last question allows us to analyse caregivers' level of commitment to their values (consistency). As it is important to track caregivers' evolution with regard to values clarity and commitment, several measures of these variables are taken throughout the programme, focusing on the three or four most central values in their life, among which the value of caring is always present.

As it is usual in ACT interventions, the main therapeutic tools in our intervention programme are metaphors and experiential exercises. Some of these techniques have been taken from the ACT manual (Hayes et al., 1999), and others have been specifically developed by us. As an example, in Table 2

we present a metaphor which was developed in order to help caregivers to understand the importance of being in touch with their personal values, in general, and with the values involved in caregiving, in particular (see Márquez-González et al., 2010, for more examples of metaphors).

This metaphor is intended to transmit to caregivers the importance of reconnecting with the values that make care so important for them: sacrifice, love, filial responsibility, etc. It is very helpful for caregivers to remind themselves of the life values that led them to accept becoming caregivers some time ago (with more or less family or social pressure); those life values they pursue every single day when they keep choosing to remain being caregivers. Hence, living in awareness of their life values may help caregivers to live their lives with more purpose, meaning, and satisfaction, in such a way that makes obstacles more like challenges than like problems, and facilitates the acceptance of the unavoidable suffering which comes along the way of life.

The work on caregivers' values in the intervention programme does not stop when

caregivers get their values clarified, as it continues with an important training on figuring out, performing and monitoring committed actions, this is, specific behaviours which allow them to get closer to each of their most important values (to increase their consistency with them). An example of the record sheet we used to schedule and monitor the realisation of committed actions by the caregiver is offered in Table 3.

Mindfulness is another component of the programme, which is very related to acceptance, as its objective is to train caregivers to develop a non-judgemental attitude which helps them observe their thoughts, emotions and sensations without any attempt to modify them, just letting them be (accepting them). Diverse mindfulness exercises are included in the programme, such as the '*Leaves on a Stream*'.

As it has been already commented, acceptance is not resignation. Neither is it giving up when something can be done to solve problems or modify situations in adaptive ways. Hence, given that both acceptance and change are pertinent in caregiving,

**Table 2: Example of a metaphor used in the Acceptance-based intervention programme.**

Metaphor 'Lost in the jungle'
<p><i>'Imagine you are an explorer and you have organised an expedition to the Amazon rainforest to find a new route to the sea. Full of hope, you start out on your journey and plunge into the jungle, following a route you have mapped out from the beginning... You walk for several days, full of confidence, overcoming all the obstacles in your way, putting up with the terrible heat, and torrential rain... defending yourself against the wild animals you encounter... but full of hope. Suddenly you begin to feel tired... Although you have a compass, the map you are using as a guide is very general, and does not allow you to orient yourself well... One day you realise you might be lost... You've been walking for weeks, and you don't know where you are... Now you start to feel anxious... the wild animals you meet seem more savage, and start to scare you... you feel the oppressive heat is getting to you... and the torrential rain sweeps away with it the little strength you have left... Suddenly you see in the distance some higher ground, a high hill that stands out above the trees... and you decide to go toward it. When finally, your strength running out, you get to the top of the hill to have a look... from that height you have a view over the whole jungle. Far in the distance you can see the point you left from, and the whole way you have come so far... You've walked further than you thought... and you can make out, also far in the distance, the shining sea, your destination... All at once it is as though your strength had come back, and with it your hope and confidence, because you had lost sight of the meaning of your expedition... and you have just regained it..'</i></p>

**Table 3: Record sheet: programming and monitoring committed actions.**

Value 1: To care for my mum giving her the best of me: love, tenderness, patience and respect		
Committed Action	No. of times/days that the action was performed	Obstacles/Barriers
To ask her about her preferences when I help her dress	Monday, Tuesday, Wednesday Thursday, and Saturday	On Friday and Sunday I woke up in a bad mood...
To comb her hair sometimes (as I know that she loves that)	Thursday and Saturday	She relaxed a lot... it was great

we consider the ability to opt for acceptance or for change in a flexible and adaptive way, according to the characteristics of the situation or problem to be faced, to be a central skill to be developed by caregivers. In this sense, another central objective of the intervention is helping caregivers to *‘learn the dance between acceptance and change’*, that is, to help them learn to analyse situations in order to opt for change when it is possible and adaptive, or for acceptance, when they can do anything to modify that situation in a direct way, and/or when avoidance is counterproductive and interferes in a caregivers’ life. We use the *‘Serenity Prayer’* by Reinhold Niebuhr (‘God grant me the serenity to accept the things I cannot change; the courage to change the things I can; and the wisdom to know the difference between them’), as a frame for training this ability, and also use an adaptation of the problem solving technique (D’Zurilla & Nezu, 1982) which includes the option to turn to *acceptance* when either a rational analysis of the situation, or unsuccessful attempts to solve the problem lead to the conclusion that acceptance may be the best chance (‘the route of problem analysis’) (see Márquez-González et al., 2010). Internalising the schema of the ‘route of problem analysis’ can be extremely helpful for caregivers. Key elements to be here encouraged in caregivers are attitudes of flexibility and openness to accepting the possibility that things may not be changeable, as well as abilities of creativity for generating potential solutions, and persistence and patience for carefully

observing and analysing the problems and trying out the potential solutions. This exercise shows how acceptance and other therapeutic techniques, such as behavioural modification of problematic situations in dementia or techniques based on emotional regulation, can be complementary. In many cases, problems are not an ‘all or nothing’ issue, as they may contain elements that can be changed and unchangeable elements that it might be better for caregivers to just accept. As it can be deduced from the description of its objectives and contents, our acceptance-based intervention programme is not an orthodox application of ACT as it has been described by its authors (see Hayes et al., 1999 for an overview of ACT structure), and it actually includes this therapeutic technique (adaptation of the problem solving technique) which is typically included in CBT interventions.

Given that our intervention study is still going on, we do not have conclusive data available regarding the efficacy of ACT versus CBT interventions with caregivers. Preliminary results suggest that both interventions are leading to better results than the Control condition.

**Concluding comments**

After reviewing the scientific literature on caregiving interventions, and reflecting on our group’s clinical experience in this regard, some conclusions may be formulated.

It seems necessary to include as outcome variables in our interventions with caregivers some more related with the eudemonic

perspective of well-being: assessing and targeting caregivers' sense of purpose and consistency with their own values may lead us to more effective interventions and to a better understanding of what does it mean for a caregiver 'to increase their well-being'.

Difficulties for accepting different components of the caregiving situation (situational and experiential avoidance) seem to have a very important role in caregivers' experience and should be also considered both in the assessment and the intervention with this population.

The Acceptance and Commitment Therapy (ACT; Hayes et al., 1999) offers interesting and potentially helpful tools helping avoidant caregivers to disengage from their experiential avoidance in order to be more able to satisfactorily maintain their caregiving role and keep on walking towards their valued life directions.

It is still too soon to draw conclusions on the differential efficacy of CBT and ACT with caregivers and the potential role of EA as a mediator of this efficacy, but soon we will have enough data to analyse these issues and hopefully add some light in this regard.

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# Working psychologically with hallucinations in later life

Daniel Collerton, Robert Dudley & Urs Peter Mosimann

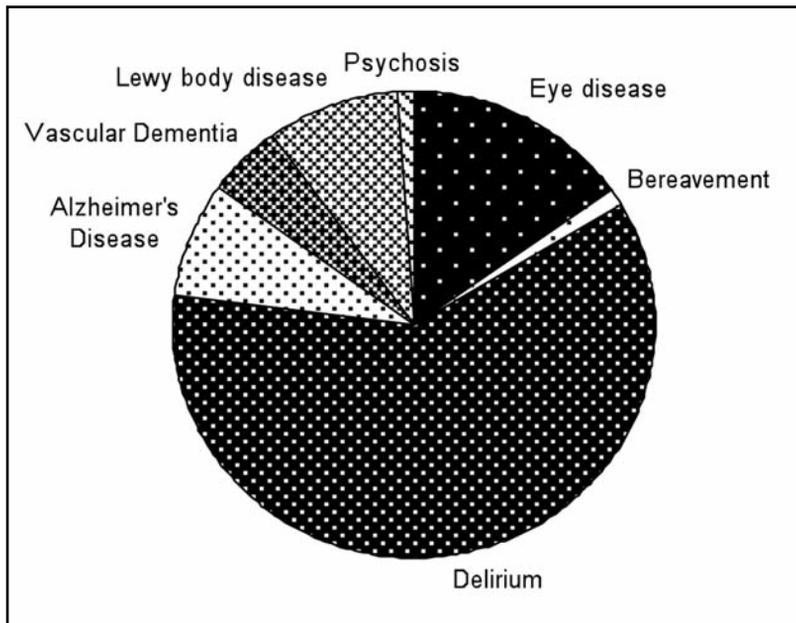
**H**ALLUCINATIONS in all modalities are frequent features of a number of disorders which are common in later life; particularly delirium, dementia, and eye disease (Collerton, Dudley & Mosimann, accepted for publication). Hallucinations are also seen in rarer disorders such as late onset psychosis, and as part of natural grief following bereavement (Figure 1, adapted from Collerton, Perry & McKeith 2005). Combined pathologies appear to increase the risk of hallucinations further.

In virtually all of these disorders, visual hallucinations occur most often followed by auditory, then tactile hallucinations. Hallucinations in different modalities commonly

occur in the same patient (with the exception of eye disease), but rarely at the same time. Owing to their high frequency, we will focus on the identification, assessment, and potential treatment of visual hallucinations in this article, though much of the discussion could also be applied to hallucinations in other modalities.

No-one quite yet knows why some people hallucinate and others do not (Collerton & Mosimann 2010), though there are a number of candidate theories which variably emphasise sensory, perceptual, attentional, and integrative processes. Most probably, a number of different dysfunctions across the distributed visual system can lead to hallucinations.

Figure 1: Associations with visual hallucinations.

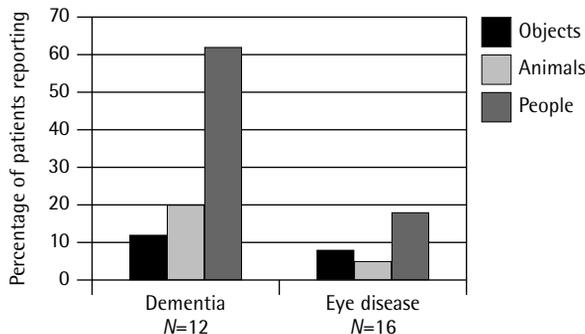


The first challenge in working with visual hallucinations is in finding them. Most patients tend to keep their experiences to themselves owing to a natural concern that others might think them mad or developing dementia if they admit to seeing things that are not there. Sensitive, repeated questions may be needed. General enquires; along the lines of ‘Do your eyes ever play tricks upon you’, while good opening questions, are less effective than telling patients that many others in their situation experience hallucinations, that this is not something to fear, and then asking them if they have such experiences (Mosimann et al., 2008). Thus, Menon (2005) found a nine-fold increase in hallucinations when he asked patients with eye disease ‘It is well known that some people whose vision is blurred can sometimes see things that are not real. Have you experienced anything like this?’, compared to when he said ‘Apart from blurred vision, have you noticed anything else unusual about your vision? Have you had any unusual visual experiences?’ In patients who find it less easy to express themselves, perhaps because of delirium, psychosis, or cognitive

impairment, carer and staff report can be helpful, though it may underestimate true prevalence.

Once a patient reports seeing things that are not there, classifying their experiences can be problematic, with blurred practical and conceptual boundaries between hallucinations (seeing something that is not there – a figure of a person, for example), illusions (seeing something as a different class of thing – a person instead of a tall lamp), and misperceptions (seeing one person instead of another, as an instance). Hallucinations are generally classed as simple (sometimes called elementary) and complex (often termed formed). Simple hallucinations are of dots, lines, flashes, and other meaningless stimuli, while complex hallucinations are of recognisable shapes – people, animals, flowers, and objects. Across most disorders, people are the most common complex hallucination, followed by animals and objects (Figure 2). Complex hallucinations are generally lifelike, though distortions of size and shape, and historical incongruities (for example, old fashioned clothing) are not uncommon.

**Figure 2: Percentage of patients reporting hallucinations within each category**  
(from Makin, Redman, Mosimann, Dudley, Clarke, Colbourn & Collerton, submitted for publication).



### Hallucinations and distress

When working psychologically with hallucinations, however, it is not necessarily the presence or content that is most significant, rather it is the emotional reaction of the patient that is most relevant. Indeed, non distressing hallucinations are generally best left well alone. The frequency of distress varies markedly across disorders (Figure 3), strongly suggesting that a number of factors may intervene between the hallucination and the emotional reaction to it.

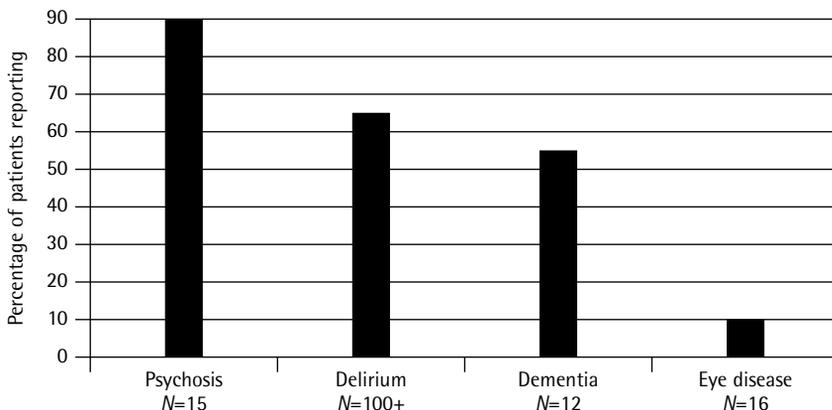
We have already said that concerns about other people's reactions influences how people may react to their hallucinations, but a qualitative study by Andrews, et al. (2007) showed that the people's explanations for the hallucination, the effectiveness of coping strategies, and their effects on the patient's perception of the self were also influential, just as in the emotional reactions of younger people with psychosis (Gauntlett-Gilbert & Kuipers, 2005). These factors open the possibility of a number of psychological intervention strategies, though as yet none have been evaluated so they must be regarded as experimental rather than established (Eperjesi &

Akbarali, 2004). Set against this limited evidence, other approaches, specifically the antipsychotic medication which is the mainstay of treatment in younger adults, have limited effectiveness and significant excess morbidity and mortality associated with their use in older people; particularly those with dementing illnesses. Medication interventions therefore tend to focus on reducing the use of the wide range of commonly prescribed medications whose anticholinergic effects may potentiate hallucinations; for example, antiemetics, antispasmodics, bronchodilators, antiarrhythmic drugs, antihistamines, analgesics, antihypertensives, antiparkinsonian agents, corticosteroids, skeletal muscle relaxants, ulcer drugs, and psychotropic drugs.

### Assessment

In light of the understanding outlined above, a good, systematic clinical assessment which covers the phenomenology of the hallucination, the affect associated with it, beliefs and appraisals and consequent behaviours is more than adequate, but we have developed two structured tools which can

Figure 3: Percentage of patients reporting distress as a consequence of their hallucinations in different disorders. Data from Makin et al., submitted for publication, Dudley et al., submitted for publication, Stagno, Gibson & Breitbart (2004).



also be used; the North East Visual Hallucinations Inventory (Mosimann et al., 2008) which assesses presence and phenomenology, and the Appraisals and Reactions to Visual Hallucinations Interview (Dudley et al., submitted for publication) which records appraisal, affect, and behaviour.

### Working with attributions

There is no invariable relationship between the content of a hallucination and distress. Thus, in both eye disease and dementia, around 60 per cent of hallucinations have unpleasant content, but only 15 per cent of people with eye disease, compared to 50 per cent of those with dementia are frightened by the experience (Makin et al., submitted for publication). Drawing heavily on cognitive behavioural models of emotional distress resulting from auditory hallucinations in psychosis (for reviews, see Laroi & Aleman, 2010), we have suggested (Collerton & Dudley, 2005) that appraisals are a key mediating factor between the occurrence (what it means to be hallucinating at all) and the content (what it means to be seeing this specific thing) of hallucinations and subsequent emotional reactions. Table 1 shows a range of potential emotions and attributions about the content of hallucinations. In most cases, distressing hallucinations are seen as a threat to physical or emotional well-being, with the usual emotional reactions to threats – fear and anger. Important aspects of attributions to the hallucinatory experience include its intention, whether to help or harm; the power, whether easily resistible or not; and the specific threat to mental or physical health. These attributions can be very specific. The following quote from a patient illustrates how he was able to tolerate the content of the hallucination (he did not think his friend turning into a monster was a threat) but was worried by its occurrence ‘So I tended to let my friend turn into a monster. I tended to ignore, ignore that, what he looked like. But, at the same time, it was worrying. I thought I was going out of my mind.’

Treatment would aim to replace these threat appraisals with more functional alternatives which aim to build a sense of security and safety. Key alternative messages to try to convey both to the person with the hallucination and their carers include:

- Visual hallucinations are common – around 2,000,000 people in the UK have them each year.
- They are not necessarily a sign of madness or losing your mind (unless there is other evidence to the contrary).
- They are found in many natural states – sleep, stress, deprivation, and bereavement.
- They usually improve or disappear in time and can be controlled through self-management techniques.
- Most importantly, that they do not have to be distressing.

Conveying these messages may be challenging in working with patients with significant cognitive impairment, since the ability to consider alternative explanations can be restricted (Llebaria et al., 2010). In these cases, the emotional reaction of other people to the hallucinations and enhancing the use of and value of control techniques may be particularly influential.

### Improving control over hallucinations

Patients commonly develop their own ways of managing hallucinations. Diederich, Pieri and Goetz (2003) classified them into ‘visual techniques, including better focusing on the hallucinatory object, focusing at another object, or looking away from the hallucination; cognitive techniques, related to the patient’s self-initiated reactions that do not involve other people, specifically turning the lights on, consciously noting that the hallucinations are not real or purposefully reassuring oneself that they will resolve shortly; and interactive techniques, relying on discussions with family and other caregivers to gain comfort and reassurance as well as verification of the non-reality of the hallucinations.’ In their study population of patients with Parkinson’s disease, cognitive techniques

**Table 1: Potential positive and negative emotional and attributional reactions to visual hallucinations** (from Dudley, Wood, Spencer, Brabban, Mosimann & Collerton, submitted for publication).

Possible negative emotions	Possible malign intentions	Possible positive emotions	Possible benign intentions
Hostile Ashamed Afraid Upset Distressed Nervous Scared Guilty	Physically harm you Harm your mind and thinking Trying to stop you achieving your goals Trying to unsettle you	Interested Inspired Excited Proud Comforted Supported	Trying to help you Protect you Help you develop Help you achieve your goals Reassure you

were used most frequently with visual and interactive techniques less frequent. The presence of dementia reduced the use of these techniques to 30 to 40 per cent compared to the 30 to 70 per cent seen in participants without cognitive impairment, suggesting that poor cognition reduces but does not abolish the utility of these coping mechanisms.

Building upon these spontaneous techniques, a range of interventions can be tried. Changing the visual environment by improving lighting, removing specific stimuli which trigger hallucinations (patterned cushions or curtains are frequent culprits), or adding interest to a featureless environment may be effective. Improving vision, or changing the focus of attention either away from, or towards the hallucination can not only change the hallucinatory experience, but also be used as behavioural experiments to test the appraisals that people make. Thus, reality testing can include checking whether other people can also see it, whether the experience is congruent with other senses, whether it looks realistic or not, and whether it moves or appears and disappears in normal ways. Combining these experiments with education about the usual qualities of hallucinations can be effective in replacing threat attributions with more benign ones. An important cautionary note, however, is that some people, particularly

those with cognitive difficulties cannot participate actively in such approaches. In these cases, carers working as co-therapists can try to use specific techniques when hallucinations are occurring. In all cases, focus on the hallucination may make things worse before they, hopefully, get better and of course people need to be aware of this before engaging in treatment.

One question to consider is whether a specific behaviour has a positive or negative outcome for the patient. The distinction between helpful coping behaviours, which should be encouraged, and unhelpful safety seeking behaviours, which should be discouraged (or at least put to the test in a behavioural experiment) is not always straight forward. Both may be functional as the patient sees it in preventing a feared or unpleasant outcome thus reducing distress in the short term, but safety seeking behaviours additionally serve to maintain a longer term sense of threat which is not really likely to materialise, and may also be counter productive in other ways. Thus, for example, the man who shouts at his hallucinations to drive them away feels better when they go, but never learns that they would go anyway, and his shouting alienates him from people around him. An alternative ‘cognitive’ coping behaviour which could be more functional would be for him to ignore them and relax until they go.

Working with safety seeking behaviours is challenging and depends upon good therapeutic relationships and careful pacing. There is the potential that removing a safety behaviour without replacing it with either a functional attribution which makes it no longer relevant, or with an effective coping behaviour will lead to an increase in distress to no therapeutic benefit. Caution is usually a sensible attitude; only moving forwards with the patient's understanding and agreement.

### Conclusions

Research into the effective psychological treatment of distress associated with visual hallucinations is in its early stages. Though there are grounds for tempered optimism, much work needs to be done before interventions will have a firm evidence base. In the interim, however, disciplined experiment with individual patients may well be productive.

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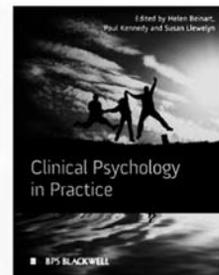
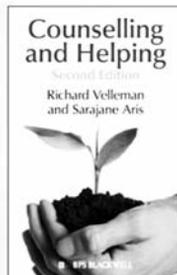
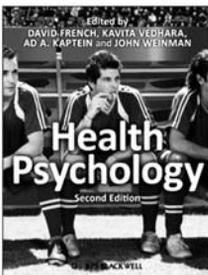
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# The challenges of equipping care home staff with psychosocial skills: Reflections from developing training in a novel approach to communication

Arlene J. Astell & Maggie P. Ellis

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*Evaluation of staff training in psychosocial approaches to dementia typically reveals good knowledge at the end of the training but poor adoption and translation into practice after training ends. Here we describe our experiences piloting a training package designed to equip nursing home staff with the skills to communicate with residents with very advanced dementia who can no longer speak. We have previously described in this publication (PSIGE Newsletter 105, 2008) our first tentative attempt to use this approach to communication, which we call Adaptive Interaction, with a lady with very advanced dementia. Adaptive Interaction is based on Intensive Interaction, which uses the nonverbal fundamentals of communication as the basis for non-speech based interaction. We consider the challenges of enabling and supporting care home staff to adopt this approach and use it confidently and the lessons learnt for delivering similar psychosocial interventions in care settings.*

**S**TAFF TRAINING is critical for improving quality of life and quality of service for people with a diagnosis of dementia. Training can enable staff to gain a better understanding of the experience of the individual with dementia, which in turn should improve the quality of interactions between them (Moniz-Cook, Woods & Gardiner, 2000). In addition, training has been shown to directly impact on staff mental health and well-being (Magai, Cohen & Gomberg, 2002) and to play a critical part in the retention of both qualified and unqualified staff (Grant et al., 1996).

A major challenge in delivering training for staff is to ensure that once training ends the benefits are maintained (Cohen-Mansfield et al., 1997) and that approaches taught in training become part of routine care. Barriers to achieving change may be due to a lack of on-going support and commitment from the care institution, or lack of specialist supervision to keep the interventions learnt in training going (Moniz-Cook, et al., 1998). At the staff level barriers include poor pay, minimal long-term benefits, and lack of recognition and support for their physically

and emotionally demanding jobs (Kuske et al., 2007).

In care homes the staff are carrying out these demanding roles with people who have very complex needs and who may be nearing the end of their lives. In addition, they may be caring for residents whose dementia is so advanced they can no longer carry out any activities of daily life, walk, or even speak. This makes developing caregiving relationships extremely difficult as it is hard to relate to individuals who communicate in ways that we cannot comprehend or who appear to be completely unreachable. Unsurprisingly attempts by care staff at communication and social interactions may become limited to those that occur during basic activities of daily living (Bowie & Mountain, 1993).

When speech is no longer possible for individuals with advanced dementia they may engage in non-verbal behaviours that may not be immediately recognisable as attempts to communicate. In this respect, individuals with advanced dementia have much in common with other populations who have either lost or have yet to develop the ability to use speech. For example, indi-

viduals with severe and profound learning disabilities (SPLD) may have similar communication difficulties to individuals with advanced dementia in terms of their inability to use functional speech. Furthermore, this population is also known to engage in behaviours such as making repetitive sounds or movements. There has been much research conducted on facilitating communication for people with SPLD including the development of intensive interaction.

Intensive Interaction (II) focuses on the 'fundamentals' of communication, i.e. those communicative behaviours that we engage in from infancy. These fundamental communicative behaviours such as eye gaze, bodily movement and sound-making represent the human infants' initial foray into the social world. Parents recognise these behaviours and respond 'as if' they are meaningful to them. In other words, the parent accepts the behaviour of her baby as intentionally communicative and responds by mirroring the baby's actions and developing these into interactive games. II uses the building blocks of parent-infant interaction and incorporates them into a framework that can be used with individuals with SPLD. As a mother reflects her baby's 'language' back to him, caregivers communicate with people with SPLD by learning and using their individual communicative repertoire to attain a mutually meaningful interaction without the need for speech.

Within the II framework it is the quality, not the quantity or content of the interaction that is all-important (Nind, 1999). In II all behaviours are deemed to be communicative and the focus is to 'learn the language' of the individual without speech (Caldwell, 2005). This form of interaction affords the individual with SPLD entry into a social world from which she may previously have been excluded and opening up a means of developing interactions and relationships. We have previously demonstrated the utility of applying the principles of II in a case study of Edie an 89-year-old lady with advanced dementia (Ellis & Astell, 2008).

This approach revealed Edie's communication repertoire, which included vocalisations, movements, facial expressions, and eye gaze. Edie was able to take turns in the interaction and initiate new turns often taking the lead by introducing a new behaviour (Ellis & Astell, 2008). She also smiled and laughed during the sessions using the principles of II (ibid). However the memory problems characteristic of severe dementia meant that it was not possible to develop the interaction to create an enduring relationship as the interaction partner had to adapt to Edie's behaviour anew each time. As such, we introduced the term 'Adaptive Interaction' to describe our experience of using II with a person with advanced dementia. Building on the success of this case study we worked with a further four people with advanced dementia to explore the utility of AI in uncovering their communication repertoires. This confirmed that AI provides a way to 'learn the language' of people with advanced dementia and that each individual has their own communication repertoire. These comprised various combinations of movements, eye gaze, vocalisation, and facial expressions. As with Edie there were instances of smiling and laughter and evidence in all four people of turn-taking and initiation. These results encouraged us to consider how the approach could be translated into practice to support care staff to communicate with people with advanced dementia. However, there were lessons to be learned by previous attempts to instigate a change to the approach of care staff of people with dementia via training.

In addition to the barriers identified above, we recognised from the outset that there might be a further set of obstacles to professional caregivers taking up the AI approach to communicating with their service users. For example, feelings of self-consciousness and embarrassment associated with communicating nonverbally might overpower the experience of interacting with a person with advanced dementia in this way. Furthermore, the imitative element of

the interactions might possibly make staff feel uncomfortable or concerned that they were mocking the person with dementia. To address this we developed a basic training programme in AI and carried out a small pilot study to examine the barriers to helping care staff to try this technique, which we report here.

### **Participants**

Two groups of participants were recruited.

**Caregivers:** All caregiving staff at a local nursing home that specialises in the care of people with dementia were given the opportunity to take part in the training programme. Four caregivers (one man, three women, age range 23 to 51) gave informed consent to take part. One staff member did not attend beyond the first training session leaving three caregiver participants (all women, aged 23 to 41). These were an activities co-ordinator, a senior carer and a staff nurse with between three and seven years' experience of working with people with advanced dementia.

**Residents:** The Manager of the nursing home distributed information sheets to the families of residents who were non-verbal and/or had extreme difficulties with communication. The families of five people with dementia consented to their relatives taking part. Three of these were paired up with the three staff members who took part.

### **Ethical approval**

Favourable ethical opinions were gained from the Scotland A Research Ethics Committee and the University Teaching and Research Ethics Committee (UTREC) at the University of St. Andrews. Staff participants gave informed consent both to take part in the research and for parts of the training to be videotaped. In accordance with the Adults with Incapacity (Scotland) Act 2001 proxy consent for the participants with dementia to take part and to be videotaped was gained from family members.

### **Observation**

Prior to the training, two consecutive days were spent observing the communication environment within the care home. This involved examining the opportunities for communication that occurred during daily life within the home plus observation of the behavioural repertoires of the residents who were participating in the study. An adapted version of Bowie and Mountain's (1993) direct observation tool for recording the behaviour of long-stay people with dementia was used. The residents in the study were observed for one minute every 10 minutes and a decision made as to what behaviour they were engaging in at each time point between 10.00 a.m. and 3.00 p.m. on each of the two observation days.

### **Training programme**

A total of seven sessions were carried out over a five-month period. In brief these were an introductory session for staff and the families of residents to demonstrate AI and seek participants. Sessions 2 to 5 were the training sessions, Session 6 was a follow-up for the staff and Session 7 was a feedback session for the families and staff.

#### ***Session 1 – Introduction to AI***

Care staff and families of residents with advanced dementia that were interested in their relatives taking part in the study were invited to this session. A brief presentation was delivered by MPE, which outlined the origins of AI, what the training and interaction sessions would consist of supported by video recorded examples of AI in action from previous studies.

#### ***Assessment methods***

The impact of training was assessed using a number of pre- and post-training measures. These comprised the English version of the Swedish Strain in Nursing Care Assessment Scale, which provides a measure of attitude towards people with dementia (Brodsky et al., 2003); a modified version of the Staff Burnout Scale (Åström et al., 1991) previ-

ously adapted by us to provide a measure of work satisfaction; the Checklist of Communicative Competencies (Triple C; Iacono et al., 2009) to provide a proxy measure of communication ability; plus three vignettes developed specifically for this study.

### ***Training Sessions 2 to 5***

Four training sessions of two hours each were delivered over a five-week period. The training programme was developed using an active learner model, providing theoretical background information and incorporating practical activities for the staff to practice between sessions. The approach also encouraged the staff participants to share their experiences and support each other in the use of AI. Details of the training programme are being published elsewhere, along with the results of the pre- and post-training measures and we encourage any reader who is interested to find out more about the details of the training to contact us.

### ***Session 6 – Follow-up***

This took place two weeks after the end of the training to repeat the formal measures and vignettes and gain feedback about the course from the staff.

### ***Session 7 – Presenting results***

This session took place two weeks after the follow-up session and included family members of participants with advanced dementia and the caregivers who took part in the training. During the session MPE explained the findings of the study and showed video clips of AI being used to facilitate interactions between the care staff and people with advanced dementia.

### **Reflection**

The overall impact of the training course was extremely positive. Trainees felt more able to identify communicative behaviours in and were better equipped to communicate with people with advanced dementia. The measures showed that staff regarded the communication of the residents to be of a

higher standard than before the training. This suggests that trainees began to ‘learn the language’ of the individuals they worked with. However, several points were raised and observations made throughout the training programme that illuminated the possible obstacles to the care staffs’ acceptance of the course.

Firstly, it was clear that the staff trainees initially questioned the validity of AI as it was an approach that they had never previously heard of or witnessed. As such, it was essential that we showed video clips of AI in action. These examples initially allowed the trainees to see how the approach is conducted and to view the positive impact it has on interactions between people with advanced dementia and their communication partners. Not only was it important for trainees to see the approach being successfully conducted by someone else, it was also essential that they experienced the positive impact themselves. We learned that when trainees feel better equipped to recognise communicative behaviours in individuals with advanced dementia they feel less embarrassed about reflecting them back to the individual. Prior to training the trainees felt that the behaviours engaged in by the residents with advanced dementia were non-communicative, meaningless and without aim. However, once they had been introduced to the notion of these behaviours representing the fundamentals of communication even the slightest movement or sound on the part of participants with dementia was recognised as a communicative bid. This represented a significant turnaround in approach for the trainees as not only did they begin to recognise non-verbal behaviour, they felt equipped and began to use it.

The sensitive and flexible approach to training that was used in this study was essential. It had to be acknowledged that AI is an approach to communication that would most probably be completely alien to the trainees. Furthermore, it was possible that the concepts upon which the approach is based may not sit well with them. For example, it was conceivable that they may

have felt that because II is based on parent-infant interactions that we expected them to treat the residents as if they were also infants. It was therefore necessary to make sure that in no way did we equate older people with advanced dementia to infants. Rather we regarded people with advanced dementia as maintaining some of the communicative skills that infants strive to develop. In this sense we presented people with advanced dementia as experts in communication who find themselves left with the skills they began with – in essence, the opposite of infants. This approach was beneficial as it allowed the trainees to understand the underlying concepts of AI in a way that encouraged them to regard people with advanced dementia with respect and dignity.

Another main consideration in this training was the element of self-consciousness that was experienced by the trainees. The trainees remarked that they initially felt uncomfortable with imitating the behaviour of individuals with advanced dementia. Not only because they felt that they might be seen to be mocking the person and but also because they felt that they might make a fool of themselves. This is a thorny issue that requires sensitive handling. As such, the group discussion that was encouraged during training sessions allowed the trainees to air their concerns about AI itself, their abilities to conduct the approach and to provide each other with the encouragement to continue. As such, the inclusion of peer support proved to be an extremely useful tool in facilitating both the adoption of AI and the trainees' confidence in using the approach.

Finally, the inclusion of Session 7: 'Presenting Results' was invaluable to the entire research and training process. Trainees, management of the nursing home and family members attended this session where they were given a re-cap on the research, findings of the training and shown video clips of the participants with dementia interacting with the trainees. The trainees and management were clearly proud of their

achievements and entered into discussions with family members about their relatives with dementia and their communication skills. Family members enjoyed watching their loved ones interacting with caregivers in a way that they had never previously witnessed. Some family members commented that they had not seen their relatives communicate so readily in a long time and this was a great encouragement to the trainees. Additionally, the AI training course helped staff members to recognise communicative behaviours that they would not have previously. As such, the 'improvements' in communication that they noted in people with dementia after the training may have occurred as a result of this enlightened position. However, the sense of achievement and confidence to recognise and communicate with residents with advanced dementia can be viewed as a positive outcome of the training.

## **Conclusions**

The experience of developing and delivering a training programme for care home staff to use AI provided an illuminating case study of the challenges of trying to equip staff with new skills and enabling them to use these in practice. We experienced scepticism, disdain and outright ridicule at the start. At the end the staff who took part admitted that they thought the idea was 'mad' when they first heard about it. However, gratifyingly they also feedback that 'it was the best training' they had ever had and wished that it could have lasted longer. In some respects AI can be viewed as an extreme case study – for example in the way that it asks staff to behave in ways that feel unnatural and certainly uncomfortable. However, in trying to fundamentally change the behaviour of care staff and enable them to feel more comfortable when engaging with the people with dementia they care for, hopefully AI can be seen as an example of the broader challenges faced in trying to bring psychosocial approaches into care homes.

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# Cognitive rehabilitation for people with early-stage Alzheimer's disease

Linda Clare

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**P**EOPLE in the early stages of Alzheimer's disease (AD) face the challenge of adjusting to living with progressive cognitive impairment, and are often acutely aware of the everyday impact of their memory difficulties. Despite their impairments, they retain some ability to learn and to adjust their behaviour. Methods and techniques from neuropsychological rehabilitation can be applied to support this process and to assist people in managing the impact of memory difficulties.

An individualised, client-centred cognitive rehabilitation approach is aimed at reducing functional disability, supporting self-management, and maximising engagement and participation through addressing personally-meaningful goals in the everyday setting (Clare, 2008). People with dementia and their families work together with a health professional over a number of sessions to identify needs and goals, and to devise and implement strategies for achieving these goals, with specific evidence-based restorative or compensatory strategies introduced as appropriate. This provides modelling of, and practice in, problem-solving strategies and self-management skills. Involvement of a family carer helps to ensure that skills are maintained and applied to novel situations, and facilitates communication about how difficulties might be managed.

The first randomised controlled trial evaluating the clinical efficacy of CR has recently been completed (Clare et al., 2010). This single-blind randomised controlled trial, funded by the Alzheimer's Society, compared CR with relaxation therapy (RT) and no treatment (NT). Participants were 69

individuals (41 female, 28 male; mean age=77.78, SD=6.32, range 56 to 89) with a diagnosis of AD or mixed AD and vascular dementia and an MMSE score of 18 or above, and receiving a stable dose of acetylcholinesterase-inhibiting medication. Forty-four family carers also contributed. Participants randomised to the CR group received eight weekly individual home-based sessions of CR. The primary outcomes were goal performance and satisfaction with performance, assessed using the Canadian Occupational Performance Measure. Questionnaires assessing mood and quality of life, and a brief neuropsychological test battery, were also administered, and carers completed a measure of carer strain. A subset of participants underwent functional magnetic resonance imaging (fMRI). Following intervention the CR group showed significant improvement in ratings of goal performance and satisfaction, while scores in the other two groups did not change. Moderate effect sizes were observed for cognition, mood and QoL, as well as for carer stress and QoL. Behavioural changes in the CR group were supported by fMRI data for a sub-set of participants. The findings provide preliminary support for the clinical efficacy of CR in early-stage AD.

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# Using Compassion Focussed Therapy to work with shame and self attack: A transdiagnostic approach (or moving from the Red zone into the Green zone!). A reflection on Deborah Lee's workshop

Jean McFarlane

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**I**NDIVIDUALS prone to high levels of shame and self-criticism can find it very difficult to generate feelings of contentment, safeness or warmth in their relationships with themselves or others. These problems are often chronic and entrenched and, therefore, highly relevant in our work with Older People. Dr Deborah Lees' workshop at the PSIGE 2011 National Conference in Glasgow was lively and stimulating and addressed these issues.

Workshop participants were asked to think about something we felt shameful about and then to disclose this to the participant sitting next to us. Needless to say I started to feel uncomfortable and anxious as I worried about what the person sitting next to me, whom I had never met before, would think of me. Deborah explained that this task had activated the threat and protection systems and she went on to explain that there are two other types of emotion regulation systems: the resource-seeking and excitement systems; and the contentment, soothing and safeness systems. These systems form a foundation for Compassion Focused Therapy (CFT) and it is believed that these three systems can become unbalanced and rebalancing is one of the goals of therapy. Deborah used the 'disclosing task' to effectively activate my threat focused system and I was very much in what Deborah called the Red zone.

Part of the focus of therapy is to help individuals move from the Red zone into the Green zone. Heightened sensitivity and over activity of the threat protection and/or resource-seeking systems is common in people with high shame and self criticism and individuals find it hard to feel content or safe within themselves or in interpersonal relationships. The contentment system which provides a sense of relief and calming is insufficiently accessible to them.

The workshop then moved on to explain how CFT draws on social mentality theory to explore the nature of shame based, negative self-evaluations and presented theory practice links on how to work more effectively with these cases. A case presentation of an Older Person experiencing high levels of shame and self-criticism helpfully illustrated this.

Deborah finished the workshop with a slide show of compassionate images which left me feeling soothed and calm even more so when I realised there was no time left to disclose anything shameful to the participant sitting next to me. I was now truly in the Green zone. I left this workshop wanting to know more about the CFT approach and thinking about how often the themes of shame and self criticism arise in my clinical work.

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# Treating depression in dementia: A pilot dyadic cognitive behavioural approach

Donna Gilroy, Ken Laidlaw & Guy Holloway

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**I**NCREASED life expectancy and recent national policy drivers, in particular the National Dementia Strategies across the Home Nations, to improve early identification of dementia place a further spotlight on the emotional and psychological needs of this population. The co-morbid existence of depression for individuals with a diagnosis of dementia is well-established within the literature, although incidence rates are variable. One commonly suggested incidence rate has been 20 per cent (Ballard, Bannister & Oyebode, 1996). Individuals with coexistent depression and dementia have been shown to have higher rates of behavioural and functional problems, and their caregivers report higher levels of distress, burden, and depression (e.g. Teri, 1994; Teri, McKenzie & LaFazia, 2005).

Despite the dominance of pharmacological treatments in older adult care, one relatively recent review of randomised controlled trials on the use of anti-depressant medications for the treatment of depression in dementia revealed only eight published placebo-controlled trials, with five of these failing to demonstrate clinical efficacy (Olin et al., 2002). There is clear need to develop and systematically evaluate psychosocial interventions. Clinical evidence does not support the resolution of depression with increased dementia severity, although it is neither clear at which point psychotherapeutic and psychosocial interventions become less effective, or ineffective, due to cognitive decline.

Indeed the evidence base for direct psychotherapy, including cognitive behavioural therapies, for older people with dementia (PWD) in alleviating co-existing depression and anxiety is particularly limited

at the present time. Many psychological therapists have shied away from working with older people with cognitive impairment as they fear people will be unable to engage in the process. It may be especially at the early stages following diagnosis that an individual can benefit most from psychotherapy, as they contemplate the impact of the diagnosis in their own lives and the lives of their loved ones (Laidlaw, 2010a). For instance, Scholey and Woods (2003) presented an interesting commentary on a series of individual case work using cognitive therapy for depression with individuals with a diagnosis with dementia. Here, cognitive impairment did not provide a major obstacle for the development of effective individualised treatment protocols. There has, however, been more demonstrable progress with interventions involving caregivers. These have included behavioural interventions utilising the caregiver as a 'co-therapist' (e.g. Teri, 1994) in addition to interventions with the primary aim of reducing caregiver distress (e.g. Coon, Gallagher-Thompson & Thompson, 2003).

Previous attempts to provide structured individual therapy with this group have primarily been aimed at one party (PWD or caregiver) with ad-hoc involvement from the other at some stage. Yet, to date, there has been no specific development of cognitive and/or behavioural interventions for both PWD and their caregivers that is conducted in parallel with individualised content for either party. Our paper presented an overview of the rationale, methodology and treatment protocol of a pilot research study examining whether individualised CBT for PWD and individualised CBT intervention for their primary caregiver delivered at the same time will result in reductions in the

level of depression in the PWD and enhance the sense of competence in caregivers. Adopting a single case series quasi-experimental AB design both the PWD and caregivers will be offered up to 10 sessions of individualised CBT delivered in parallel, with the inclusion of up to two of these sessions involving both members of the dyad and their therapists. Our paper highlighted how current thinking on caregiver over-identification and guilt (Monin & Shultz, 2009), Balte's model of Selective Optimisation and Compensation, wisdom enhancement strategies (Laidlaw, 2010b) and attention training (Mohlman & Gorman, 2005) has influenced the potential adjustments to the standard cognitive and behavioural therapy protocols in our pilot intervention.

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# Poster Presentations

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## **IAPT and people with dementia in residential care – a training programme for care home staff**

**Dr Ross Warwick & Dr Fionnuala Edga**

*Department of Psychological Services and Research, Nithbank, Dumfries, DG1 2SA*

This poster summarised a training programme for staff working in residential care and hospital settings. The training aimed to provide delegates with the skills necessary to manage challenging behaviour in dementia using psychological methods. The programme corresponds with the general principles of the IAPT initiative by providing an improved, accessible psychological service to people with dementia through enhancing the skills of staff who provide care. It also relates to the nationwide efforts to reduce the use of anti-psychotic medication in managing challenging behaviour.

The training programme adopted a targeted cascade approach wherein representatives from each facility attended training with the expectation that they would disseminate what they had learned on their return to their base. Since its inception in March 2010, 286 delegates representing facilities across Dumfries and Galloway have completed training. Delegates completed self-report questionnaires pre- and post-training which evaluated attributions about challenging behaviour.

Preliminary analysis suggest that post-training, delegates felt more optimistic about effecting change in challenging behaviour cases and reported more confidence in their ability to cope with individuals who present with behaviour that challenges.

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## **Effort testing in neuropsychological assessments in Scotland**

**Anna Graham**

*Clinical Psychologist in Training, University of Edinburgh and NHS Dumfries and Galloway.*

**Dr John Higgon**

*Consultant Clinical Psychologist, NHS Dumfries and Galloway.*

Recent recommendations for professional bodies encourage the use of effort testing as part of routine practice in neuropsychological assessments. This study explored the attitudes and practices of clinical psychologists in Scotland ( $N=51$ ) with regard to effort or symptom validity testing.

Participants were recruited via emails cascaded from heads of psychology specialities across Scotland. An anonymous online survey was used to gather the data. Although 82 per cent of clinicians reported that they 'always' comment on the test taker's level of effort in a clinical report, only 16 per cent employ effort or symptom validity tests in more than half of their assessments. In contrast, the clinicians involved in conducting medico-legal assessments ( $N=21$ ) all reported that they always comment on the test taker's level of co-operation and 62 per cent of them reported using effort or symptom validity tests in almost every case (>95 per cent). In addition, the Test of Memory Malingering was listed as the most frequently used method of assessing effort.

The results of this study are in line with previous research conducted in the UK, both in relation to the attitudes and practices of clinical psychologists. However, studies from North America report more frequent use of effort testing in both clinical and medico-legal settings. Clinical implications of this study point to the need to raise awareness of the issues surrounding effort testing and to provide training for clinical psychologists engaging in neuropsychological assessments.

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## **The lived experience of depression in older women: An Interpretative Phenomenological Analysis**

**G. Murphy et al.**

This summary paper describes the rationale for the analysis of older women's experiences of depression, the findings, clinical implications and questions for future research.

Research has shown that women experience depression to a greater degree than men and that this discrepancy continues into older age (Bebbington, 1996; Nolen-Hoeksema & Girus, 1994; Piccinelli & Wilkinson, 2000). However, despite a significant body of qualitative research regarding women's experience of depression this has mainly involved working age women.

Semi-structured interviews were conducted with six older women who had accessed mental health services perceived themselves as someone who had depression. Using Interpretative Phenomenological Analysis (IPA) three super-ordinate themes representing their journey with depression were developed: making sense of depression, the experience of depression, and moving on with life with or without depression. The women made sense of their depression within the context of current life experiences, in many cases involving changes to their body due to physical illness. These changes impacted on their ability to perform routine tasks in life impacting on their sense of identity. The women made sense of their depression by referring to bereavement and loss, relationship difficulties, difficulty coping with life and bio-medical factors. Whilst drawing on a range of explanations to make sense of their depression, many women continued to have difficulty making sense of their experiences. Depression was experienced as an active retreat from life. Moving on with life, more often than not, involved implementing active self-focused coping strategies, negotiating the changed sense of identity, talking about depression, being with other people and feeling safe.

The findings are discussed in light of existing research regarding the impact of physical illness on identity and specific models of adjustment, stress and coping. Self-silencing theory (Jack, 1991) and a material-discursive model of depression (Stoppard, 2000) are further considered to inform our understanding of the findings. The strengths, limitations and clinical implications of this study are explored along with suggestions for future research.

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## **Psychological formulation as a basis for changing inpatient staff understanding of psychosis**

**Karen Barton**

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**Jon Williamson**

*Clinical Psychologist in Training,  
Birmingham and Solihull Mental Health  
NHS Foundation Trust.*

**Objective:** Research (Butt et al., 2010) has suggested that training and seminars delivered to ward staff can increase understanding of psychological approaches to psychosis, increase confidence, knowledge and skills of the staff involved. Furthermore, one of the least intensive ways to decrease distress associated with positive psychotic

symptoms is through enhancement of coping strategies (TARRIER et al., 1990). The authors, therefore, undertook to deliver seminars illustrating the rationale for this approach.

**Method:** The authors delivered two 30-minute seminars to 15 staff, suggesting that staff might help clients to learn coping strategies to provide a more subtle challenge to those beliefs over time, rather than challenging those beliefs directly. Each seminar used an ABC model where 'B' indicates the beliefs of the person. Participants completed the Working with Psychosis Questionnaire (WPQ) (Butt et al., 2010), as well as a general evaluation questionnaire.

**Results:** The WPQ illustrated that the majority of participants felt the training had increased their knowledge, understanding, the importance of talking, level of supervision, perceived satisfaction and support. After the training 70 per cent felt more confident in their abilities.

**Conclusions:** Ward staff benefit from training in understanding the importance of coping strategies in helping clients with psychosis to challenge psychotic beliefs. There was an increase post-seminar of both knowledge and skills and the perceived ability to relate to people with psychosis. However, there was no objective follow-up of this training, future seminars will need to look at work on the ward, to evaluate the impact on the care received by clients.

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### References

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### Is the Doors and People a valid memory test for older adults?

**Dr Lucy S Birch**

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This work was carried out as an audit.

**Introduction:** The Doors and People (D&P) was designed to be a sensitive memory assessment battery across a spectrum of memory functioning, including dementia. There is little available literature supporting the validity of the D&P test for older adults. The validity of the D&P was explored in routine clinical practice, in two Community Mental Health Teams for older adults with subjective memory complaints.

**Method:** A retrospective case note review was undertaken. Cases eligible for inclusion were those who had a neuropsychological assessment during a consecutive 18-month period. Participants' standard scores on the D&P were compared with standard scores on other memory tests administered as part of the same neuropsychological assessment. The comparison tests were the Rey Auditory Verbal Learning Test and the Rey Complex Figure Test.

**Results:** Agreement regarding classification of standard score for each D&P test was explored in relation to the comparison test administered. The degree of agreement was quantified by Kappa. There was poor agreement between standard scores on the D&P and comparison memory tests for tests of recall. The D&P more often gave a lower standard score than the comparison memory test on tests of recall, for both visual and verbal material. Recognition test scores did not show this effect.

**Discussion:** The results raise doubts about the validity of the Doors and People for assessing memory recall with older adults.

**Reminiscence work in dementia care**  
**Ruth Elvish, John Keady, Philippa Gardener**  
**& Sammi-Jo Lever**

*(in collaboration with the REMcare Team)*

Whilst reminiscence work has an extensive history (Gibson, 2004), there is little effectiveness research available to support its use (Woods et al., 2005). The current study is a randomised controlled trial which is being undertaken across six sites in England and Wales (Bangor, Manchester, Hull, Bradford, Newport, and London). The aim of the project is to compare the effectiveness of joint reminiscence groups for people with dementia and family members with 'usual treatment'. The trial intervention uses the 'Remembering Yesterday, Caring Today' programme (Schweitzer & Bruce, 2008), an approach which uses a variety of ways to share memories, including miming and re-enactment.

In addition to quantitative data from the study, qualitative data has also been collected from participants who have undertaken the reminiscence intervention. The aims of the qualitative data analysis are to develop understanding of the mechanisms of change underpinning the 'Remembering Yesterday, Caring Today' programme. This poster presents a working model from the Manchester site, which suggests that 'feeling connected' is a central theme. The final qualitative data analysis will incorporate data from all study sites, and the current proposed model will be adapted and developed accordingly.

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**Devising a new interpretation method**  
**for the Cambridge Cognitive**  
**Examination (CAMCOG)**

**Rose Knight**

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**Aims and Objectives:** The aim of the current project was to develop a new interpretation of the CAMCOG to increase its clinical utility in an older adult population, specifically in stroke patients. The original manual scoring method using standard deviations had many limitations, the most prominent being age differences. This was consistently found not to be a true reflection of the patient's cognitive performance. For example, a 65- and a 90-year-old would have the same level of ability on the same score, when in reality, the former may be significantly impaired, the latter may have a normal ability.

**Methods:** Thus, an in-depth analysis of a population norms paper (Williams et al., 2003) was made to ascertain its suitability to our clinical population. Significant findings from this paper were that age, gender and education all had large effects upon the CAMCOG scores. A new scoring interpretation was devised, taking into these variables. Case studies were conducted on nine stroke patients comparing the new method to the old.

**Results:** Considering demographic characteristics was found to produce a more accurate picture of a stroke patient's cognitive ability. For example, including age resulted in two patients previously interpreted to have a slight impairment to be classed differently, with the younger patient found to have a severe impairment.

**Conclusions:** Initial implementation of this approach has been useful within stroke psychology. The revised CAMCOG scoring method can be piloted in other areas of older adult psychology to increase its application within the field.

**Acknowledgments**

Dedicated to Dr Ann Davies. Thank you for input from the stroke psychology team: Dr Vicky Molyneaux, Samantha Jones, Eleanor Taylor and Charlotte Taylor.

**References**

Williams, J.G., Huppert, F.A., Matthews, F.E. & Nickson, J. (2003). Performance and normative values of a concise neuropsychological test (CAMCOG) in an elderly population sample. *International Journal of Geriatric Psychiatry*, 18(7), 631-644.

**Mindfulness-Based Stress Reduction (MBSR) Group Intervention for Older Adults: A Pilot Evaluation of Psychological Outcomes**

**Larisa Butenko, Emma Harris & Claudia Coelho**

*Clinical Psychology Service for Older People, Royal Edinburgh Hospital, Edinburgh.*

**Objective:** Within the older adults' population, studies have reported an increase in the use of mindfulness related interventions. This pilot study aims to evaluate the effectiveness of the eight-week MBSR course as a group treatment for older adults with recurrent depression or long standing anxiety.

**Method:** 14 participants (13 female and one male, mean age=72) were recruited from day services, psychology and psychiatry care of the elderly at the Royal Edinburgh Hospital (REH). They were assessed using questionnaires administered pre-, post-course and three-months' follow-up: World Health Organisation- Quality of Life Bref (WHO-QOL Bref), Geriatric Depression Scale (GDS), Cognitive Fusion Questionnaire-13 (CFQ-13), Acceptance and Action Questionnaire-2 (AAQ-2), Geriatrics Anxiety Inventory (GAI), and the CORE.

**Results:** The mean scores of the CORE subscales were reduced indicating lower levels of symptoms reported in the Wellbeing outcome (pre-course mean=18.3, SD=8.3, follow-up mean=9.4, SD=8.3), Problems outcome (pre-course mean=19.7, SD=7.6, follow-up mean=16.9, SD=9.7). The mean scores of GDS and CFQ were also reduced at

three-months' follow up (GDS: pre-course mean=7.4, SD=4.2, follow-up mean=6.8, SD=3.9. CFQ: (pre-course mean=57.1, SD=8.9, post-course mean=52.8, SD=5.8, follow-up mean=55.5, SD=10.1).

**Conclusions:** Overall it was found that there was a mixed trend in some of the domains that were measured; these included the quality of life and acceptance and avoidance measures. Despite this, this innovative study within NHS Lothian had found that for some older adults suffering from recurrent depression and chronic anxiety MBSR may be an acceptable approach for treatment.

**Acknowledgements**

We would like to thank Dr Ken Laidlaw for his input and support, as well as Angela Harris and Dr. David Gillanders. Thanks are due to day care staff and psychiatry services at the Jardine Clinic at Royal Edinburgh Hospital.

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**Investigation of carers' satisfaction of patient care during admission to a physical health rehabilitation ward for older people**

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*Consultant Clinical Psychologist*

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*Senior Charge Nurse*

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**Aims:** To ascertain levels of satisfaction patients' families or carers feel regarding the care their relative or friend received on a

physical rehabilitation ward for older people. To measure the impact of introducing the 'Getting to Know You' (GTKY) form, a piece of person centred practice, on satisfaction.

**Method:** A Carer Satisfaction Questionnaire (CSQ) was developed, addressing aspects of person centred care covered in the GTKY form, to measure the impact of introducing this practice. Baseline CSQ data for patients' families and friends who had not received the GTKY form was compared to CSQ scores of those who had.

**Results:** Generally respondents were satisfied with the care their relative or friend received. However, some concerns were voiced regarding staff being approachable and informative about medical issues, paying attention to the patient's social needs, emotional distress, likes and dislikes and treating the patient as a person. No statistically significant differences on CSQ scores between groups were found.

**Discussion & Conclusions:** The results and limitations are discussed in the context of the Dementia Strategy and training development. Specifically, how satisfaction and psychological well-being can be improved through systemic and indirect working, and improved communication with families and carers of patients.

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**A systematic review of the accuracy and clinical utility of the Addenbrooke's Cognitive Examination and the Addenbrooke's Cognitive Examination – Revised in the diagnosis of dementia**  
**Stephanie Crawford**

*Clinical Psychologist, Eastwood Resource Centre, NHS Greater Glasgow & Clyde.*

**Objectives:** To review the evidence relating to the diagnostic accuracy and clinical utility of the Addenbrooke's Cognitive Examination (ACE) and its updated version, the Addenbrooke's Cognitive Examination – Revised (ACE-R) in relation to the diagnosis of dementia.

**Design:** A systematic search of relevant databases was conducted covering the period 2000 to April 2010. Specific journals and reference lists were hand searched. Identified studies that fulfilled the inclusion criteria were reviewed using a tailored, methodological quality rating checklist.

**Results:** The systematic search process identified nine studies for review (seven relating to the ACE, two on the ACE-R). Strengths and weaknesses across studies are considered and diagnostic accuracy measures are presented for six out of the nine studies.

**Conclusion:** The evidence suggests that the ACE/ACE-R are capable of providing information on a range of cognitive domains and differentiating well between those with and those without cognitive impairment. Further research examining how the tools distinguish between dementia subtypes and Mild Cognitive Impairment (MCI) will further benefit the evidence base.

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# Independent Practitioner Forum

The Society's Professional Practice Board has set up an electronic forum for independent and private practitioners.

If you are interested in joining, please send an e-mail to Nigel Atter at the Leicester office:  
**nigel.atter@bps.org.uk**

# PSIGE Conferences: Hosting arrangements

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Geographical Group	Next Hosting
Scotland	2011
South Western	2012
Essex and Herts	2013
West Midlands	2014
Wessex	2015
Oxford	2016
Northern	2017
East Anglia	2018
North West	2019
South Thames	2020
Trent	2021
Yorkshire/Humberside	2022
Wales (North and South)	2023
North Thames	2024

# Annual Conference 2012



The  
British  
Psychological  
Society

100 concession places  
available for qualifying  
Society members

**18–20 April**  
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is open**

Poster submission  
deadline open until  
30 November

[www.bps.org.uk/ac2012](http://www.bps.org.uk/ac2012)

# Notes for Contributors

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

## Articles

Articles form the bulk of contents submitted to the *Newsletter*. As the *Newsletter* aims to cover a broad, cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication. These can cover empirical investigations, pilot studies, descriptions of service developments, audits and evaluations. Articles should be submitted three months before publication (i.e. October for the January issue, January for the April issue, April for the July issue, and July for the October issue).

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

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

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

## Research Updates

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

## Letters to the Editor

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

## Book reviews

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

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

## Images

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

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

## Submission Procedure

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

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

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

When submitting articles please send the following information:

Full name;

Affiliation (title, place of work);

Contact details (should you be willing to be contacted by the membership);

Acknowledgements (as appropriate).

Finally, all reports of research should indicate whether or not Ethics Committee approval was awarded, and by which Ethics Committee, or whether the work was carried out as an audit/service evaluation project.

All contributions should be sent to: [louisa.jackman@hotmail.co.uk](mailto:louisa.jackman@hotmail.co.uk)

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