



Division of  
Clinical Psychology  
Faculty of Old Age Psychology



The  
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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.

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# Letter from the Editor

Louisa Jackman

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I AM HAPPY to introduce the Wessex edition of the *Newsletter*. Many thanks to its contributors who were taken somewhat by surprise by how quickly it crept up. I must shoulder some responsibility for not having been proactive in reminding the group about the deadlines, and I would recommend that other groups look closely at the timetable which appeared in the conference edition of the newsletter to spot their own slot.

I was finally able to attend a national committee meeting in November and catch up properly on where we are at with the various strands of National PSIGE work. There was interesting debate about how we present our function to the wider world, and the potential acronyms that could emerge from a change in name. As part of our discussions, it became increasingly obvious how much the *Newsletter* is valued by its contributors and its readers. We know that the special edition on supervision and formulation and the edition on IAPT have been extremely helpful to PSIGE members as a tangible means to introduce ideas to managers and commissioners and to showcase good practice, and we are looking forward to producing another special edition reflecting our other work stream on dementia. Also of relevance to the newsletter was the discussion on the need for closer links between the *Newsletter* and website content. I have had several enquiries from people searching for references which have appeared in previous copies of the *Newsletter*. We have agreed the importance of keeping the pdf's of past editions up-to-date and available.

In this edition, Rik Cheston and his colleagues have developed a number of papers with a back drop of existentialism. Cheston initially introduces us to the threats to self emanating from the dementia process, and, in introducing 'Terror Manage-

ment Theory', encapsulates the experience of dementia in a way that simply referring to 'anxiety' or 'uncertainty' does not. Ashurst, Cheston, and Gleeson continue the theme by looking at how people with dementia might use the objects around them as a way of feeling more safe and secure in the face of the threat of dementia. Importantly, they suggest that those of us working with people with dementia have a role in promoting this aspect of everyday objects to enable this process to take place. Betts and Cheston present a paper which considers the positive effects of enabling people suffering from dementia to come to terms with their condition through their application of the Assimilation Model of Problematic Voices to the experiences of the person with dementia. They helpfully provide case study material to bring life to their discussion and conclude that this process could be a helpful part of the memory assessment process.

Richardson and Marshall describe their trust's efforts to address the inequity of dementia services up-take for Black and Ethnic Minority groups. The organisation is raising awareness among different cultural communities through a national mental health campaign and give a list of steps they have taken which would be helpful for others considering tackling this issue. Young and Keetch outline a project looking at staff experience of supervision in response to concerns about blurred patient-clinician boundaries in their organisation. On a positive note, they found that there were many good experiences of supervision describes by respondents, but some respondents continued to feel that supervision was not given the time or space it required to make it a useful tool for problem-solving or feedback. Whitby provides us with an excellent review of 'Teach us to sit still....' which I think will significantly boost the author's

New Year sales(!), and he also summarises his experiences of successfully applying for an award from the Winston Churchill Memorial Trust. Both contributions leaving me thinking I must get out more... Finally, I loved Hodge's reflections on using ACT with an 80-year-old lady, and beginning to apply some its principles to her own outlook.

I am looking forward to presenting you with April's general papers edition which is packed full of submissions received over the last year. Thanks to the many contributors and their patience in waiting for a slot to showcase their work.

Best wishes for the New Year.

**Louisa**

PS: Could I please draw your attention to a mistake in the last edition of the Newsletter where we should have listed Dr Gemma Murphy as the presenter of the poster 'The lived experience of older women with depression....' on the back cover of the journal.

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# Guest Editorial

Paul Whitby

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**W**ELCOME to the Wessex Edition of the *PSIGE Newsletter*.

The term Wessex, originating from West Saxony is a geographically antiquated one and can no longer be found on a modern map. Historically though Wessex is quintessentially important to the process of England becoming a unified country. King Alfred the Great ruled Wessex from 871 to 899 AD when the rest of England was controlled by the Vikings and united warring tribes to fight the Danish invaders. Alfred was a great military leader, but he was also a very learned man, establishing a programme for translating Latin documents into the vernacular of what we would now call Old English.

It could be argued then that English literature was founded in Wessex and the region certainly has strong literary connections. Thomas Hardy is the most famous of these as he drew sketch maps of Wessex, which gives it the loose geographical definition we rely on today. It stretches from Berkshire, Hampshire and Isle of Wight in the east to Wiltshire, Somerset, Dorset and Devon in the west. Hardy created fictional alter-egos for real towns and cities in his novels such as Christminster for Oxford in *Jude the Obscure* and Wintonchester for Winchester in *Tess of the D'Urbervilles*.

Winchester, which was the capital of England under Alfred and remained so until after the Norman conquest, is spoilt for literary heritage. Jane Austen lived in the nearby village of Chawton and when she became ill moved to a house on College Street in Winchester which is still standing today. She sadly died at 41 in 1817 and is buried in the north aisle of Winchester Cathedral. The romantic poet John Keats, wrote one of his most famous sonnets, *To Autumn*, in 1819 whilst walking besides the River Itchen in what is known locally at the water-meadows and it is possible to retrace his footsteps today. Finally, the Victorian writer Anthony Trollope attended the boy's public school Winchester college, founded in 1382 it is thought to have the longest unbroken history of any school in England. Trollope based his *Chronicles of Barchester* novels on his experiences of the city which was later made into a television series.

Wessex continued to inspire writers in to the 20th century, especially John Fowles whose genre defying classic *The French Lieutenant's Woman* put Lyme Regis on the map for international audiences, Fowles spent the latter part of his life in Lyme and served as the curator of the local museum. More recently Ian McEwan's 2007 novel *On Chesil Beach* will once more return attention to the Dorset coast as a film starring Carey Mulligan is currently in the making.

**Paul Whitby**

# Letter from the Chair

Cath Burley

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I AM WRITING THIS balancing a laptop on my knee on a very crowded train from London to the snowy hills of Shropshire (as I finally have a seat). After a (very) early start to get to a meeting with the Division of Neuropsychology about how we can make closer links between our groups – and a meeting about IAPT and Long Term Conditions with the DH Lead. The last couple of months have been very busy for the National Committee with attendance at the New Savoy Partnerships Conference, National Committee meeting, DCP conference, Commissioning Groups, Dementia Action Alliance and work stream meetings and teleconferences. Not bad as most of this is done by everyone on top of the day job! So where to start?

This edition of the *Newsletter* feeds well into both the dementia and the IAPT work streams, with food for thought about supporting older people with dementia and in therapy, together with looking after staff and each other through a stronger process of supervision and some reflection on Mindfulness for therapists. I look forward to more than a quick skim read when I clear my 'to do list' and get the Christmas cards written. Who knows I might even take up Paul's suggestion of applying for a Churchill scholarship and go travelling. My recent trip to Zululand has reminded me that one of the aspects of many peoples' retirement is travel!

So where to start?

Firstly a date for your diary: I met with Philippa and Kate last week for discussions about the 2012 conference in Bristol on 14–15 June 2012. We are hoping to get special rates for people wanting a two- to four-day residential break to make a weekend of it. Clifton has great places to eat and Bristol has a fascinating history of the slave trade to explore. I have a special love of

Bristol as it is where I did my degree (as did Kate and Philippa – so we were able to reminisce, as well as to plan). The proposed topics on systemic issues for the Friday look fascinating. Thursday will be a workshop day on both the IAPT and the Dementia work streams. Flyers will be out shortly. The venue can only hold 100 people so first come first served.

I went from there to the IAPT South West Collaborative in Taunton to talk about the IAPT work stream (see presentation on their website). The group was very enthusiastic and has been doing some fascinating work with user groups about why they don't access services and some useful outreach work with groups such as the WI to try to explain how psychological interventions can help improve mood. I hope they will submit this for a future *Newsletter*. The IAPT work streams are going very well. The Department of Health has agreed to more formally adopt the work we have been doing (although we have to thank them for being actively involved with us all the way through) and they will have a member of their teams involved in each of the four working groups – Commissioning, Workforce, Long term conditions, and People with dementia and their careers. We had teleconferences at the beginning of this week to build on the work from 11 October and we have another full day at the Society's London office on 28 January. If anyone would like to contribute to one of the work streams we would be delighted to have you join us. We are hoping to develop commissioning guidance, Q and A sheets, workforce, training and supervision recommendations, and to improve the evidence base for this work.

Some of it will be showcased at Bristol and some through the October edition of the *Newsletter*.

Some of you will have received information recently through the IAPT collaborative for an expression of interest in developing Pathfinder sites for Long Term Conditions – the deadline for initial ideas was 3 January, but the detailed work will start in the new year – please send in submissions and encourage your managers/commissioners to do so to – we need to highlight your good practice.

Julia Boot has also visited the NW collaborative where many stunning pieces of work are going on – so we are slowly working our way around the country. Also on the IAPT front, a strong PSIGE contingent attended the New Savoy Partnerships conference in November – where Sue Watts and I presented a case for equality for older people. We were vociferous as a group in questioning the speakers and the conference was an excellent net working opportunity. Don set up a twitter relationship with Claire Gerada from the Royal College of GPs who was an excellent speaker. The presentations are available on the NSP website.

Liz Baikie is leading on the Dementia working group which has been actively contributing to discussions with Alstair Burns, National Dementia Advisor and the Department of Health – their work plan is developing and you will be asked to contribute actively to this.

Polly Kaiser has been contributing to the commissioning debate and the development of commissioning guidelines for older people and in primary care. Many of us followed this further at the DCP conference where the last afternoon was a very stimulating debate by four commissioners – they were clear that they would welcome conversations from psychologists working in the

field at all levels – so please find out who your local commissioners are and go and talk with them. The DCP conference this year was very relevant to our work, with excellent presentations on sleep, pain and head injury. Check out the sleep questionnaire on [www.greatbritishsleepsurvey.com](http://www.greatbritishsleepsurvey.com) as interesting for clients and ourselves.

At our last committee meeting we spent some time reviewing work Don Brechin has done on the Constitution – which now looks more up-to-date. We will be asking for your comments shortly at a special general meeting. We also discussed on a new title for PSIGE which would be more intelligible as we now much more outwardly facing work with colleagues from other professions and voluntary agencies and need a name which describes more clearly what we do and who we are.

Back to today: the DoN would welcome closes links between our two groups and is offering to co-opt someone who is a PSIGE and DoN member to attend both their and our committee meetings to join up work that we are doing and represent us in both groups: please contact me if you would be prepared to do this.

Finally – the DCP continues to call for suggestions for nominations for people for early, mid- and late-career awards – please send in some names and PSIGE will support your nominations –we need to publicise the strength of what we do more widely and recognise your skills and talents.

So – almost time to change trains, so I will sign off wishing you a healthy and active New Year.

**Cath**



# Using Terror Management Theory to understand the existential threat of dementia

Richard Cheston

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*This paper sets out an argument for understanding the subjective experience of people with dementia in terms of Terror Management Theory (TMT). This theory is a broad and detailed account derived from experimental psychological research of the way in which material that represents an existential threat to psychological equanimity triggers a range of social and personal defences. These responses are mediated by levels of self-esteem and include the process of mnemonic neglect in which threatening material is processed less efficiently and recalled less thoroughly. Using TMT to understand the responses of people with dementia has a range of clinical implications.*

Judith: *I just wonder where it's all going to end, that's my fear ...*

Janet: **When** *it's going to end?*

Judith: **Where** *it's going to end, where am I going to end up, just before the end, you know.*

Janet: *Oh, I see you mean, I talk about death...*

Judith: *Yeah*

Janet: *...to my family and I think the only thing that I'm frightened of is the unknown and that is death to me.*

Judith: *and after that. Oh, no I'm worried about what comes just before [laughs] it could be years before, couldn't it?*

Janet: *It could be tomorrow*

Robert: *Is it the dying that?*

Judith: *I don't feel that at all, no, because we all go through that, no I'm not frightened about that, no. It's not really my religion to say it at all, but I don't know if there's anything else and I'm not going to worry about that right now, you know.*

Facilitator: *So what is the frightening, when you say about the future?*

Judith: *Being, being useless, you know.*

Janet: *Yes.*

Judith: *Not having all my faculties, I dread that, I dread that, its as if I'm going to come to it one morning, perhaps, you know and think 'Oh my godfathers, what's left?', I really worry about that ... so I'm quite happy in a situation unless I chose to sort of sit there and think. And it's when I think about that, that the curtain comes down.*

From Cheston (2004).

**D**EMENTIA is not only a terminal illness, but one which involves progressive decline and impairment caused by neurological deterioration of most areas of the brain. The consequences of this deterioration in brain functioning are the gradual erosion of capacities that, for many of us, define what it is to be human. For those people who are affected by this illness, the

process of dementia is likely to involve ever-increasing levels of dependency until the point of death. With increasing dependency comes not only the loss of independence and the threat of becoming a burden on those we love and cherish the most, but also the occurrence of socially demeaning, even, shaming behaviours and capacities (such as incontinence and incoherence). As such,

dementia needs to be understood as being much more than a neurological process, but rather as one that both includes a complex network of social and personal factors, and as one in which death and deterioration are central features.

In this paper I will outline how findings from experimental psychology that relate to how people without memory problems react to reminders of their own mortality, can be used to further our understanding of the responses of people to their own dementia. Although these findings come from a branch of psychology that hitherto has not been widely applied to the experiences of people with dementia, I will argue that existential psychology can help us to understand both the nature of people's experiences of dementia, and also the reaction of those people who live around the person with dementia – their family care-givers, and also the health and social care professionals.

### **Existential approaches to dementia.**

Where issues around death have been explicitly addressed in dementia care, then this has tended to be in terms of palliative care or the religious or spiritual needs of people with dementia. However, whilst an explicit existential narrative may have been largely absent in dementia care, nevertheless existential themes abound throughout the psychosocial literature. We can see these existential themes in the concern about attachment (e.g. Miesen, 1993, 1999), through accounts of the person with dementia searching to establish meaning in life (e.g. Graneheim & Jansson, 2006; Örvulv & Hydén, 2006), or struggling with the dislocating loss of identity produced by a deteriorating memory (Sabat & Harré, 1992; Kitwood, 1997). Death and deterioration are sometimes like the elephant in the room in dementia care and research – we all are aware it is all about us, but finding a way to talk about it is harder: death permeates not just the experiences of the person with dementia, but also of those around him or her.

### **Existential psychology**

Existential thought holds that there are five essential realities, confrontation with of any one of which can be understood as a psychological threat :

- That death is both inevitable and final;
- That the achievement of independence and autonomy is limited and temporary;
- That life is essentially meaningless, and that no altruistic guiding hand or purpose exists other than those which we create;
- That each of us is inevitably alone, and that no matter how close our relationships are with others, we can never be truly and fully known; and
- That our identity as unique and valued individuals with special and distinctive qualities is a construct that we impose on the world.

Dementia places all of these threats before us: with increasing dependency comes the threat of personal and social isolation. The loss of cognitive integrity creates not only a threat to the way that we make sense out of the world, but also brings with it the threat of diminished self-esteem. In this paper, however, I will focus largely on the threat of death and decay that is implicit in the diagnosis of dementia

### **Death anxiety, terror management theory and 'the denial of death'**

Yalom (1980) defines death anxiety as a *'dread of death that resides in the unconscious, a dread that is formed early in life at a time prior to the development of precise conceptual formation, a dread that is terrible and inchoate and exists outside of language and image'* (p.189). Death anxiety, he argues, often shows in many apparently unconnected ways in the clinic:

*'It's not easy to live every moment wholly unaware of death. It's like trying to stare the sun in the face: you can only stand so much of it. Because we cannot live frozen in fear, we generate methods to soften death's terror. We project ourselves into the future through our children; we grow rich, famous, ever larger; we develop compulsive protective rituals; or we*

*embrace an impregnable belief in an ultimate rescuer ... But despite the staunchest, most venerable defences, we can never completely subdue death anxiety: it is always there, lurking in some hidden ravine of the mind ... Death has a long reach, with an impact that is often concealed. Though fear of dying can totally immobilise some people, often the fear is covert and expressed in something that appears to have nothing to do with one's mortality.'* (Yalom, 2008, pp.5-7)

Physical deterioration and death are fundamental and ever-present parts of a wide variety of health care services – including those services that focus on the needs of older people. Death anxiety is largely denied or repressed – it is not something that is typically a part of conscious experience but rather, to use Yalom's phrase, lurks *'in the hidden ravine of the mind'*. When we encounter reminders of death, even if this involves such an apparently trivial act such as passing an undertaker's office or a cemetery, then research evidence suggests that this activates defences that reduce death anxiety (Solomon, Greenberg & Pyszczynski, 2004). The experimental study of these social and cognitive processes involved is referred to as Terror Management Theory (or TMT) and seeks to explain the way in which individuals, when confronted within an existential threat, may manage to prevent knowledge or awareness of that threat from impinging upon their daily life.

TMT is a broad theory that seeks to explain how we deal with these existential threats. It is an answer to two, related questions posed by Ernst Becker – first, why people are so enormously concerned with their self-esteem? Secondly, why is it that people can often cling so tenaciously to their own cultural beliefs and have such a difficult time co-existing with others who hold different cultural beliefs to their own.

*According to TMT, to have feelings of self-esteem is to have a sense that one is not merely an animal destined to die and be forgotten, but someone who has lived a life of purpose and significance, someone who has made an*

*important and lasting contribution to a meaningful and enduring world.* (Routledge et al., 2010, p.898)

TMT argues that human society has evolved a series of structures and processes (such as the development of organised religion) that allow such existential terror to be managed. As a consequence of the use of these terror management strategies, for the most part, we humans are unaware of this terror in our lives. We live, as Ernst Becker has argued, within social systems that have evolved in Western society, to remove death from view, and to place the occurrence of death into hospitals, hospices and into the sanitised care of nurses and doctors (Becker, 1973). This removal of death to the margins of society prevents it from impinging on the mainstream consciousness – and thus the reality of death has, in effect been denied.

A central pillar of TMT is that when people are reminded of the inevitability of their own death then there is a strong tendency for them to act in ways that increase their levels of self-esteem. The principal way in which this occurs, according to TMT, is by the person re-investing themselves in what are termed *cultural world views*. These cultural world views may be religious, political, social or national in nature – they are those modes of organisation and belief structure which provide people with a sense of meaning, identity, and purpose. For some people this might be through a belief in the importance of their nation, whilst for others it might be through religious faith:

*'These world views consist of humanly constructed beliefs about reality shared by individuals in groups that provide a sense that one is a person of value in a world of meaning. Psychological equanimity thus depends on maintaining faith in an individualised version of the cultural worldview and perceiving oneself to be meeting or exceeding the standards of value prescribed by the social role that one inhabits in the context of that worldview.'* (Solomon, Greenberg & Pyszczynski, 2004, p.16)

The development of cultural world views means that in the face of threat, the world becomes a stable and orderly place – reminders of threats to our existence paradoxically provide meaning, identity and opportunities to increase self-esteem. Experimentally induced reminders of death (e.g. asking people to write about their own death, seeing photographs of death-related images) leads to participants:

- Showing greater commitment to romantic relationships (Mikulincer, Florian & Hirschberger, 2004);
- Having stronger feelings of affinity towards others who share important cultural beliefs and traditions, responding in a more hostile and aggressive way to those people seen to threaten or to be critical of these beliefs and a stronger certainty that these cultural groups are real entities and that they will exist into the future;
- Emphasising the importance of cultural icons (such as flags, anthems, people in symbolic positions of authority within the culture), and denigrating those symbols that seem to undermine one's cultural beliefs (Solomon, Greenberg & Pyszczynski, 2004);
- Stronger belief in the supernatural and in divine intervention, and a belief that one's collective self or cultural identity will continue to thrive in the future (Batson & Stocks, 2004).

In addition, intra-psyche defences are also activated: material that is threatening to self-concept is more poorly processed and thus is less well remembered than material that is more peripheral to the person's self-concept or which is self-affirming. This phenomenon is known as Mnemic Neglect (see below).

TMT focuses on how humans cope with the awareness of mortality and suggests that people buffer the potential for death related anxiety by advocating cultural worldviews that give their life meaning, by striving to attain and maintain feelings of self-worth, and by investing in personal relationships. Experiments that have tested these theoret-

ical postulates tend to make use of the mortality salience (MS) hypothesis. This proposes that if cultural worldviews provide protection from the psychological consequences of death awareness, then the activation of death thoughts through experimental conditions such as showing people images associated with death, or asking them to write about their own death (i.e. increasing mortality salience) will in turn increase the person's investment in their worldview, their strivings to maintain self-esteem, as well as investment in close relationships

In addition bolstering these structures either before or after MS induction lessens the need to deploy further psychological defences (Routledge et al., 2008). In other words, these psychological defences prevent the awareness of death turning into anxiety about death.

*In sum, when individuals are reminded that they are mortal and thus transient entities, they cling to the relationships, groups and beliefs that imbue their lives with purpose, stability and permanence; and these responses prevent death cognition from turning into death anxiety. (Juhl et al., 2010, pp.309–310)*

If, as I have argued above, the experience of dementia acts as an existential threat, then the behaviour of many people with dementia can be understood in terms of TMT. More specifically, many of the different ways in which people with dementia behave can be understood as serving a function of preserving psychological equanimity in response to an existential threat. Amongst these behaviours are those that are often represented as indicating a lack of awareness or insight – for instance the man who positions himself in a psychiatric interview as unimpaired, or the elderly woman who avoids contact with services and asserts that she still cooks, cleans and sews for herself even when her husband insists that he has taken these tasks over. Often this combination of a person attempting to bolster their self-esteem, and of selectively forgetting instances in which a memory problem has

been revealed is maintained even when this causes conflict with people and distress around them. At the same time, other people respond to their dementia with a thoughtful acceptance and determination to make the best out of their life. As such, these variations in behaviour are likely to be linked to social and personal differences in emotional resilience and fragility

### **Fragility and resilience**

TMT suggests that self-esteem is a buffer that serves to insulate humans from the anxiety that arises from existential threats. People with intrinsically high levels of self-esteem (i.e. a secure sense of their own identity and place in the world) are less likely to react to reminders of their mortality by retreating into a cultural world view. Conversely, people with low self-esteem – those, for instance, who, to borrow Yalom's phrase have a strong sense of an 'unlived life' – are more likely to be over-whelmed by both death anxiety and by the prospect of the decay and deterioration of dementia.

Research also indicates that other factors in addition to cultural worldviews and self-esteem may serve as a buffer against death anxiety. Thus, the existence of close and loving relationships may function as a death anxiety buffer. Social forces may also play a role as people may respond to death anxiety in gender stereotyped ways: males by withdrawing emotion and compassion (because they are socialised to display emotional strength and to value independence and instrumentality), whereas females increase compassionate responses (because they are socialised to be responsive to the needs of others and to show concern and care)

### **Mnemic neglect – hiding away from threatening material**

*'The mnemic neglect model posits that people are motivated to believe that they are good and to defend this belief.'* (Sedikides & Green, 2009, p.1057)

Mnemic neglect is a term that has been coined by Sedikides and colleagues (e.g.

Green, Sedikides & Gregg, 2008; Sedikides & Green, 2004, 2006; Sedikides & Spencer, 2007) to account for findings from the experimental literature which suggest that threatening material is processed in a different way to self-confirming material. The mnemic neglect model holds that people tend to think of themselves in positive terms – for instance, as worthwhile, competent and moral. However, it is only possible to hold onto this self-concept by guarding against material that is threatening to this version of self. Mnemic neglect is a first line of cognitive protection, and can be overwhelmed by more traumatic memories, which may be resistant to being pushed away.

Mnemic neglect suggests that although individuals attend to threatening material, they subsequently process it in a superficial manner, and without it being linked to other knowledge and memories that the individual has about themselves – in effect they tend to think about this material less and to remember it on fewer occasions. By contrast, individuals not only attend to and encode self-affirming feedback but also process it more thoroughly. Consequently, links are made between this self-affirming material and other memories, and the material is recalled more often. It is as if events or occurrences that suggest a critical view of ourselves, and which go against a positive view of ourselves are less likely to be understood as being representative – they are somehow pushed out of our memory in a way that events which confirm someone's view of ourselves are not. These, self-confirmatory events are more likely to be remembered, whereas self-threatening events are likely to be ignored (Sedikides & Green, 2009).

Whereas some psychological theories suggest that people try to resolve inconsistencies in how they view themselves and others, the mnemic neglect model emphasises the way in which individuals try to maintain the positivity of their self-conceptions, principally by protecting the self from unfavourable social feedback. Feedback which is negative (rather than positive),

which relates to central (rather than to peripheral) traits and which refers to oneself (rather than to others) is defined as self-threatening.

*'The thrust of the model is that people fail to process self-threatening feedback thoroughly. Self-threatening feedback ... will receive relatively shallow processing ... less long-term elaboration will ensue, resulting in fewer retrieval routes, and ultimately poorer recall. In contrast self-affirming feedback ... will receive relatively deep processing.'* (Green, Sedikides & Gregg, 2008, p.548)

Thus people not only tend to be poor at remembering unpleasant things that have happened to them, but are also poor at remembering things that threaten their sense of self. Mnemic neglect thus seems to be a self-protective strategy. At the same time, people are able to switch from avoiding negative feedback to trying to improve themselves and looking for positive feedback. When Sedikides and his colleagues looked at recognition rather than recall – that is to say when people were given an appropriate prompt – then they did remember what had happened. So at some level, this threatening material did exist within a person's memory – it was being pushed away rather than being lost completely (Green, Sedikides & Gregg, 2008).

A number of issues make the model of mnemic neglect relevant to dementia care. First, there are potentially a huge number of factors that can threaten the sense of self of a person with dementia: everything from an embarrassing moment of public forgetfulness, to a private moment of incontinence. If there are cognitive processes of self-protection that push this threatening material out of conscious recall, then this adds weight to an understanding of insight as not just a process of neurological deterioration, but also one that concerns emotions and the protection of an individual's sense of self.

A second important finding concerns the potentially cumulative effect of favourable and unfavourable feedback. Thus, for people with dementia, there is normally not

just a one-off event which can be pushed away, but a series of events which are all potentially threatening. When Green, Sedikides and Gregg (2008) looked at what happened when they gave subjects a series of different sorts of feedback, they found that while providing the person with a small amount of positive feedback before giving the negative feedback reduced mnemic neglect, receiving feedback which was unfavourable seemed to enhance the mnemic neglect effect. Thus if a person with dementia receives a series of unfavourable feedback, then they will be less likely to process this feedback or subsequently to recall this. Conversely, if we want to talk to someone about something that is personally difficult for them, such as aspects of their dementia, then it's probably best to begin the feedback with a more positive message to provide a boost to their self-concept.

Finally, there is the way in which research shows that the phenomenon of mnemic neglect is flexible. Under the right circumstances, for instance, subjects in research trials were able to switch from a self-protective stance of avoiding negative feedback, to an alternative position such as striving for feedback to improve performance. Experimentally, one set of circumstances that can trigger this switch was when feedback was provided by somebody that participants were close to, rather than by a stranger. What this holds out, then, is that if we are able to attend closely to the way in which feedback is given, then some people with dementia may be able to a more realistic way of talking about their problems and thinking about their needs. Talking about your dementia within a group of people with whom you feel comfortable and safe is easier, and more rewarding, than talking about your dementia to strangers.

As Sedikides and his colleagues recognise, the process of mnemic neglect in many ways seems to be an experimentally derived testing of features about memory and self-concept which psychologists and others have known about for many years. For instance,

it seems to act in a similar manner to the analytic concept of repression in which threatening experiences are unconsciously defended against. Moreover, research into autobiographical memory suggests that unpleasant things that happen to people are recalled less well than are pleasant life events. In part, this may be because positive events tend to happen twice as many times as negative events, but it may also suggest that as humans we are programmed to selectively remember some events more than others.

Mnemic feedback is also more likely to occur when feedback is provided to an individual about traits that are seen to be central and fixed, than about traits that are more likely to be seen as peripheral and modifiable. In this sense it is important to remember that dementia involves a threat to aspects of a person's being that are both central and fixed – dementia threatens such fundamental aspects of a person's being and which will not only persist, but become intensified over time. It is reasonable to suspect, therefore, that dementia will almost inevitably trigger those self-protective cognitive processes described in the mnemic neglect model. That is to say that once a person has been told about their diagnosis of dementia, they will attend to this, but process it more superficially, and be less likely to make associations between the dementia and the rest of their life. They will be more likely to attend to self-confirmatory feedback such as success in certain areas of their life, and to spend less time thinking about and processing those errors that occur.

The self-neglect for material related to dementia is a ubiquitous part of working, and living, with people with dementia. Time and again when I have met couples and asked them to talk about their lives, I have received a different version from the person with dementia and their partner: the person with dementia may acknowledge that they have been diagnosed as having this illness, but then describe how little their life has been affected, and list the many things that

they continue to do as they have always done. In contrast their husband or wife may gently (and some times not so gently) refute this list of non-changes, reminding the person of what they cannot do.

We can, of course, attribute the disparity between these two different versions to a loss of insight caused directly by the same neurological impairment that caused the inability to perform these tasks in the first place. What is also true, however, is that we are witnessing an interaction between neurological impairment and the self-protective cognitive processes involved in mnemic neglect. That is to say, the failure to process and remember their dementia reflects the person with dementia protecting themselves against the threat to their self-concept that dementia represents. As Linda Clare has argued, awareness involves both self-protective and self-maintaining strategies (e.g. Clare et al, 2008)

## **Conclusion**

*In sum, when death is salient, people deploy a variety of self-enhancement tactics and go to great lengths to live up to cultural contingencies of self-worth. Further, having a positive view of one's self typically reduces the need to rely on other psychological defences that bolster the symbolic self. Therefore, if death awareness has the potential to compromise psychological adjustment, self-esteem may play a critical mitigating role. (Routledge et al., 2010, p.899)*

Understanding dementia in terms of an existential threat to psychological equanimity, which is mediated by levels of self-esteem and can trigger a variety of social and personal defences has important implications for the work of clinical psychologists. First of all TMT allows us to understand many of the things that people with dementia say and do. Rather than indicating a lack of awareness, we can understand such behaviour as attempts to bolster self-esteem and to hold onto a world view which is consistent with a higher level of self-esteem. Where possible, creating an environment

which enhances a person's self-esteem, and which diminishes threats to the person's self-esteem are more likely to lead to the person being able to talk or think about threats to their self. Secondly, it is possible to create circumstances that increase and decrease the ability of people to think about their dementia. If we provide the right sort of environment (for instance, in group psychotherapy) where people can recognise themselves, then this will enable them to begin to discuss what is happening. Moreover, if we can convert our feedback about problems they experience into material that relates to peripheral and malleable aspects of self (rather than central and fixed aspects) and have it delivered by people they feel safe talking to, then it can be more easily processed. Once again this replicates an

important aspect of psychotherapy – the way in which people with dementia in groups are able to move from being overwhelmed by their dementia and instead see themselves as being essentially unchanged – the same person as they have always been, but coping with the effects of memory loss and the other aspects of dementia. In the jargon of experimental research participants moved from self-protection to self-improvement.

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# Dementia in Black and Minority Ethnic communities in Hampshire: Development of a Time to Change campaign

Thomas Richardson & Ann Marshall

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**I**T IS PREDICTED that by 2051 Black and Ethnic Minority (BME) groups will make up more than a third of the population of England and Wales and there will be 3.8 million older adults from BME groups (Lievesley, 2010). At present there are as many as 10,000 older adults from a BME background with dementia in England and Wales (Shah, 2008), and as the number of older adults from BME backgrounds is set to rise this will also increase rapidly. Given this it is important to note that those from a BME background appear to be at a greater risk of dementia. In the US, African-Americans have been found to have nearly twice the prevalence of dementia as their white counterparts (Demirovic et al., 2003). Similarly research in the UK has shown a higher prevalence of dementia in those from African-Caribbean backgrounds (Adelman, 2009; Richards et al., 2000). Richards et al. (2000) found that 22 per cent of an older African-Caribbean sample in London met the criteria for dementia, compared to four per cent for white British, after accounting for differences in education and occupation. There is also evidence that those with dementia from this ethnic group are younger, and have higher levels of vascular dementia, possibly due to higher rates of hypertension (Adelman, 2009). Other research suggests that the prevalence of dementia is only higher in those from BME background who have poor English (McCracken et al., 1997). However, those from a BME background with dementia also appear to be more cognitively impaired (Cooper et al., 2010).

Despite possibly being at a greater risk of dementia, there is considerable evidence for a lack of awareness in BME communities in the UK (Azam, 2007; Seabrooke & Milne, 2004). Many BME carers report having not heard about dementia before the person they care for was diagnosed, and many still not know the appropriate diagnostic term (Adamson et al., 2001). Indeed there is no word for dementia in Asian languages (Azam, 2007; Seabrooke & Milne, 2004), and many Asian service users with dementia do not see terms such as dementia or Alzheimer's as applying to them (Lawrence et al., 2011). Those from Asian backgrounds often see dementia as a part of normal ageing (Seabrooke & Milne, 2004; Turner, Christie & Haworth, 2005), and few see it as an organic disease (Seabrooke & Milne, 2004). There is a lack of knowledge about symptoms, with less awareness that personality and speech can be affected (Purandare et al., 2007), and those from BME background are less likely to see dementia as treatable (Seabrooke & Milne, 2004; Turner, et al., 2005). In addition there are high levels of social stigma around the illness in Asian communities (Azam, 2007; Seabrooke & Milne, 2004), with some seeing dementia as due to a lack of family care (La Fontaine et al., 2007) or related to religion (MacKenzie & Coates, 2003). Similarly Eastern European carers feel stigmatised and see dementia as 'insanity' and often attribute memory problems to physical health incidents such as falls (MacKenzie & Coates, 2003). Other research suggests those from BME communities sometimes blame the patient for their symptoms (Adamson, 2001; La Fontaine et

al., 2007), and those from Asian communities may fear dementia in the family damaging their prospects of arranged marriage (Mackenzie, 2006).

Perhaps as a result of this lack of awareness and stigma, research suggests that those from BME backgrounds do not know where to get help (Bowes & Wilkinson, 2003; La Fontaine et al., 2007). In addition language problems, stigma and concerns about confidentiality are seen as barriers to accessing services (Westminster Advocacy Service for Senior Residents/Dementia Advocacy Network, 2009; Seabrooke & Milne, 2004). A systematic review of evidence mainly from the US suggests that those from BME backgrounds access services later when their dementia is more severe (Cooper et al., 2010). In the UK research suggests that many from Asian communities often try to hide problems (MacKenzie & Coates, 2003), and only come to the attention of services when symptoms are severe (Seabrooke & Milne, 2004), or when people comment or carers can no longer cope (Mukadam et al., 2011). This means that it is harder for preventive interventions to be employed (Seabrooke & Milne, 2004).

Thus, there is of a lack of awareness about dementia in BME communities, and such a lack of awareness appears to prevent help seeking and may account for the underrepresentation of BME groups in dementia services (Moriarty, Sharif & Robinson, 2011; Seabrooke & Milne, 2004). There is evidence that increasing knowledge about dementia in these communities and helping them see it as an illness helps facilitate access to services (Mukadam, Cooper & Livingston, 2011; Seabrooke & Milne, 2009). Providing information and education for BME communities is, therefore, indicated (Moriarty et al., 2011; Seabrooke & Milne, 2003).

The Time to Change campaign ([www.time-to-change.org.uk/](http://www.time-to-change.org.uk/)) is a national campaign launched in October 2007 which aims to reduce stigma against mental health problems. This has tried to tackle discrimination in a number of different ways such as a

high profile media campaign with the help of celebrities such as Stephen Fry, community events, training for health professionals, and resources for employers. This campaign has reached 34 million people in England so far, and has been shown to improve public attitudes and reduce discrimination. An overview of campaign is provided by Henderson and Thornicroft (2009). Recently Time to Change has tried to target attitudes towards mental health problems in the South Asian community, after research showed specific problems in this community, such as causes being misunderstood, shame and secrecy, and fear of marriage prospects being damaged. Leaflets have been made available in Tamil and Gujarati, and a campaign was launched this summer in Harrow for the South Asian community. A local Time to Change campaign has also been running in Hampshire with various events to improve awareness including a stand at an Asian festival.

In Older People's Mental Health services in Hampshire, psychologists are currently working with the local Time to Change Campaign Manager and other staff to extend this anti-stigma campaign to target older adults. This will focus predominantly on attitudes towards dementia. We will link this with a campaign shortly to be launched with the South Asian community (this is the largest BME population in Hampshire, Hampshire County Council, 2009). Given the research described above, we believe it is especially important to tackle stigma and attitudes towards dementia in order to increase the number of ethnic minority older adults seeking help for memory difficulties.

We hope to achieve this in a number of ways using similar methods to previous local and national campaigns. Current ideas are:

1. Develop a leaflet on dementia for South Asian elders specifically. This will take a similar format to leaflets used on the national campaign and translations will be available. This will include a quote from a community elder about stigma in the Asian community, as well as information about dementia and available services.

2. Display a billboard at the local acute hospital. This is a work in progress, but is likely to contain a myth fact statement as has been done in the national campaign: Myth: Dementia is a normal part of ageing. Fact: Dementia is a disease of the brain. A focus group with a community mental health team for older adults has been conducted to develop additional ideas for anti-stigma for posters.
3. Liaise with local community elders, organisations such as the Asian elders' network, and religious leaders to help distribute leaflets and information.
4. Measure attitudes before and after the campaign in a sample from the BME community.
5. Work with shopkeepers to tackle stigma: service users and carers reported finding it frustrating as some do not understand dementia and sometimes ban service users from shops. It was suggested at a local user carer meeting to develop stickers for shops to put in their window to show that they are 'dementia friendly'.
6. Combine this work with a DVD which has been developed for the trust for those with early stages of dementia attending a 'Memory Matters' course. This includes a section by an Asian community elder on stigma.
7. Put descriptions of these activities on the trust website, and discuss at trust events.

This project in the early stages of development at present, and how many of these aims will be achieved is unclear. However, we believe that this campaign is important given that BME communities appear to be especially stigmatised towards dementia. Given the increasing number of older adults from a BME background, tackling attitudes towards dementia is essential so that help is accessed as early as possible.

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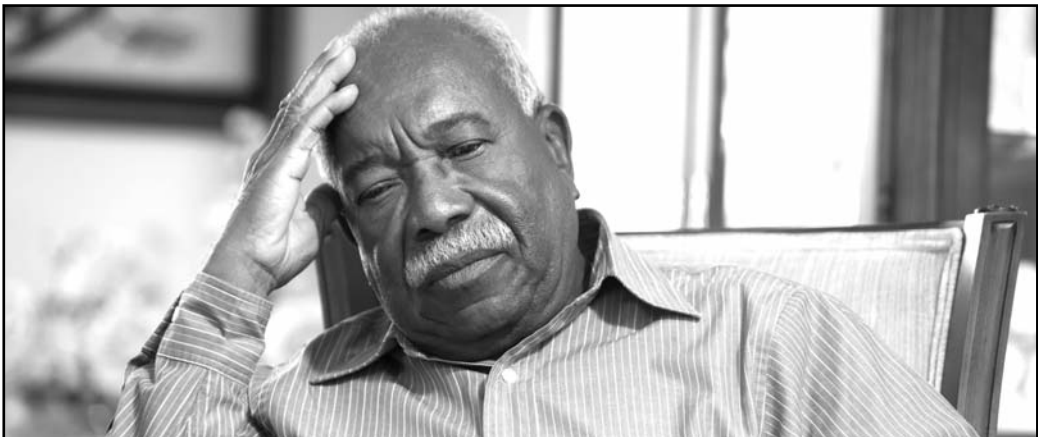
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# The use of naturally-occurring objects within nursing homes by residents with dementia

Alex Stephens, Richard Cheston & Kate Gleeson

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*This paper presents material from 30 hours of observations within a nursing home in the south-west of England. The residents' use of objects is evaluated in terms of a framework developed from Winnicott's description of transitional objects. The paper concludes that there is evidence that a number of residents were using objects in ways that met Winnicott's criteria, and that other instances of attachment-related behaviour were also observed. The implications of this for dementia care is discussed.*

**E**XISTENTIAL THOUGHT alerts us to one of the starkest of realities: that no matter the closeness of our relationships, we can never be truly known by others – that nobody else can completely understand us, our motivations, our desires and needs; no one else can truly walk a mile in our footsteps, let alone a yard or an inch. In this sense we are born alone, live alone and die alone. Even within the closest relationship lies another truth – that none of us can ever, ultimately, be known in the sense of that our experiences of life are, by their nature, ours and ours alone (Yalom, 2008).

And yet, human beings are invariably social animals. Indeed, it has been argued that it is the development of the skills necessary for social life, such as empathy and the ability to de-centre, that has enabled much of human evolution. Thus, our passing through the world is experienced as our being one among many – we build families and live in a multiplicity of groups. Moreover, it is the closeness of relationships – the feeling that I live as a 'we', and not as a solitary being that, for many, provides life with meaning and purpose.

The dilemma, then, is that of finding a way to balance what seems to be an almost universal need for companionship, friendship and love with a desire not to be overwhelmed or engulfed – to feel part of something whilst at the same time to remain

unique. This need for both closeness and support in the face of the inherent loneliness that we carry through life becomes most poignant when the external world is at its most threatening.

## **Isolation, abandonment and dementia**

Psychological ideas about the significance of loss and separation are especially important for dementia care, precisely because of the existential threat that dementia creates. As dementia erodes a person's capacity to communicate and to understand the world, so the ways in which someone has managed to create security is in turn undermined. The subjective experiences of people with dementia have thus been characterised as marked by feelings of loss, insecurity and separation, and represented within the paradigm of attachment (Miesen, 1993, 1999; Browne & Schlosberg, 2005, 2006). Within this conceptualisation, a person's fragmented experiences may lead to an increase in attachment-seeking behaviour, with the aim of restoring the person's feelings of security.

The experience of being lost or of living in a world that is both familiar and yet, at times foreign and unrecognisable, seems to permeate the descriptions of many people with dementia, especially when there are moderate or severe levels of cognitive impairment. Graneheim and Jansson (2006)

provide just one example of how dementia is often represented as being intimately connected to loss and isolation. They described a small-scale, qualitative study in which three people with dementia in a small residential home were interviewed over 10 sessions. Loss and isolation, even when that person lived in the midst of others, was the central aspect that connected the experiences of these three people living with dementia and their behaviour. What emerged from their observations and interviews was:

*A feeling of loss of meaning and emptiness ... the meaning of living with dementia and disturbing behaviour, as narrated by three persons at a residential home, was being in a world of disorder, wondering and restriction. Living with dementia further meant feeling lonely despite being surrounded by lots of people. (Graneheim & Jansson, 2006, pp.1399–1400)*

### **Transitional objects**

A transitional object is an object that the child can imbue with a wealth of emotions – anger, rage, grief, happiness. For children a transitional object eases the child between dependency on his/her mother and greater emotional independence (Busch, 1974). For a person with dementia, the goal is different. It is to cope with *'trauma and grief, to attain the best level of functioning, and to develop a treatment alliance for a patient with a progressively degenerative neurological illness'* (Loboprabhu, Molinari & Lomax, 2007). For a person with dementia, a transitional object or phenomena has *'a soothing function in the setting of gradual and progressive loss of self and object relations (including the internalised representation of the mother and various internalised objects) due to dementia'* (LoboPrabhu et al., 2007).

A handful of writers have discussed the use of transitional objects in dementia (e.g. Perrin & May, 2000). LoboPrabhu et al. (2007) have framed dementia as a reflection of childhood development and an increasingly unsafe situation in which people with dementia find it progressively harder to

access safe internal objects. They suggested that transitional objects can act as an 'anchor' in this period of uncertainty aiding the person with dementia with the transition to dependence.

One way in which the use of transitional objects by people with dementia has been explored has been through introducing dolls, or other objects onto a ward or nursing home (e.g. Fraser & James, 2008). Thus James, MacKenzie and Mukaetova-Ladinska (2006) introduced 14 dolls into two residential homes and recorded the reactions of 37 people with dementia living there. They asked carers in the homes about their impression of the impact of the dolls. Despite initial concerns, all staff reported that there were clear benefits of introducing the dolls, and that they felt their residents' lives had improved as a result. Thirteen of the 14 key workers also thought dolls improved communication. Residents tended to be more active, showed greater levels of interaction with staff and fellow residents, appeared happier, less agitated and more amenable to personal-care activities.

However, this research, like others relate to items, such as dolls, which are introduced onto a nursing or residential home. They do not concern how residents make use of materials that, if you like, occur naturally within the nursing home environment.

The study reported here examines the way in which residents within a nursing home used objects within their environment. The observations made across 30 hours of observations have been analysed in terms of whether or not they meet the seven criteria that Winnicott established to define transitional objects (see Table 1).

By investigating the relationships that people with dementia have with physical objects that occur naturally in their environment allows us to examine how attachment theory and specifically transitional and precursor objects apply to people with dementia. This would help to establish whether these theories can be viably discussed in relation to dementia and may

**Table 1: Winnicott's seven criteria for transitional objects.**

Winnicott's initial theory of transitional objects states seven criteria which must be fulfilled for an object to be considered transitional:

- The person assumes rights over the object and others agree to this assumption.
- The object is affectionately cuddled as well as excitedly loved and mutilated
- It must never change unless changed by the person
- It must survive instinctual loving, and also hating
- It must seem to the person to ... show it has a vitality or reality of its own.
- It comes from without from our point of view, but not so from the point of view of the person ... it is not a hallucination.
- Its fate is to be gradually allowed to be decathected (attachment feelings are withdrawn), so that over the course of years it becomes not so much forgotten as relegated to limbo. It is also possible to distinguish between transitional objects and precursor objects (Gaddini, 1978), which are soothing objects that infants can make use of before they have the capacity to invest in transitional objects.

Transitional objects may be particularly important during separation from the primary caregiver, supporting the child as they form an internal representation of the 'mother', and warding off anxiety and depression (Winnicott, 1953, 1971). Winnicott (1953) gives examples of transitional objects, including blankets, soft toys or repetitive words or phrases. However, he cautions that what is important is not *what* the object is but how it is used.

provide insight into some of the ways people with dementia find security. It would also add weight to the further use of other psychodynamic and developmental models in understanding the internal worlds of people with dementia.

### **Aims**

The study described in this paper aimed to use focussed ethnography to explore how people with dementia use the objects around them, and to consider whether they may employ some objects transitionally.

### **Method**

The study used a focussed ethnography method as described by Knoblauch (2005). Focussed ethnography is a shortened version of ethnography and can be used to evaluate a new addition to a system, or to shed light on a specific question or questions. Ethnography not only employs observations but can also use interviews, information from conver-

sations, photographs and documents. It was used in this study as it allows the observer to explore the world of the person with dementia, and tentatively interpret what they are observing (Hubbard, Downs & Tester, 2003).

### **Participants**

The study was completed in an adult community care home for people with dementia, Woodleigh<sup>1</sup>, which is situated in South-West England. At the time of the observations Woodleigh had twenty four residents all of whom had a diagnosis of dementia. In total, 27 staff members consented to be involved in the study. Twenty-one residents also consented to be included in the study, following the procedures set out in the Mental Capacity Act (2005). The study received approval from the Local NHS ethics committee and also complied with the lead Trust and the University of Bristol research process.

<sup>1</sup> The name of the care home, its residents and staff, have all been changed to provide anonymity.



### **Observations**

Thirty hours of observations were completed over a two-month period by the lead author. The data consisted of behaviour observations of the residents and staff and the researcher's conversations with residents and staff members. The researcher also took particular note of when a resident or staff member was interacting with an object in some way.

### **Analysis**

Ethnography alternates between data collection, the generation of hypotheses and the gathering of further information to confirm or deny the hypotheses in an iterative process (Hammersley & Atkinson, 2006). After a number of days of data collection and analysis, seven people were identified who seemed to represent different levels of functioning and had attachments to objects or other related behaviour. Although subsequent observation periods focussed around these people, other residents were not excluded from the observations.

### **Results**

For clarity the results that are presented here will be organised around Winnicott's seven criteria of a transitional object (see Table 1).

1. *The person assumes rights over the object and we agree to this assumption.* Encapsulated within this theme is the dual idea both that the person knows that object belongs to them and that others understand its value to the person. There were many examples both of people at Woodleigh ensuring that others know the object belongs to them, and of staff understanding the value of certain objects. Evidence for this came from residents being distressed when they are separated from the object, as well as carers and other residents taking care to reunite the resident with the object.

*Alice* – Alice had arrived at Woodleigh with her husband. For a number of reasons her husband had had to go to another care home. Since his departure Alice had carried around a plastic doll in the style of a young

baby. Over recent months she had begun to use the doll only at night. On the one occasion Alice was observed with the doll during the day she would not let go of it, and become distressed at the thought of it being taken from her:

(1.1) *Day 4, page 10: Paul (a care assistant) returns to help Alice with her tea, she is staring straight ahead, the doll up by her chin.*

*P: Why so serious? (Paul goes to move the doll away from her chin) I'm just moving the baby down.*

*A: My ba baby. You can't have my ba baby. No! (she hangs onto the doll's foot).*

2. *The object is affectionately cuddled as well as excitedly loved and mutilated.* There were many examples of objects being affectionately cuddled, generally these were dolls or soft toys, but other objects were held affectionately, for example, a cup and a tambourine. For instance, Henry was a gentleman with Down's syndrome who had recently arrived at Woodleigh. During the observations Henry was regularly seen with a Popeye doll; he was also observed to carry teddy bears and magazines in Popeye's absence. However, it seemed clear from his facial expressions that he had a preference for Popeye.

(2.1) *Day 1, page 11: Henry holds Popeye to his chest and then picks it up so they are face to face. He touches noses with it. (.) He watches Popeye and then shakes him from side to side.*

Mutilation was operationally defined as misuse, including being spat upon, ripped or torn. At times the person with dementia did not show any obvious indication that they were consciously aware of the misuse of the object, but the object would nonetheless be required to withstand this rough treatment. Thus, Ruby had been at Woodleigh for a number of months. Before her arrival she had started to carry a knitted doll at home. She had named him Robert, but often referred to him as 'my baby'.

(2.2) *Day 5, pages 5–6: Ruby puts her doll down on the table; she places him on a gravy patch. She picks him up again.*

R: *He's all wet, he keeps getting wet. I don't know.*

*She puts him in the gravy again. I notice that she has gravy all over her hands.*

3. *It must never change unless changed by the person.* Just as many parents recognise that to change their children's transitional object, risks the object losing some special quality known only to the child, so staff at Woodleigh also recognised that they should not alter those objects which seemed important to the residents. In a preliminary visit to the home the deputy manager explained that Robert would often get very dirty but the staff knew Ruby would not want him washed. If he got particularly bad they would try and take him from Ruby in the night and wash him and tumble dry him so he was available quickly. During the observation period Ruby became distressed at Robert being changed:.

(3.1) *Day 9, page 2: Ruby enters the sun lounge. She has spilt some juice and Robert has got wet. She sits down next to me.*

R: *My baby. (She raises Robert to her mouth and goes to kiss him.) You smell Robert you do, I don't want you now.*

*She puts him on the chair next to her. She then picks him up, holds him and puts him down again. She picks him up and stands. 'I'm going home' She leaves the room.*

4. *It must survive instinctual loving, and also hating, and, if it be a feature, pure aggression.* Winnicott's fourth criterion differs from the second (the object is affectionately cuddled as well as excitedly loved and mutilated) in that it requires the object to be strong enough to survive primitive loving and hating. This concept is tied up with Melanie Klein's work on primitive relating; the child tests out aggressive and loving instincts with the transitional object and the object is required to withstand both.

(4.1) *Day 1, page 3: Henry wakes and picks up Popeye. He holds the doll's nose to his nose and rubs noses with him. He lifts Popeye up higher and then bounces him on his knee.*

*He lifts him up as high as he can and brings him down saying 'Weeeee'. He then cuddles Popeye hard holding him to his chest and vigorously pats his back saying 'Ahhhh'.*

*Henry holds Popeye tight and rocks him hard.*

Here Henry bounces Popeye in an aggressive form of loving and he is expected to withstand this. This is similar to observation 3.1 where Ruby states she doesn't want her doll. However, in this example, the doll is expected to withstand this strong physical expression of affection and still be available when Ruby reaches for it.

5. *It must seem to the individual to give warmth or to move, or to have texture, or to do something that seems to show it has a vitality or reality of its own.'* There were many examples of instances when the object seemed not only to give warmth or have texture, but also to be animated by residents, who seemed to give them 'life'. It seemed that these individuals both 'knew' their objects were not real but also acted 'as if' they were real.

(5.1) *Day 4, page 8: (Alice) looks down and smiles at the doll.*

A: *So yeah, yup, yeah (she bounces the doll up and down) up, yeah (she smiles at the baby and then rubs her knee). Yeah yeah, um um, yeah yeah (she is looking at the doll and this seems to be a soothing chant to the doll) yeah yeah.*

Later on the doll is moved and Alice hangs onto it just by its foot, indicating that she may know that it is not real. In this sense the object appears to have both the qualities of a baby (who can be played with and affectionately cuddled) and also an inanimate doll, who can be suspended upside down.

6. *It comes from without from our point of view, but not so from the point of view of the person. Neither does it come from within; it is not a hallucination.'* This is a particularly difficult criterion to observe and involves the idea that the object both 'stands for' part of the infant but also 'stands for' part of the mother.

(6.1) *Day 8, page 2: After a few minutes Marge comes in carrying the blanket, her*

*cardigan/book bundle and now a coat hanger. Paul asks if he can carry something for her, but she says she has responsibility for them. She is struggling to carry all of this and her two sticks. I approach her.*

*I: Are you alright Marge? What are you carrying?*

*M: Myself dear.*

The observations at Woodleigh indicated that there were times when the objects stood for an attachment figure. However, as the individuals had experienced numerous attachment relationships the object could potentially stand for any, or all of these attachments.

*(6.2) Day 4, page 3: Marge starts handing the cards to Phoebe again.*

*M: They remind me of my children. I am mother to one and aunt to another.*

When writing about transitional objects, Winnicott (1971) was clear that although they partly stood for the attachment figure they could become more important to the child than the attachment figure. This appeared to occur for the participants and some individuals held onto their important objects throughout visits from their family. In addition the researcher was told Ruby had arrived at Woodleigh with Robert and that she had used him while still living at home.

*(6.3) Day 14, page 2: Ruby came (to Woodleigh) with Robert. ... When her family visit she holds onto Robert just the same as when they are not there.*

In summary there often seemed to be a connection between the person's objects and either their attachment relationships or themselves. Frequently the same object seemed to be representing both at different times.

7. *Its fate is to be gradually allowed to be deattached (attachment feelings are withdrawn), so that over the course of years it becomes not so much forgotten as relegated to limbo. People may have changing relationships with objects based on their internal state. For instance, objects may be more important to people at times of greater insecurity, such as moving from one form of care to another. This is*

perhaps best illustrated by Alice who was using her doll less frequently during the day.

*(7.1) Day 6, page 7: The staff also said that they thought Alice felt differently now about her doll than she used to. They thought she wouldn't be as upset now if someone tried to take it.*

Carers who had been at the home for a number of years remembered Alice carrying her doll everywhere. Now, as Alice mainly held the doll during the night, carers believed it helped her sleep, and instead she spent much of the day rubbing the fabric of her clothing and her skin.

## **Discussion**

The results suggest that at least two residents (Ruby and Henry) employed their objects in a traditional transitional object way, in that their objects fulfilled all the criteria of a transitional object and they had used them over a period of time. Alice appeared to have used her doll in a transitional way but her use of objects seemed to be moving into a more precursor phase and she made use of the tactile nature of her surroundings. She still used her doll at night, but its importance during the day was gradually being lost. Finally, Flo appeared to use objects in a way that is described in the literature as purely precursor way. She would stroke and feel her environment, move her mouth in an exploratory way and suck hard on anything that was introduced into her mouth. The key difference between precursor objects and transitional objects is that precursor objects are thus not discovered by the individual, but given to them by another. Precursor objects are thus not invested into in the same way transitional objects are, rather it is something about their tactile quality which is important.

### ***Use of transitional objects in dementia***

While the course of this study was for a matter of weeks, and not months or years, the history provided by care staff suggests that at least three residents had used the objects over at least a year. However, some objects that residents used, seemed to be

used on a temporary basis, in that at different times they seemed to have a meaning that was subsequently not present. Interestingly, the child literature suggests that transitional objects can occasionally be transient and change over time (Mahalski, 1983). In these cases the objects often all have some similar special quality, such as a specific tactile sensation, and in actuality it is this sensation that serves as the transitional phenomena.

One reason for the temporary nature of some objects in dementia is our differing responses to people with dementia and children. In child development parents may encourage their children to form attachments to objects by carrying them round and making them available (Litt, 1986). The observations did not show staff consistently acting in the same way and while staff would help an individual to find their treasured object, at other times the temporary transitional objects would be taken from an individual. If staff had more effectively encouraged attachment to objects rather than to remove them, then more people may have had traditional transitional objects.

#### ***Why might transitional objects be useful for people with dementia?***

Winnicott (1953) suggested that there exists for all of us a third space between external and internal reality, the transitional space. In childhood, with good enough mothering, this space can be traversed and the transitional object aids this process. In healthy development the third space never disappears but is thinned, and expressed in play and creativity. A similar, but reversed, process may be occurring in dementia where increased cognitive impairment results in increased difficulties in making sense of the external world. Consequently people's sense of self and their internal objects are under threat or degraded (Loboprabhu et al., 2007). As a result of these changes the intermediate space may be opened further and a transitional object could again be useful to help the person traverse this space.

Just as the child is soothed by investing the object with a sense of their attachment figure, so in the dementia care home attachment figures are not always present and the process of dementia may render internal representations of these attachment figures unavailable at times. Therefore, a transitional object may help people with dementia by being something tangible which represents an attachment figure or figures, when the internal representations of these may be elusive. The observations indicated that at times people did invest their objects with a sense of their attachment figures, for example, Ruby naming her doll after her husband or Marge saying that the cards reminded her of 'her children'.

#### ***Why might precursor objects be useful for people with dementia?***

Initially, in child development, precursor objects are thought to gain their effectiveness as they are reminiscent of the sensations the infant experiences during feeding. Hence the first precursor objects are 'into the mouth' objects. Later a tactile precursor object may also provide soothing qualities, but this too represents the tactile sensations experienced during feeding (Gaddini, 1978). In dementia something subtly different may be occurring. While the soothing nature of an oral or precursor object might not represent the feeding sensations experienced in infancy, there is something inherently comforting about tactile and oral soothing gestures, which may come in part from this early experience. This could explain the repetitive stroking and oral movements observed during this study.

In summary it appears that at least some of the people at Woodleigh were using either transitional or precursor objects for some of the time. It could be that these objects enable the person to 'conjure up' a sense of good enough attachment relationships that they have experienced throughout their life and thereby support them with their transition from independence to dependence.

## **Conclusions and clinical implications**

The process of the research looked at the symbolic ways in which people used naturally occurring objects and it was clear that often objects would serve purposes other than as transitional objects, such as activity or status. Similarly, the use of repetitive movements could also be seen as offering occupation and activity as well as being a 'precursor behaviour'. Although Winnicott's theory on transitional objects may not offer a definitive explanation for how people with dementia use objects it is a useful theory to help explain what is happening in the relationship between people and their objects and what psychological struggles this may represent. It can be a framework for not only understanding why interventions such as doll therapy may be effective, but also why people have a need to 'hang on' to objects beyond their initial use. In addition it may provide at least one explanation as to why people with dementia use repetitive movements and vocalisations.

Dementia care research is at an early stage in applying both attachment theory in general and Winnicott's theory on transitional objects to the experience of dementia. However, this study shows that people with dementia can make use of transitional objects and thereby lends weight to the use of Winnicott's theory on transitional objects in exploring and explaining the internal worlds of people with dementia. If these objects are indeed an '*external sign of an internal process*' (Winnicott, 1953), then Winnicott's theory on transitional objects can be a valuable tool in understanding the behaviour of people with dementia, in looking at why certain interventions such as doll therapy or Simulated Presence Therapy (Cheston et al., 2004) might prove beneficial, and in training and supporting people

who work in this area. In order for dementia care to develop a fuller understanding of the phenomenology and needs of people with dementia, it is important that other psychodynamic theories including object-relations and attachment should be considered when working with people with dementia and their carers (Davenhill, 2007).

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# Maintaining professional boundaries: Looking at the quality of supervision

Liz Young & Kate Keetch

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**I**N COMMON with most trusts, there has been a need locally in recent months to try and re-focus the area of professional and personal boundaries, the lines that need to be maintained between staff and the people they care for in their work. As happens from time to time, there were a series of incidents in which boundaries were not observed, where relationships between staff and patients or relatives were muddled, and clear lines were not observed. The Trust has a clearly defined policy on professional and personal boundaries, which states that 'staff must recognise and understand that they are in a position of power... (which) must not be abused at any time. ... This is essential to protect service users at a time when they are vulnerable, and to protect staff from risk of potential false allegations.' The policy goes on to list the ways in which things can go wrong, such as sexual misconduct, financial abuse of patients, use of service users' belongings and intrusion in their homes, to name but a few.

However, as with any policy, it was not clear how many staff knew of its existence, and had read it, and understood its significance. On talking to staff, views ranged from knowing nothing about boundaries or the policy, to full knowledge and understanding, but there was concern among some managers that too many staff seemed to have no idea about why maintaining boundaries is so clinically important. It emerged that many staff have had no training in this area, and it is not something that is addressed at induction. Arising out of this concern, coupled with some disciplinary issues in other local areas, it was decided that there should be some training delivered to reinforce the message of the policy. In the course of doing

the training, the issue of supervision came up over and over again. Many of the issues we were discussing could and should have been raised in supervision, but it seemed that, especially on the wards, supervision was not always happening at the appropriate intervals, or even at all in some cases, particularly, it seemed, for unqualified staff. Health care support workers in particular seemed to lack supervision, or to have had negative experiences in their supervision. Good, supportive supervision relies on many factors, some resource-based such as confidential room space and time, but there are also some psychological factors such as the quality of the relationship between participants. For it to be supportive and helpful, the supervisee must be able to trust their supervisor, particularly in terms of confidentiality. Good supervision is described as giving '...empowerment and support ... the cornerstone of clinical/professional practice' (Faugier & Butterworth, 1994). Our local policy describes the focus to be to '...allow time for exploration of problems ... to reflect on the content and process of their work.' It is self-evident that good supervision is a complex psychological process which needs time and attention to work well.

There had been an audit of supervision carried out some months prior to this, which established good figures for the frequency of supervision for clinical staff. However, this only looked at the regularity of supervision, not the quality of the experience for either party. Therefore, we thought it would be helpful to look at this in more detail – the importance of good supervision is stressed in all professions, it is deemed to be essential to good nursing, medical and psychological practice, and if there were problems,

it seemed vital to know this. So a small-scale survey was carried out to try and get an idea of staff's experience of supervision.

**Method**

A questionnaire was designed by the clinical psychologist and the assistant psychologist, and we tried to make it short and user-friendly to encourage co-operation. There were eight questions, relating to satisfaction, confidentiality and time available, offering yes/no options but with space for further expanded replies if wished. The last two questions are more open ones, asking about the value of supervision to them, and about anything respondents would like to change about their supervision.

The questionnaire was sent out to all clinical staff in the locality OPMH service, except doctors, as they have different arrangements for clinical supervision. The potential number of respondents was 184. The questionnaire was sent out via email, as being the quickest way to reach all staff, and the route was via managers of community

teams and inpatient areas, which we were advised was the most efficient route. The email was sent for forwarding on to all staff, and in terms of return, we offered several options. Respondents could choose to email it straight back to us, and it was pointed out to them that this would not be anonymous, or alternatively to maintain anonymity they could complete the questionnaire, print it out and send it back to us through the post, or place it in a sealed envelope in the box which we provided in each area for this purpose.

**Results**

We received 64 responses, out of a possible total of 184, a response rate of 35 per cent. The numbers and percentages for each response are set out in Table 1.

In general, most people were largely satisfied with their supervision, and feel supported and valued. The large majority felt that supervision happens in an appropriate space, that they have enough time to talk and that it is confidential. Most feel safe

**Table 1: Responses to the questionnaire.**

Questions	Yes	No	Other comments
How satisfied are you in general with your supervision?	50% (N=35)	8% (N=5)	'Somewhat' and 'Not' = 46% (N=29)
Do you always have supervision at the appropriate time interval?	71% (N=46)	28% (N=18)	
Is it in a comfortable confidential space?	92% (N=59)	8% (N=5)	
Do you feel you have enough time to talk about everything you need to?	84% (N=54)	15% (N=10)	
How much do you trust supervision to be confidential?	89% (N=57)	11% (N=6)	
How safe do you feel to talk about issues, whether professional, or personal issues which you feel may affect your work?	81% (N=52)	19% (N=12)	
What do you feel is the value of supervision?	See comments	See comments	
Is there anything you would like to change about supervision?	16% (N=10)	48% (N=31)	No answer = 36% (N=23)



to talk about difficult issues, and when asked to give details, people felt supported and valued the opportunity to discuss any issues and concerns, both clinical and personal. Those that chose to give comments about the value of supervision were very positive:

*'I have been able to discuss many aspects of my role including professional issues and reflection on practice. Supervision is an aspect of my working role that I look forward to each month.'*

*'I feel supervision is of great value. I also feel supported by my supervisor and find her trustworthy and she tackles any issues and concerns relevant to my job role.'*

*'To be able to have confidential discussions with my manager whether about clinical or personal issues.'*

However areas of concern were identified. We identified several themes of dissatisfaction from the questionnaire data:

- Lack of frequency and protected time;
- Lack of appropriate space;
- Lack of confidentiality;
- Issues raised not addressed;
- Box-ticking exercise;
- Changes needed.

### **Lack of frequency and protected time**

Eighteen people did not think they had supervision at the appropriate time interval (Question 2).

Ten people did not think they had enough time to talk about everything they needed to (Question 4).

*'Too rushed. Staff required to give patient care or staff have too much to do to relax and give full attention, often disturbed.'*

*'Tends to be whenever it can be 'squeezed in' between clinical work and sometimes it becomes overdue because of workload other commitments.'*

*'Done during lunch leaving barely any staff to serve lunch.'*

*'Usually go six months in between.'*

*'I went for over 18 months without supervision, even though I kept requesting it. I have a new supervisor now, last had supervision February 2011.'*

### **Lack of appropriate space**

Five people did not think they had supervision in a comfortable space, or no rooms suitable

*'There are no really comfortable spaces, we usually use the manager's office but can be and quite often are disturbed.'*

*'No rooms on ward suitable.'*

*'(Takes place) at nurses station due to need to keep watch on patients.'*

### **Lack of confidentiality**

Six people did not trust their supervision to be confidential (Question 5). Twelve people did not feel safe to talk about issues affecting their work (Question 6).

*'Has left confidential documents lying around. Worry it will be gossip.'*

*'People's personal paperwork left lying around.'*

*'I have overheard 'gossip' about other people's affairs.'*

### **Issues raised in supervision are never addressed**

Nine people felt no value to supervision (Question 7).

*'I can't see the point of supervision at it doesn't sort out any difficulties.'*

*'Issues raised never seem to be addressed.'*

*'Not listened to, opinions not valued. I feel de-skilled and undervalued.'*

*'No interest is taken, no support or loyalty.'*

*'Things, problems, queries do not get sorted.'*

*'Staff feel undervalued. Morale is very low.'*

### **Box-ticking exercise**

Nine people felt no value of supervision (Question 7).

*'Rushed, it's a paper exercise, always short-staffed, no time to talk.'*

*'A rushed paperwork exercise for the supervisor. A compulsory 'thing' that has to be done!'*

*'Tends to be a 'box-ticking' exercise, and an opportunity for management to 'dump' more work and responsibility on me!'*

*'No value, paper exercise, don't feel supported.'*

## Changes needed

Ten people wanted to change things about their supervision (Question 8).

*'I would like to feel supported. I would like to feel that my contribution and experience count for something and are taken into consideration, instead of feeling health care support workers are dogsbodies that have no intelligence or right to speak.'*

*'To choose my own supervisor. Have enough notice to prepare for next session. Have a personal copy of the supervision session.'*

*'Supervision should be set in advance and staff given date and time so they have time to prepare anything they may wish to discuss especially if they feel the allotted time is not adequate.'*

*'Perhaps that there is more protected time for the supervisor as one feels that somehow they are always pressed for time and that this is not a valuing experience for the person being supervised'*

*'There should be protected time for this to happen, if there is a shortage of staff supervision is postponed and it should not be. There is a lot of supervision to be completed every month for so many staff so the staffing levels should reflect that.'*

*'I have only had two supervisions since joining the Trust, both with different people, so I would like consistency.'*

## Discussion

The method chosen for this survey might appear highly inefficient, in that in the form of an email it left room for people to simply ignore it, and it may also be that not everyone actually received the survey, since it relied on managers to disseminate it to staff. It is also probably the case that some staff still do not often use email, or may not have easy access to a computer at work. It is certainly true that another method might have achieved a greater return rate, but the disadvantages should be weighed against the benefit of anonymity. Using this method helped to ensure anonymity as far as possible because people did not have to use email to return the questionnaire, and did not even

have to send it back through the post. Thus, people were hopefully freed to say whatever they wished in the knowledge that they or their work area could not be identified. However, this of course makes it hard to know which areas are doing well in terms of supervision, and which are not and may need attention, but it seemed important to access people's honest views and opinions, since a 100 per cent return without real opinions is worth very little. Therefore, we felt that 'quick and dirty' was better than the alternative.

It was good to see that the majority of people are fairly content with their supervision, and many people expressed positive views. Some made a point of saying how much they value the chance to discuss issues and concerns, both clinical and personal, and it helped them to feel valued and supported. They feel listened to, can plan training needs, and reflect on clinical practice.

However, it is also vital to know something about where the process is going wrong, and a proportion of staff made some very pertinent comments. Problems raised were that supervision does not happen often enough, it's too rushed, or it doesn't happen at all (e.g. six to 18 months without). Sometimes there is no appropriate space, including supervision at the nurses' station, supervision is often disturbed, confidential documents have been left on view and issues raised have been repeated to others. Some cannot see the point of supervision, staff feel undervalued and morale is low, difficulties are not sorted out. To some, it feels like just a paperwork exercise done so that the box can be ticked, but with no real interest or motivation.

It is disturbing to hear that these kinds of problems are occurring about supervision, and there are implications to consider. Firstly, if people are not receiving good quality supervision at regular intervals, they will feel undervalued, morale will be low, and retention of staff may suffer as a result. Care given to patients may not be as good if staff are not

supported to do the job well, which is of course a concern. There may also be problems with professional boundaries which go unchecked if staff cannot raise these issues in supervision, problems such as overly close relationships with patients, offers of money, or issues with families of patients, for example. Good supervision should enable staff to talk about these issues before they become big problems. But in order for staff to feel able to talk about difficult things, supervision must be seen and felt to be confidential and the supervisor trustworthy, it must be in a place and at a time that is protected, and there must be enough time to do this.

Difficulties in ensuring this may stem from various issues such as staff shortages, which may mean that staff members cannot be released to go to supervision, managers may feel they have not got the time and that there are too many other demands on them. Supervision may come low down in the priority order on a ward, and if it is too low down it may never happen. However, these difficulties in turn may not be the fault of the manager, who may value supervision very highly, but who may be frustrated herself with all the demands on her time. So responsibility must come back to localities and trusts to ensure that supervision can be prioritised, and that there are both the time and staff numbers to make this possible. There may also be training issues – have all managers had the opportunity to do any supervisor training, and if they have done this training, is it a one-off event, or should it be repeated every few years?

To sum up, most respondents responded with positive comments about their supervision, but a significant number made very negative comments, including one or two who were considering leaving because of the perceived lack of support. It seems that there are issues to be addressed here, and that perhaps more training is needed, both in why supervision is vital to good patient care, and also how to make it happen, and this is also something that trusts need to ensure.

In general, then, it seems that for some, supervision a positive experience, while for others it may be stressful, uncomfortable, or frustrating, or indeed may not happen at all. In discussing these findings with senior staff, the importance of supervision was recognised, but they admit that, in a time of scarce resources, it has to come further down the priority list than patient care, and may well just not get done. Vital tasks of patient care rightly come first, and there is often not the time or space to prioritise supervision.

This may mean, therefore, that issues relating to professional boundaries cannot always be discussed in the appropriate way, in a timely manner, and may therefore be missed. Staff may not be supported to manage difficult professional boundary situations in the best way, which may in turn allow problems to occur which could have been forestalled with good supervision.

Like so many other issues to do with working practice, when looked at from a psychological viewpoint, things become more subtle and complex, and this is difficult to manage in the context of high demand and financial pressures. It seems that there has to be a compromise, between good working practice and staff support, and the efficient and appropriate allocation of resources and time, in order to maintain both staff job satisfaction and good patient care.

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# From warding off to working through: Helping people facing a diagnosis of dementia to change their relationship with their memory problems

Naomi Betts & Richard Cheston

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**T**HE PROSPECT of facing dementia understandably provokes strong and powerful feelings. Dementia is a progressive illness, that can be treated but not cured, and which leads to the loss of many of those aspects of our being that most people see as defining themselves. A recent poll supports the argument that dementia presents an existential threat to psychological well-being. A 2011 YouGov poll commissioned by Alzheimer's Research UK showed that 31 per cent of 2000 respondents of all ages feared dementia more than any other illness – more than feared cancer (27 per cent) or death itself (18 per cent). When retirees were specifically questioned about which condition they worried about, then 52 per cent said that they worried about dementia, compared to only 33 per cent who worried about cancer and 30 per cent who worried about having a stroke.

This paper outlines how the Assimilation Model of Problematic Voices (APV), a model of change developed within psychotherapy process research by Bill Stiles and colleagues (e.g. Stiles et al., 1992; Honos-Webb et al., 1999; Stiles, 2001; Osatuke & Stiles, 2006) can be used to describe the relationship which a person with dementia has with their illness. The assimilation model suggests that most experiences in a person's life are unproblematic and can be assimilated routinely into that person's existing understanding of the world. However, some experiences are so traumatic and their implications are so threatening that they resist an easy or early assimilation. The

psychological processes that are often referred to as avoidance and repression (and which in the APV model are described as 'warding off') may act to push knowledge or awareness to one side. Yet unless these defences are exceptionally strong, the occurrence of such problematic experiences are almost invariably signalled by powerful emotions that accompany the partial assimilation of painful material.

## **Dementia as a problematic experience**

Events may become problematic for one of three reasons. First of all it may be that some events because of their extreme and traumatic nature are such that almost anyone would struggle to take the experience on board easily. Secondly, the capacity of different people to bear the emotional difficulties and pain inherent in assimilation will vary – with the intra-psychic processes of some people being more fragile or less resilient than others. Finally, if the ability of the social world around the person to sustain that person's attempts at exploration and assimilation is limited, then it will be hard for any change to occur.

The concept of dementia can be understood as being problematic, then, in the sense that the profound existential threat that dementia presents for individuals prevents an easy assimilation into existing schema. Within the Assimilation framework, the process of assimilation of problematic events within psychotherapy is represented as progressing through a series of eight levels, from Level 0 ('warding off') to Level 7

(‘mastery’). Not everyone who experiences events as problematic will pass through all eight stages – some may enter therapy with material already relatively well processed, whilst others may lead satisfying lives without ever fully integrating all their experiences.

The model outlined by Stiles and his colleagues has been applied to psychological intervention with people with dementia (Cheston, Jones & Gilliard, 2004; and Watkins et al., 2006). However, in this paper this model will be adapted to focus on the psychological tasks that dementia confronts people with, so that the eight levels of Stiles, will be grouped in terms of their tasks: helping dementia to emerge as the problems without being overwhelmed; identifying dementia as the problem while gaining distance; and working through by trying out problem solutions or partial solutions.

### **First task: Helping dementia to emerge as the problem without being overwhelmed**

The process of recognising dementia as the problem in a person’s life is inevitably a painful and difficult one. This is not just a cognitive process involving recognising, remembering and acting upon knowledge of a diagnosis, but a process that fundamentally involves affective and social components. Stiles and his colleagues suggest that the emergence of awareness is characterised by ambivalence in which opposing voices gradually become clearer.

*Warding off.* At first, in order to prevent the person from being emotionally overwhelmed by their experiences, information and knowledge about dementia is pushed away or warded off. Clients working at this level attribute all of their dementia-related difficulties to less threatening causes, such as a physical or sensory disability or just to a process of growing older. The person actively avoids discussing dementia and subjects related to dementia and does not recognise dementia or the problems associated with dementia as having relevance in their life.

Clients may avoid and not acknowledge difficulties in daily living or tensions within their relationships with others arising from greater dependency.

Successful warding off any problematic experience requires a high level of emotional energy, not only through the intra-psychic process of turning away from and avoiding any reminders of the problematic material, but also because of the high levels of conflict that consequently often arise within relationships. While levels of affect related to dementia are reduced, there can be powerful expressions of emotion related to the need to avoid situations associated with dementia. In this way, although the person with dementia maintains a powerful determination that nothing is wrong, often their avoidance of dementia-related experiences (such as agreeing to meet a doctor or nurse from a mental health team) suggests that they know enough to not want to know anymore.

*Unwanted thoughts.* Material related to the person’s experience of dementia tend to leak through and begin to come into conscious awareness. This can be intensely distressing or frightening as it threatens the loss of psychological equilibrium. Thinking about dementia is seen to be too disruptive or threatening to be tolerated. Dementia may be referred to indirectly – for instance, as ‘the problem’ or as ‘it’ or externalised, for instance, as a problem belonging only to other people. The person with dementia tends to change the conversation when the topic is brought up, or to stray quickly from the discussion of problematic, dementia-related experiences, typically leaving it to others to introduce the topic. One verbal marker of this level of assimilation can be seen when people describe a fear of losing control if they continue to think about the material. This occurred during the first sessions of the therapy group described in Watkins et al. (2006) where Mr E explains why he feels he needs to leave:

*Mr E: I find what we're doing now, it brings all memories to me, so and being around listening to you all, talking. I find I just want to be ... I don't think a memory loss and I don't, talking, and being around each other ... I'm not being funny about that. I'm trying to make a point that I'd rather be at home doing what I need to do, and want to do ... And I'm more energetic shall we say, more energetic than. And this is why I really don't want to talk about that you know, I mean I'm sure it's being selfish but, it's just the way I feel about it, I don't really want to be here.*

*Facilitator: Sometimes the things you remember that are the most painful, and you do want to forget about it all.*

*Mr E: Yes, that's exactly, yes that's exactly what it is ... Well I just, don't want to be here. I just want to be. I've got lots of things I'd like to do, and er. Well, I can't think about coming here, it just brings it all back.*

Honos-Webb and Stiles (1998) describe how the client in psychotherapy *'feels he or she should be able to cope with the distressing material without acknowledging its psychological/ emotional bases. And may use phrases such as 'tough it out' or 'soldier on'. The emphasis is on controlling or suppressing painful emotional material.'*

***Vague Awareness – the emergence of talk about dementia-related problems.*** In this level, the client manages to acknowledge the existence of problems related to dementia, but will, in the most part, not be able to name their problems as specifically being 'Alzheimer's disease' or 'dementia'. Alzheimer's or dementia are acknowledged to exist, but are talked about in general terms. While the person with dementia can talk about something being wrong, that 'something' may not be specifically associated with dementia. The hallmark of this level is intense, negative emotion.

The person with dementia may describe behaviours or episodes from their daily life that were unexpected and which they can not fully explain. These experiences are connected to cognitive or other errors that are potentially associated with dementia.

The client questions his or her own reactions but does not specifically associate these errors with dementia. The client describes the feelings of pain, vulnerability or distress associated with their experiences of dementia but without stepping back from this – it is as if they are at risk of being overwhelmed by these intense feelings, without being able to step back from them. Indications of this level include expressions of feeling stupid, silly, hurt, sad and anger. The feelings are implicitly associated with an experience or aspect of dementia, but this association is not made explicit. Thus one participant in a group said:

*But it's the, it's the quality of the emotions inside me that really, really gets to me. Because I think I've done something terribly wrong. Not wrong entirely wrong, it's just that it goes wrong. I mean today, I didn't have a clue where I was going to go to put my car. I don't think that comes into your, your mind, and as soon as that started, I just felt ridiculous.*

*I can't describe how really, really stupid I felt.*

The person with dementia is in distress, therefore, and this distress seems to come from some internal conflict relating either to dementia or to a primary symptom of dementia, and in talking seems to be caught up in the moment of the emotion. Thus the person may express feelings of sadness, depression, worry or anxiety or be angry or irritated about some aspect of dementia, or the reaction of people to them. At times the person may describe feeling overwhelmed and feel that things are getting worse.

### **Second task: Identifying dementia as the problem while gaining distance and perspective**

Clarifying dementia as the problem. The naming of dementia as the problem enables the client to talk about the impact that dementia is having on him or her and to describe how the dementia makes them feel (e.g. being angry, silly, embarrassed or sad). However, within this level, the person is not as caught up in the emotion of the moment as they are in the previous levels. This level is

marked by the emergence of mixed feelings about dementia – the person is able to describe both the sense of something being wrong, **and** also other aspects of themselves. The person with dementia is engaged in a process of stepping back and looking at him or herself and noticing how he or she is reacting to the dementia. Sometimes this takes the form of ‘yes ... but...’ statements in which the person seems curious about their feelings.

*Mr K: I tend to forget things that I've done the day before. It can be a bit embarrassing. If I'm, if I'm er, I'm reminded I get cross ... I suppose I'm feeling a bit silly when I've forgotten ... Well I realise I'm being silly, but even so I get a bit cross at times.*

*Facilitator: Are you cross with yourself or another person?*

*Mr K: I suppose it is against myself and I'm also, initially, I'm cross with the person who reminds me [laughs].*

In the later stages of this level, the client identifies aspects of their experience of dementia that makes it hard for them to talk about the dementia, or which produces another method of covering up. The stepping back from one's feelings may be indicated by using the past tense, and also the way in which a behaviour (e.g. hiding away, covering up, being silent, being angry) is associated with a feeling that the dementia-related experience has caused (e.g. being embarrassed, being scared). One woman told her therapy group that RC lead:

*I went into the local shop, around the corner from ours and I got to the front of the queue, and they asked me for my money, and I couldn't find it. I didn't know what I wanted or where I was so I ran out, and my husband was there. He said 'What are you making such a fuss about?' He always treats me as if I'm a little girl, it's embarrassing, but he's right – I need to try harder and to do things, but I'm scared to do them, so I don't know what to do.*

**Understanding and gaining perspective.** At this point, the person with dementia begins to be able to take some perspective on their

illness, and to talk about, rather than to be immersed within their feelings. They begin to make links between their reaction to the problematic material and other aspects of their lives. The most awful aspects of dementia are understood not to apply in all situations, once again resulting in an increasing level of complexity in the person's description of their dementia. For instance, the person may talk about a way in which their fear that they are going mad, causes them to avoid going to places where this feeling would be intensified, or where their dementia would be uncovered. Both the feelings about dementia, and also the reaction to these feelings can be described. The person's level of affect may be mixed with some unpleasant recognition, but with curiosity and even pleasant surprise as they begin to make sense out of the feelings that the dementia has provoked.

What distinguishes this level from the previous level is that the person with dementia understands how their feelings about dementia or aspects of their illness, relates to their wider life. For instance, they may make links with their past, or find some way in which their feelings can be managed. In this way, the person is moving away from being overwhelmed by the dementia to being able to talk about it, and to have some distance from it. The stuckness of previous levels begins to give way to some sense that the feelings around this dementia can be managed. As one woman said in a group:

*I know that my husband finds it hard when I can't remember things, it must be awful for him. So I try not to say anything at those times, or to go to my room when I want to cry. I know that it's silly, to have to cry, but I want to hide it from him, so that he doesn't worry. He's got enough to put up with, and even if it makes me feel a bit more lonely, well I feel that at least I'm doing something for him for a change.*

The person with dementia acknowledges the existence of a dementia or a central aspect of dementia such as a memory problem and is also able to describe how this makes them feel or how they react to this (but is able to

stand back from their feelings). Additionally, they either make links between the past and the present or between how they respond to some aspects of dementia and others areas of their life or other areas of dementia. Alternatively, the person is able to identify instances where their feelings are more or less intense, or their problems are more or less difficult or otherwise show that they have achieved some emotional distance from the dementia, rather than being overwhelmed by it, for instance, through use of humour or by comparing themselves with others in a worse position.

### **Third task: Working through, trying out problem solutions**

In the final levels of the assimilation model the person with dementia is able to find partial solutions to their problem, for instance, through making decisions about their life and their care. Often, they are able to talk about having made a change in how they understand their life and their dementia – and how others see them. At the same time, people understand that the problem of dementia has not left them and that indeed, their physical well-being will deteriorate. Watkins et al. (2006) described how Robert, a member of a psychotherapy group, looked back on the changes that he had made during the group.

*Mrs A: You have to face it to start with.*

*Robert: Well I think that's inevitable, we all wouldn't be here if we didn't do that. And so once we've accepted it, you need help from other people, you need help from ourselves, we need help from groups like this. I find I've got a great deal of moral uplift by coming here. Meeting with you, listening to the way you do it. And I don't see the problem now it frightened me the way, the problem of declining memory, until I came here the way I did before...*

*Mrs A: You didn't accept it then before?*

*Robert: Well I did accept it but it frightened me, because I thought, well I'm going mad,*

*I'm going crazy. What am, what am I going to be like in another five years? But now I realise that everyone here has the problem. So right stage two, so we're all going to get the problem, what do we do about it? You have to develop techniques to help you to remember.*

It may be that the person with dementia who is functioning at this level is more able to engage in trying out other strategies which offer a partial solution to aspects of their dementia, from using mnemonic aids to engaging in planning for a decline in their health by making an enduring power of attorney.

### **Case study: Laura<sup>1</sup>**

Laura is 59-years-old and is married to Steve. They have three children and two grandchildren. When she was referred to the memory clinic, she had just chosen to take early retirement in the expectation that she could spend more time sewing and walking their dogs.

At her first meeting in the memory clinic, Laura told the psychology assistant (NB) that while her memory wasn't much of a problem for her, it was worse when she was stressed and that consequently her confidence has declined. She felt there had been a gradual decline over the previous year but when she had first seen her GP about her memory she said he had told her that the memory loss was probably due to the menopause. Her husband, Steve, felt the decline has been more rapid in the last six months, saying that Laura is more repetitive, that she repeatedly checks things about the house, that she is often unsure about the day and date and that she struggles to learn new things. He also believed that Laura's personality had changed – she had become more bad-tempered and tearful. In terms of her day-to-day life, Laura continues to drive without difficulty and enjoys walking the dogs. Although she and Steve now share the cooking because he says she now needs help, this annoys Laura who strongly disagreed

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<sup>1</sup> All names and personal details in this case study have been changed to provide anonymity.



with him, saying that she didn't need any help at all. She maintained in the interview that she does the housework and that she often does her sewing (which is her hobby). Steve quietly corrected her, saying that they have a cleaner who had only been to their house that morning and that Laura hasn't done any sewing for the last two years. Similarly, while Laura said that she organised all of the household finances, her husband clarified this by saying all the bills are paid by direct debit and that all she does in pay cheques into the bank.

Laura found it difficult to listen to her husband's account and quickly justified or denied his observations. Laura could not remember that the cleaner had been to the house that morning. Talking about her functional ability made her very defensive and there was clearly tension between the two of them, as Laura swore at him in a half-joking, half-serious way.

At this point, Laura did not agree with Steve that there were significant problems with her memory. Any difficulties that he brought up, she attributed to poor concentration or to the menopause. Given that Laura's initial presentation included changes in behaviour, such as a decline in motivation, unexplained euphoria and irritability the possibility of frontal lobe changes could not be discounted. However, Laura's nervous laughter and heightened emotion within the assessment could equally be interpreted as fear and anxiety.

In retrospect, Laura's justifications and behaviour changes can be seen to fit within the assimilation model presented above. Whilst she vaguely acknowledged memory problems, her attribution of these to poor concentration or to symptoms of the menopause are consistent with someone who is struggling to acknowledge their dementia without being overwhelmed by this. In Stiles' APV model, these descriptions fall within the 'unwanted thoughts' level. Similarly her behaviour (e.g. her defensive approach towards her husband and choosing to stay in bed until mid-day), seem

to be an effective ways to avoid hearing or dealing with this problematic experience. This, together with her heightened levels of affect, are, again consistent with someone who is struggling to think about the emotional threat of dementia.

The results of the neuropsychological assessment revealed a series of deficits that were consistent with Alzheimer's disease. At this point, however, the doctors within the memory service were reluctant to confirm the diagnosis as Laura was still waiting to have an MRI scan. In this interim period, without a diagnosis, NB agreed to meet Laura weekly to work on improving her confidence by putting in place some strategies to aid her memory, plan some goals and to practise relaxation.

On NB's first visit and several subsequent visits Laura repeatedly responded to her greeting by saying *'I'm fine. I've been cooking, sewing, walking the dogs.'* It felt like a rote response. Initially, she found it difficult to engage with the relaxation session, but did agree to setting some goals, including wanting to start sewing again. Laura initially planned to completely make a pair of dungarees for her grandchild but then compromised and set a more modest, but achievable goal.

NB's next visit was very positive because Laura had achieved her goal of cutting the material for the dungarees and had really enjoyed getting back into sewing. Laura also engaged much better with the relaxation exercise, and after this had finished, she gradually began to talk about her childhood and the area where she had grown up. Eventually the conversation returned to her current memory problems and she and NB discussed her using strategies to support memory, such as writing instructions, using a calendar or diary and acknowledging that it's okay to rely more on recipes when cooking rather than stopping cooking. Again, she set goals for this next week included finishing her dungarees and baking.

Once again, Laura achieved her goals with success. She presented the cutest pair of dungarees which were completely finished

and to a very competent standard and she had also baked a lovely banana cake. She and NB reflected on her success and discussed how she felt more confident in herself. This week she engaged fully with the relaxation and asked NB whether she could notice an improvement in her.

At NB's next visit Laura reported that she had written herself instructions for operating the television and washing machine and had started writing the day's events and future plans in her Filofax. She had implemented these strategies independently, without help from her husband and was very pleased with herself, as she had found them helpful. This was really the first time that Laura seemed to acknowledge that she had a memory problem.

Laura was really feeling the benefits of regular relaxation and made one of her goals to do some relaxation every day. She also acknowledged other ways she relaxed, such as walking her dogs daily. She was now establishing more of a routine for her week and getting up with her husband instead of sleeping in, and while she still repeated her rote response of, *'I'm fine. I've been cooking, sewing, walking the dogs'*, she was talking more in the sessions about her memory loss and how she was managing it. She was developing a more resilient attitude towards the situation often stating, *'It's not going to beat me.'* She was also much calmer and the nervous giggles and outbursts of emotion had subsided. She and her husband felt like they had the 'old Laura' back. What had initially seemed possible indicators of frontal lobe damage, now seem much more clearly to have been caused by fear and anxiety about her memory problems.

The emergence of talk about dementia-related problems indicates that Laura was beginning to deal with this problematic experience and progress through the levels of the assimilation model. By developing strategies to support her memory, Laura was demonstrating some 'vague awareness' of the problem but still not at a stage where she was able to identify dementia as a cause. She

was still clearly referring to the problem as *'it'*, for instance, when she told NB *'It's not going to beat me.'* However, her initially high levels of distress had significantly reduced. There is no clear-cut progression from 'warding off' to 'unwanted thoughts' and then 'vague awareness', but her avoidance had clearly reduced and Laura was beginning to both be more open about her memory as a problem and starting to manage her difficulties more effectively. This oscillating to and fro between the different levels represents attempts to resolve the internal conflict caused by a threatening problematic experience.

While Laura was functioning better, her memory loss was still very evident. One week NB asked after her grandchildren, who Laura looked after once a week. She stopped talking, her face went blank until she recalled that her 6-year-old grandson had been attacked by a dog. She was unable to recall which hospital he was in and mistakenly replied that he was still waiting for plastic surgery, when in actual fact he had already been discharged. This tragic event had only happened four days before NB's visit, and she had visited the local hospital everyday while he was admitted.

In the weeks preceding her diagnostic appointment, Laura was now talking about her memory loss more openly. During one session with NB she commented, *'If the Doctor says, 'Laura, you have Alzheimer's', I will be knocked off my feet but I'm not going to let it beat me.'* This was the first time that Laura had raised the possibility that dementia could be a possible cause for her difficulties. Until this point Laura had maintained her position that the problem was due to the menopause or poor concentration. This spontaneous use of the word 'Alzheimer's' suggested that Laura was beginning to tackle the second task that dementia creates – to identify dementia as the problem while gaining distance and perspective. While Laura was still scared that she might have dementia, she was coping with this much better and had also started talking to others, including

her husband, about her fears. Furthermore, she was planning a future for herself, regardless of the diagnosis thus demonstrating that she was understanding the problem and gaining more of a perspective regarding its effect on her life as a whole.

The next time that Laura met her psychiatrist, he confirmed to her that it was likely that she was suffering from Alzheimer's disease. NB met with Laura a week later and she appeared to be coping well with the diagnosis. She said she felt relieved to finally know what was causing her problems and felt that her sessions with NB had prepared her to cope with living with memory loss. She didn't feel the word 'Alzheimer's' needed to change her approach to life in any way, acknowledging that she will continue to problem solve and work towards maintaining a balanced life by monitoring her stress and continuing with relaxing activities, in order to achieve a good quality of life.

## **Conclusions**

Within the Assimilation model, apparent failures of memory for threatening material may reflect the activation of self-protective mechanisms which are initiated as an attempt to retain psychological equilibrium. For a person with dementia, a difficulty in talking about memory loss, or the causes of this may reflect the role of psychological and social factors, and not just neurological ones. As such, some people with dementia may be able to benefit from supportive and thoughtful interventions that address not just their need for cognitive rehabilitation, but also their fear and distress.

An apparent lack of awareness on the part of a person with dementia about their illness, or their partial and variable expression of insight is not an incidental aspect of clinical work with people with dementia. Rather the need to help individuals with dementia to develop and to sustain their understanding of their illness needs to have a central role within dementia care. Whilst clinicians may not be able to modify neurological damage directly, we can support and

sustain (and perhaps change) the way in which people with dementia respond to the psychological threat of this neurological deterioration.

It is unlikely that a person with dementia will progress neatly from one level to another in the assimilation model. As the condition progresses and the person is challenged with further decline it is reasonable that they should move up and down the levels as the work to resolve a series of internal conflicts caused by the new challenges that their dementia causes. Moreover, as Stiles and his colleagues repeatedly show, the process of therapeutic change rarely runs smoothly – even with people who face the problems of their life without cognitive impairment.

Laura's behavioural changes along with her apparent lack of insight when she first attended the memory clinic could easily have been mis-attributed to possible frontal lobe changes. Instead, the pre-diagnostic counselling sessions that she received allowed Laura time to address her fears and enabled her and Steve to think about a future of living positively with memory loss. The reduction in negative behaviours, due to fear and anxiety, aided the diagnostic process by ruling out frontal lobe changes.

Yet, very few clients are able to access pre-diagnostic counselling and without it many clients face the same range of confounding problems that Laura and Steve had to address when they were first referred: such as challenging behaviour, depression and a decline in quality of life. If this distress is not addressed, then the avoidance that it often generates may cause people to disengage from our service. With the role of health services and many clinicians often so heavily focussed on achieving a diagnosis, then there is a clear risk that some people who are frightened about their dementia will withdraw from services as a way of managing their feelings. By giving people a safe space to explore their difficulties, we are facilitating an opportunity for them to learn to cope with their difficulties, which improves their lives and the lives of those that support them.

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# God Bless Sir Winston

Paul Whitby

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**O**N A FREEZING morning in February this year I wandered around the back streets near the Houses of Parliament to the offices of the Winston Churchill Memorial Trust for an interview. This body was set up after the great man's death in 1965 with the stated aim of:

*'The advancement and propagation of education in any part of the world for the benefit of British citizens of all walks of life in such exclusively charitable manner that such education will make its recipients more effective in their life and work, whilst benefiting themselves and their communities, and ultimately the UK as a whole.'*

I was submitting an application to study Marte Meo, a particular process of improving dementia care that has been developed in the Netherlands and other parts of northern Europe but has not reached Britain yet. To do this I had to submit a brief plan of what I wanted to do and, importantly, how I would propagate any knowledge gained on my return. The interview was gentle but probing and extremely posh (a Lord, a Dame-Professor, an academic GP and a Major General). The panel seemed genuinely interested in the project and a couple of weeks later wrote to say I had been successful.

I have not been on my trip yet but I am full of enthusiasm and hope that other members of PSIGE will consider applying for this great opportunity.

## **A few facts**

Applicants have to be British citizens. Travel has to be abroad and for a minimum of four weeks, maximum eight. The Trust will pay your travel and living expenses and also insurance. You do not have to study health care; I have seen a presentation on 'Lighting in small churches in Germany and Italy', surprisingly interesting. Applications usually are taken in the middle of the year with a deadline about October.

My advice is Go For It if you can. The website is: [www.wcmt.org.uk](http://www.wcmt.org.uk).

## **Marte Meo**

This is a form of Video Interactive Guidance that has sprung from the infant development field and has been used with people with learning disabilities and recently people with dementia. The aim is to use video recordings of episodes of care or of interactions to identify good practice, to enhance sensitivity and responsiveness to the patient's communications. Generally videos of about care last about five minutes and the Marte Meo therapist will then spend maybe half-an-hour going over the clip in discussion with the carer or a group of carers. The emphasis is remorselessly on the positive and building on strengths.

I am attracted to Marte Meo as it promises a way of building up very practical and concrete skills in applied real life situations. It appears to be accessible to all levels of care staff. The founder, Maria Aarts, said of her instruction manuals that if you found a difficult word in them you could have your money back! As such it seems a fitting complement to more theoretical or attitude-based approaches like Dementia Care Mapping.

The website is: [www.martemeo.com](http://www.martemeo.com).

## Correspondence

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## Suggested reading

Alnes, R.E., Kirkevold, M. & Skovdahl, K. (2010).

Insights gained through Marte Meo counselling: Experiences of nurses in dementia specific care units. *Int. J. Older People Nursing*, 6(2), 123–132.

Alnes, R.E. (2011). *J. Res. Nursing*, 16(5), September, 415–433.

Moser, I. (2010). Perhaps tears should not be counted but wiped away: On quality and improvement in dementia care. In A. Mol, I. Moser & J. Pols (Eds.), *Care in practice: On tinkering in clinics, homes and farms*. Verlag: Bielefeld.



# ACT in an older people's psychology service: A note to self

Emma Hodges

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I AM A second-year trainee clinical psychologist who has been on placement with the Older People's Psychology Team, a service which provides psychotherapy, consultancy and neuropsychological assessment. The following are my reflections (written as a diary entry) on the use of Acceptance and Commitment Therapy with an 80-year-old lady called Jean. This approach was used as she had had CBT before, but did not feel it was right for her. Some information has been changed to maintain confidentiality.

## Dear Reflective Journal.

'Be willing, be willing, be willing.' I remember this was my mantra before each ACT therapy session with Jean, my first ACT client. Isn't it interesting how nothing has really changed? At the time I thought the anxiety of providing a therapy I was unfamiliar with was the product of being a trainee. Perhaps it largely is, but discussion with colleagues has left me wondering if it might be a product of being a clinical psychologist, forever facing the unknown. Either way, I discovered that ACT has as much application to me as the therapist as it does to the client: ACT concepts readily lend themselves to being practiced alongside their delivery. I hope to capture my learning in this entry.

**Experiential avoidance/control:** The most obvious example of trying to avoid experiencing distress came on day one of therapy, well, let me be honest, in the weeks running up to starting therapy. Many thoughts were running through my mind on a daily basis generating enough distress to kick my avoidance/control strategies into overdrive. Such

thoughts as 'I have no idea how to do ACT therapy', 'Jean will spot you are a fake', 'How can you relate to someone who has so much life experience?', 'How can you tell Jean that her lifelong strategies aren't as successful as she thinks?' I tried distraction, rumination, reassurance seeking, thought suppression: there was no shortage of effort in trying to control my experience of the distress, at times it lessened, but unfortunately it always returned. Yet this is the crucial point, it is not through a lack of trying that Jean, or anyone else, ends up continuing to experience distress! It just isn't successful in the longer-term. For someone like Jean, who had 80 years of experiential control under her belt, I was hesitant to ask her to identify her control and avoidance coping strategies and whether they had been successful for her in the longer-term. I discovered that reinforcing that it was not due to a lack of effort and highlighting the part society plays in encouraging our avoidance of distress helped us both to be more empathetic towards the use of such an approach.

**Willingness/Acceptance:** Introducing the alternative to the avoidance/control agenda was a moment I won't forget. The look on Jean's face may have a great deal to do with my tentative and somewhat mumbling explanation, but in short, you would think I had asked her to chop off an arm! Well, I may be exaggerating, but it was evident that in her 80 years she had not considered the possibility that distress may be a realistic part of life, to be honest I'm not sure I had truly considered it either. Each time I meet a new client I am confronted by their wish to have the distress dramatically reduced, if not completely removed. I can understand why,

but just how achievable is this? In some circumstance it may well be, but when life is intent on throwing up distressing obstacles to cope with, perhaps it is unrealistic. From discussions we had I think Jean's status as an older person made it particularly difficult at times for her to contemplate a future of willingness rather than continued avoidance/control. However, true to Jean's style, after a few weeks she said to me 'I guess if avoidance truly worked we would have found the miracle cure.' It was with this in mind that we pursued the option of living a life with distress as part of it and not always engaging in avoidance/control to eliminate it (But just between you and me reflective journal, by the end of therapy Jean reported a decrease in her distress levels: a bonus, but not the aim, of being willing perhaps?)

**Values:** I feel I must quickly follow on from the previous passage with some talk about values; after all, it is only in the context of valued living that willingness and acceptance are differentiated from resignation. However, if you asked me to define my values right now I would struggle! It potentially remains the ACT component that I and clients find the most difficult to articulate and yet the most crucial for progress. I had not anticipated how complicated it would be to define what one values. Values are not equivalent to goals – they cannot be ticked off when achieved. Some people refer to them as a 'direction' for life, such as heading 'east' on your life compass; you never completely reach 'east', but aim to head that way each day. However, I realise now that having a neatly packaged set of values from day one is not necessarily the aim. Rather it is the process of introducing the concept of values, contemplating, reflecting, altering, debating, redefining and so on that assists clients with bringing to life the reasons they are engaging with the challenges of therapy; values turn willingness and acceptance from a possibility to a reality. With Jean it is evident that as soon as she began to contemplate the type of life she wanted to lead and

the kind of person she wanted to be (void of other's expectations of course), the acts of willingness and acceptance took on a much more manageable and favourable light. In her eyes, resigning to a life with distress was no longer my request.

**Defusion/Self as context:** I guess it would be easy to stop here, reflective journal – Jean is working on being willing to experience distress in pursuit of valued living – job done. Yet that would be failing to identify the cunning ways of distress, that is: ACT proposes that one should be willing to accept distress as it is and not what it says it is. When my distressing thoughts were rampant, 'You're a fake', 'You won't be any good at this', it was time to take a look at these thoughts for what they really were. ACT reminds us of the power of language to makes us believe we are as it says we are. Take my thought of 'I am useless'; it's all too easy to take this to heart and feel the distress that results. ACT encourages us to see language for what it is: symbols and sounds with no real power until we bestow it by seeing ourselves as the content of the thought or by becoming fused with the thought. I had not come across a therapy with as many techniques and metaphors up its sleeve as ACT proved to have! Many of these are designed to help us to see ourselves as separate from the thought (by saying, for example, 'I am having the thought that I am useless') and as the observer of such thoughts. Jean reaped particular reward after we completed an exercise in externalising the distress. Initial upset from being in contact with the distress soon parted to make way for an A grade example of willingness: she described the distress objects as 'pets', which could accompany her through life and that she was now willing to have, amazing.

**Being in the present moment/mindfulness:** Jean was a lifelong yoga fan and user of relaxation techniques, which both helped and hindered her with learning to be mindful. On the one hand she was experienced in



setting aside time to focus on a skill, on the other she was used to trying to empty her mind of all distraction. Mindfulness is about paying attention to the content of our minds and not judging it. ACT points out the need to live in the present moment if we are to learn whether our current behaviour is committed to our values or part of the avoidance/control agenda: being mindful assists with making this decision. Jean and I also benefited from reminding ourselves that the decision to be willing and to commit to valued action occurs moment by moment and sometimes we will fall back on avoidance and control. When Jean engaged in avoidance/control strategies during therapy it was the perfect context for us to revisit the core ACT concepts, you could say I welcomed it! Given my anxieties I began regularly practicing a few minutes of mindful breathing prior to sessions with Jean, I have since transferred this to most of my client work!

**Therapeutic relationship:** As with all therapy models, the therapeutic relationship is a key component of ACT. On reflection it appears to have a more active role compared to working with other models. Many of the techniques I shared with Jean required a demonstration; consequently a sense of humour was imperative. At times I found myself uttering 'Arriving at platform two is the thought that I am a failure' in the style of a train announcer, or 'I am useless' in the sultry tones of Marilyn Monroe. Yes, the cringe factor is huge, but it is this that makes it effective, the distress is revealed for what it really is! I have also come to see that this makes ACT a truly collaborative process.

I have to say I have made life easy for myself with this entry by splitting up the core features of ACT and telling you about each one in turn. Whilst therapy with Jean certainly started with looking at the unworkable nature of the avoidance/control approach and contemplating the alternative

of willingness and acceptance, from then on we hopped from concept to concept and back again. I really struggled with this lack of structure at the time seeing it as a result of my lack of experience (what else). However, as I become more familiar with ACT I realise it is the nature of the beast: many of the techniques and skills tap into more than one ACT component. For example, 'I am having the thought that...' illustrates self as context and cognitive defusion. Whilst this makes life tricky for a novice it inevitably becomes a feature of the therapeutic process.

To refer back to the point I made at the beginning of this entry, the way ACT concepts operate enables them to be utilised by me as therapist whilst engaging in ACT with a client: I can't think of a better way to learn.

## Correspondence

**Emma Hodges**

Trainee Clinical Psychologist,  
Southampton University.

## Resources

There were a number of resources I found extremely helpful along my ACT journey.

Flaxman, P.E., Blackledge, J.T. & Bond, F.W. (2001). *Acceptance and Commitment Therapy: The CBT Distinctive Feature Series*. East Sussex: Routledge.  
This is a very useful 'pocket-sized' book covering the essentials of ACT, very reader friendly and easy to digest.

[www.contextualpsychology.org](http://www.contextualpsychology.org)

A comprehensive website offering resources, training information, opportunities to network. Asks for a donation of the amount you wish to pay to become a member.

Hayes, S. & Smith, S. (2005). *Get out of your mind and into your life: The new acceptance and commitment therapy*. Oakland, CA: New Harbinger Publications.

A self-help book, but also very useful for activities to use in therapy.

# Advice from the Editorial Collective to contributors

Penny Priest

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This article was first published in *Clinical Psychology Forum*, 227, November 2011. Thanks are due to the Editorial Collective of *Clinical Psychology Forum* for allowing us to reprint the article.

**A**T THE MOST RECENT meeting of the *Counselling Psychology Forum* Editorial Collective, we took part in a reviewing workshop to generate greater clarity for both reviewers and contributors in the expected standards to meet for publication in CPF. Six papers were circulated prior to the meeting and members of the Editorial Collective were asked to read each paper and come to a decision on whether they would reject or accept each. During the workshop, each paper was discussed, establishing whether reviewers were of the same opinion and why each paper was either rejected or accepted.

Five out of six papers were rejected, with unanimous agreement between reviewers. Four of these five had been originally rejected by reviewers. To give a flavour of the content, Paper 1 was regarded as a 'bit of a rant', outlining a rather superficial string of ideas with nothing to hold it together. Paper 2 said nothing new, and had an insufficiently developed argument. Paper 3 was a

rather standard local service evaluation, with little relevance beyond the locality of the study. It did not add to the existing knowledge base, nor demonstrate complex, critical thinking. Paper 4 was confusing, with incoherent methodology, although could have been better presented as a reflective piece. Paper 5 was another classic example of a local study. This paper was rejected by the Editorial Collective, even though the original reviewer had accepted it. Finally, Paper 6 was accepted by both the original reviewer and the Editorial Collective. We judged this paper as clearly written, relevant to the profession, original, and with clear links between research questions and results. It was also well contextualised, drawing on clinical experience, with substance and reflection.

The Editorial Collective agreed that a good selection of papers had been provided for the workshop and drew up a list of Do's and Don'ts for future contributors and reviewers.

## Do

- Try to captivate the reviewer's interests; reviewers would be more interested in bringing work up to scratch if it's original, creative and innovative.
- Critically appraise your own opinions.
- Consider submitting service evaluations which demonstrate changes or improvements as a result.
- Make sure, as research supervisors, you coach trainees in how to write research up properly; all the thinking, time and goodwill trainees contribute can be wasted if the supervisor does not communicate this back to the trainee.
- Get local feedback on what you are writing about before submitting so that possible flaws can be eradicated.
- Use the whole word count available.
- Check that all co-authors have read the paper.
- Consider policy in relation to practice.
- Make sure you draw on the most recent relevant publications.
- Consider how relevant your work is outside your own locality and why others would want to read it.
- Thinking carefully how you structure your piece and use headings and sub-headings appropriately.
- Use a good standard of English. If unsure, ask a successful author to check your article before submission.
- Read the *Guidelines for Contributors* on the *Clinical Psychology Forum* website before submitting ([www.bps.org.uk/cpf](http://www.bps.org.uk/cpf)).

## Don't

- Present any ill-thought-through ideas.
- See a rejection as a turn-off part of your career.
- Exceed the word count.

## Dr Penny Priest, CPsychol

On behalf of the Editorial Collective.

# Book Review


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*Teach Us To Sit Still: A Sceptic's Search for Health and Healing*

Tim Parks

London: Harvill Secker (2010)

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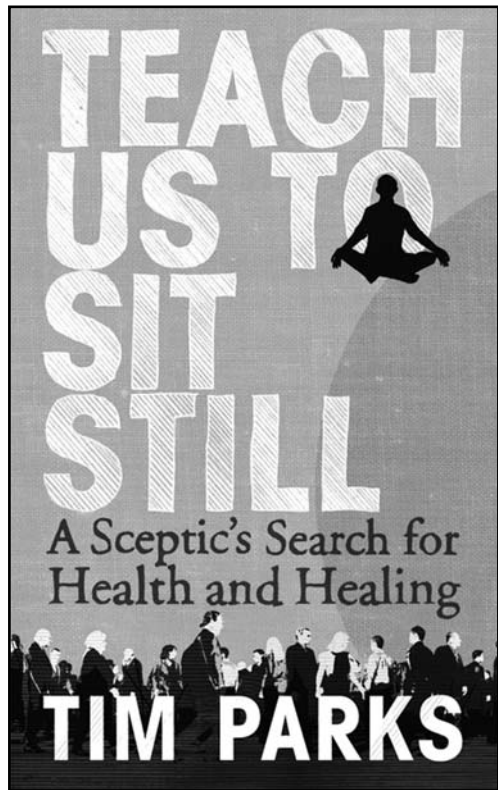
 Reviewed by Paul Whitby

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One of the disappointments of being a psychologist is that many of the books one has to read are, frankly, poorly written. I can just about live with the lifeless prose of empirical work but I do find the clumsiness of much other writing sometimes hard to bear. This is especially so with self-help books, or 'client manuals', and their frequent resorts to folksy little tales sometimes culled from clinical cases, sometimes events from the author's own life. So it is a pleasure to find Booker-nominated novelist Tim Parks showing how it should be done in this tale of living with really nasty chronic pelvic pain. Of course, this is not a self-help book and it surely is not a 'Psychology Book'; it is subtitled 'A Sceptic's Search for Health and Healing' and that is sufficient description.

While the central tale is Parks' bladder, or his prostate, or maybe all of his body and probably his mind, he finds time to include reflections on literature, kayaking, painting, Coleridge, Virginia Woolf, Christopher Hitchens and much more. His mind is active, probably too much so by his own admission, and amazingly intense; Parks, one feels, does not take life easy. The result is an exciting, erudite and really quite funny reflection on a painful and embarrassing chronic condition.

The author takes pride in his rationality and disdain for religion, or worse anything New Age. He trails around to various doctors to little effect except some fine dark humour at his own expense. He is not hugely critical of Western medicine and he is not rude about the doctors he meets, but he is clearly disappointed by the results of the consultations not to say alarmed by some of the



further procedures suggested (some fairly unsettling illustrations are provided). The disappointment is palpable and the criticism is implied rather than overt. Modern medicine, that has performed such miracles in so many areas of illness and suffering (just think antibiotics or hip replacements) has nothing to offer for prostate pain except increasingly radical interventions with no guarantee of relief. The investigations can find nothing wrong, could it all be in his head?

One can see that Parks is the sort of patient who makes clinicians feel bad. But, where to turn to next?

Throughout this first part of the narrative we are given a pretty full account of his attempts to understand his situation. Some of this looks a lot like what I would identify as rumination. There are long tracts on

possible unconscious motivations, or not, with some hefty literary references thrown in for good measure. Parks does not just suffer pain, he wants to write essays about it. He is like a dog with a bone but this gets him nowhere and he concludes that all the constant chewing over and intellectualising is a significant contribution to the problem. But he is lucky, part of this febrile search for meaning involves lots of late night Googling during which he serendipitously turns up a bit of gold from among the dross. He comes across a non-invasive treatment that relies on a very specialised and prostate-specific relaxation programme (I say non-invasive, actually direct prostate massage using an anal wand is suggested, but our hero declines). The descriptions of his rather bumpy progress through paradoxical relaxation and later into meditation are a fitting, gentle climax to the story. Parks writes beautifully and his descriptions of the trials of meditation, the difficulties, the irritations, the fleeting nature of early improvements, the mumbo jumbo that accompanies it and sticks in his throat, are all delightfully worked through. His descriptions of the triumphs are all the more impressive as this requires he use words to articulate a state with no words and no thought. This is a paradox that he relishes and in my opinion he deals with it better than any other writer I have come across.

An important part of his tale is how he has to, for at least some of the time, put aside what he calls 'The Word Project', the driven, literary-rational approach to life that has guided him up until now. The constant striving to possess and control his existence through language, logic, argument, literature and essays has to stop; the only reality we have access to is now, with this breath.

Fortunately for us Parks has not stopped writing, otherwise we would not have this intriguing book. He has managed to come to some accommodation between his old driven self and his newly-found appreciation of wordless being. The final chapter, 'Cathedral', is quite sublime. We are given a picture of a more amiable, possibly even avuncular, Parks calmly invigilating over his students in an crucial exam. The air conditioning has broken down so the windows are open and noise pours in, including the inevitable strimmer. A few years beforehand he would have been in a frenzy of irritation. Now he refuses to contribute to his own suffering. But Parks has not entirely given up all his old ways and we are treated to critical reflections on Christopher Hitchens, Virginia Woolf and Samuel Beckett to help make this point. Parks has not given up all his attachments to this world. As he says, much of the world is really quite beautiful.

Excellent.

**Paul Whitby**

*Clinical Psychologist, Devizes.*

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## as at February 2010

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# PSIGE National Committee 2011/2012

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## Notes

# Notes for Contributors

The *PSIGE Newsletter* welcomes the following submissions for publication: Articles, Research Updates, Letters to the Editor, Book Reviews. These can be on any aspect of psychological theory or practice with older people.

## Articles

Articles form the bulk of contents submitted to the *PSIGE Newsletter*. As the *PSIGE 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 *PSIGE 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 *PSIGE 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 email 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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