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Welcome to the Autumn edition of *Signpost* where the flavour of this edition is about experiential learning. Each individual is unique but developing and practicing certain skills can be the key to enable an individual to

achieve their goals. This is something I have grown to appreciate over time. Developing my skills and experience has enabled me to adapt my approach within the context of physiotherapy. Talking to patients and carers, understanding the person and focusing on their individual rehabilitation needs, enables me to bring out the best in them. I believe that there are huge opportunities to improve services for individuals with a diagnosis of dementia and carers, through communication and sharing of ideas and experience. *Signpost* is the perfect opportunity to share these ideas and reflect on experiences so that the breadth of professions reap the benefit.

I am writing this editorial at a time where we are noticing huge changes to healthcare within the UK. There is a strong emphasis on wellbeing, keeping healthy and being active. All of these principles sit particularly well within my role as a physiotherapist, and will have relevance with many others of you. They are also principles that I attempt to incorporate into my life and my family's. The health messages across the media currently are about staying active and exercising and all health professionals are able to deliver these key messages. With collaborative working with our community and voluntary partners it is easier to point individuals in the right direction, whether it's taking up 'Nordic Walking' or adapted yoga classes. Physiotherapy interventions and exercise classes can have a positive impact on individuals both physically and psychologically as well as reducing cardio-vascular risk factors. Generally building in activity to a daily routine makes a difference, walking to the table or dining room, carrying

the shopping, chair based exercises, stretches, all these help.

The Chartered Society of Physiotherapists demonstrate that physiotherapists are key health professionals for providing rehabilitation that works for individuals with a diagnosis of dementia. Current research demonstrates that 'exercise can have a significant and positive impact on behavioural and psychological symptoms of dementia, improving cognitive function and mood.' (Cerga – Pashoja A, Lowery D, Bhattacharya R, et al. Evaluation of exercise on individuals with dementia and their carers: A randomised controlled trial. 2010 13 May; 11(53)).

This edition comes at a time where it has been the sixth global World Alzheimer's month, the international campaign to raise awareness and challenge stigma. Alzheimer's Disease International believe that '2 out of 3 people globally believe there is little or no understanding of dementia in their countries.' They were using the information of 'Remember me' to raise awareness and to get people to share memories and get involved. Campaigns such as this can improve early detection, raise awareness, reduce stigma and improve services for individuals living with a diagnosis of dementia.

Following this we celebrated Older People Day on 1st October where the focus is 'enabling and expanding the contributions of older people'. Family dynamics are complex with individual roles changing. Often added is the challenge of a wider geographical distance between family members. Looking at new ways a family can function ensures that they are considering the roles of older members too. This should importantly include capturing values, opinions, and contributions and sharing them. The use of technology can be invaluable and helps keep us all connected. Both personally and professionally we are noticing a drive towards using technology more for communication. This should not, however, detract from the importance of all those factors that can be attributed to a personal interaction such as touch, expression, warmth, humility and empathy. Interacting through technology plays a part but is not a substitution.

The article that Lace Collett writes about virtual dementia training provides valuable insight for carers and health professionals. It provides insight into the complexities of a diagnosis of dementia and attempts to provide first hand experience to the participant. This type of training has been demonstrated to improve person centred care and empathy of both carers and health professionals.

The case study by Dr Varshaa Deshpande makes

for powerful reading. The conclusions and reflections that are demonstrated are a positive message within dementia care. There are opportunities for growth but strong therapeutic relationships are essential. I feel I could learn a lot from Dr Deshpande's approach which would support improved outcomes in my role.

The book that has been reviewed by Dr Helen Barker looks at how to apply CBT to both patients with and without a diagnosis of dementia. It also utilises case studies that Dr Barker highlights would be of benefit to trainees in CBT and clinical psychologists. Dr Barker summarises well what different professionals would benefit from different aspects of this book.

Samantha Staite's reflection on her time in Sri Lanka provides an amazing insight to mental health services overseas. The experience that she has gained from delivering psychological interventions in this country will remain with her for her whole career and it has made for enjoyable and thought-provoking reading. Learning through experiencing different cultures and different systems demonstrates an appreciation for services within the UK but also the power of non-verbal communication and compassion.

There is still so much to learn within this field and I hope these articles provide you with some insight and thoughts, and make you consider your practice. It offers an exploration of how experiential learning, reflective practice and learning through case studies can influence the way in which we view mental health. Go and experience. Go and learn. Help others to experience and learn. That way we can break down stigma and work to a common goal.

Many thanks to Debbie Hopkin who has worked so hard in bringing this edition together and presenting it.

Natalie Robertson
Principal Physiotherapist in Mental Health Therapies

THE VIRTUAL DEMENTIA TOUR



Lace Collett is a Psychology undergraduate at Cardiff University. And I've been working with Cardiff Memory Team at Llandough Hospital on placement for a year.

"If caregivers are unable to tolerate even for 10 minutes what those with dementia deal with routinely, how can they be expected to be patient and empathetic with those in their care?" (Beville, 2002).

Introduction

Dementia is usually associated with the loss of memory and cognitive functions. As the brain deteriorates, people with dementia (PWD) also experience difficulties in motor functioning and sensory perception which can lead to seemingly irrational behavioural symptoms of dementia. Often, the main carer for PWD is a family member who generally will have no prior experience of caregiving or expert knowledge of the disease. The majority of carers for PWD feel that as there is no training in dealing with behavioural changes they are not well-equipped to manage these sufficiently (Carers trust, 2013). As such, carers often learn how to cope with any challenges through trial and error and learning from their own experiences. PWD are often unable to describe their experience which leads to a lack of understanding by carers (Phinney & Chesla, 2003). A lack of understanding the illness can limit the quality of the care PWD receive (Beville, 2002).

The Virtual Dementia Tour® (VDT) is a mobile unit that travels the country to give people an

idea of what it might be like to have dementia. VDT was originally designed as part of a research study into attitudes towards dementia care, created by American geriatric specialist P. K Beville.

Beville wanted an innovative way to educate carers of PWD about the diseases to improve the quality of care PWD received. She found that traditional teaching methods such as giving speeches, roleplay or using interactive videos did not evoke any lasting changes. Therefore, she designed a study that aimed to use experiential learning techniques to investigate whether this could create a longer-lasting improvement in how carers look after PWD. Due to the positive results of the research, the tour was launched to the public and is now available internationally, often used by companies and organisations as an accredited CPD exercise.

What happens on the tour?

In the original research conducted by Beville (2002), 146 people who worked with PWD were invited to experience the VDT. Before entering the mobile unit, participants were asked to complete a pre-test questionnaire which aimed to measure participant's opinions on care of older people. Blood pressure and pulse readings were also taken to compare physiological signs of anxiety before and after the tour.

After this, participants were given special clothing to wear to simulate the sensory impairments PWD experience. In order to achieve this, participants were given shoe inserts with popcorn kernels inside to produce the discomfort and pain many older people experience due to peripheral neuropathy. They were also given large gloves containing popcorn kernels which were used to limit sensitivity to touch. The fingers of the gloves were taped together so participants would experience difficulty controlling their hands, similar to the difficulties imposed by arthritis, or the loss of motor skills. Participants were then given goggles which impaired peripheral vision, representing visual impairments people with later stages of dementia experience due to the loss of function in the occipital lobe.

A black dot was also placed at the centre of the goggles to simulate macular degeneration.

Participants were asked to wear headphones for the duration of the tour which continuously sounded laughter, voices, static and muted AM radio sounds. This created confusion and mimicked the sound discrimination impairments PWD experience. After putting this equipment on, participants were led into the mobile unit where they were required to complete tasks for ten minutes. The interior of the unit was designed to replicate a 'standard' residence of an older person in a care home. Participants were then verbally instructed to complete five simple tasks such as 'brush your teeth'. An empty camera flashed every three minutes to simulate the lack of privacy and dignity PWDs are faced with in care during the participants' own vulnerable state. Behavioural observations were made of the participant's reactions during the 10 minutes they had to complete the tasks. After completing the tour participants were asked the same questions as in the pre-test questionnaire, to measure the effect of the tour on attitudes of care of older people.

Beville's charity *Second wind dreams*® own VDT but Training2care run the tour throughout the UK. It has been used by various care providers, NHS trusts, hospices, universities and the emergency services. The tour is conducted in the same way as in Beville's (2002) research. VDT uses the mobile unit when workplaces have safe parking available for this. Training2care also offer the tour for environments that cannot meet this criteria, by using two meeting rooms one for the simulator experience and the other for a separate debriefing experience. The tour requires two and half hours per 12 users, with a maximum of 36 users per day. The cost of VDT varies depending on how the tour is conducted and the number of users. For a full day (36 users) the tour costs £600-£800.

Does it work?

Beville considered the tour to be successful as participants reacted to the stimuli used in the tour by displaying what she considered as typi-

cal 'dementia behaviours', suggesting their experiences were similar to those of PWD. For example, many participants displayed repetitive behaviours throughout the tour. Participants often fixated on the first task, which was not visually accessible and seemed unable to move on to other tasks. On average, participants were not able to complete half of the five simple tasks and 35% of the participants gave up trying to complete any of the tasks altogether. In a video of a news report which demonstrates the tour taken by one caregiver whose mother has dementia, the reporter shows footage comparing the behaviour of the caregiver with the behaviour of his mother (Second Wind Dreams, 2013). By viewing this footage she agrees with Beville that the tour does seem to elicit behaviours often seen in PWD.

73% of the participants produced subvocalisations such as talking to themselves, whistling and humming, behaviours which are often exhibited by PWD. It is suggested that these are not simply irrational behaviours due to the degeneration of the brain but serve as a coping mechanism of comfort and reassurance during periods of confusion and distress. Furthermore, 16% of participants denied having made any subvocalisations. This suggests that the overload of sensory stimuli caused greater anxiety and confusion to the extent that participants did not realise how they had reacted to the environment.

From the results of the pre and post-tests, Beville (2002) reported that participants appeared to have gained an enhanced understanding of dementia as well as higher levels of empathy and patience. The post-test also revealed that participants felt more strongly that PWD were not receiving the care they deserved compared to the pre-test. Furthermore, a follow-up study interviewed nursing staff 5-9 months after they had taken the tour (Lorio, Cayce, Gore et al. 2015). This study found that participants believed they had gained a better understanding of both treating and caring for PWD following their experiences in VDT. From this research, Beville suggested that experiential learning is a

better method of improving the care PWD receive, with lasting results.

Potential benefits of the tour

One potential benefit of VDT is that PWD often find it more difficult to verbally explain the difficulties they are faced with. To reproduce sensory impairments to simulate the emotional and behavioural reactions that PWD report, without causing physical damage to the participant, is a unique and novel way to improve the understanding of what dementia is like.

Another potential benefit of the tour is that the emotional experiences gained through the tour may motivate professionals to maintain higher standards when caring for PWD. Beville believes emotional experiences are more motivational than traditional teaching methods as the memory of the learning tends to last longer. PWD report that memories of emotions and feelings last longer than the details of events.

As participants experienced higher anxiety levels and confusion during the tour, they reported a better understanding of the way to interact with PWD effectively. For example, in Lorio, Cayce and Gore et al's (2015) study, participants reported in the post-test questionnaires a greater understanding of the importance of quiet environments and slow clear speech when interacting with PWD. Participants also reported greater empathy and a better understanding of typical 'dementia behaviours' such as feeling lost in familiar environments and producing subvocalisations. These emotional experiences can be used as motivation by professionals so PWD receive empathic and high quality treatment.

Limitations

However, it has to be noted that VDT only simulates sensory impairments and it is not possible to know how similar the tour is to actually having a dementia. For example, the clothing and equipment used replicates difficulties faced by people with arthritis, peripheral neuropathy and visual impairments. Although these conditions are often faced by PWD, they are not directly caused by dementia.

Another criticism of VDT is that dementia is an umbrella term for neurodegenerative diseases. Alzheimer's disease which is the most common form of dementia causes severe impairments of short term memory. This is not possible to imitate within the tour. VDT overloads a healthy participant with sensory information which causes them either to forget verbal instructions or to be so confused by other stimuli that they do not concentrate enough to register the information. So without causing permanent damage to a healthy brain, the tour does offer an incomparable experience to enhance understanding of what PWD experience and why 'dementia behaviours' are produced.

Finally, there are practical requirements that may limit the use of the tour for training purposes. *Training2care* do offer an in-house alternative to conduct the tour for workplaces that don't have space for the mobile unit. But both options are costly, quoting £600-£800 for a full day with 36 users. These practical issues also need to be considered when deciding whether the tour is feasible for training in a workplace.

Conclusion

In summary, VDT has provided a unique and novel way to educate people about dementia using experiential learning as an alternative to traditional methods of teaching. As presented, the tour does not necessarily allow people to experience what having dementia is actually like, but it does give people an opportunity to experience the sensory impairments and overload of sensory stimuli that PWD report. Users appear to react to the tour environment in a similar manner to the way PWD react in their own lives, which suggests the experience may enhance empathy and understanding of the disease. This is likely to motivate people to improve the quality of the care for PWD. Therefore, Beville feels that VDT may be a valuable experience, as it can result in long-lasting improvements in the care and treatment of PWD and hopefully then increase PWD quality of life.

References

Beville, P. K. (2002). Virtual Dementia Tour© helps sensitise health care providers. *American Journal of Alzheimer's Disease & Other Dementias*®, 17(3), 183-190.

Carerstrust. (2013, September 17th). *News report: Carers of people with dementia not receiving support they need*. Retrieved from <https://carers.org/news-item/new-report-carers-people-dementia-not-receiving-support-they-need>.

Lorio AK, Cayce B, Gore JB, Beville PK. (2015). *8 Minutes of Awareness: Can a Single Experiential Learning Exercise Transform Understanding and Awareness of Dementia in a DPT curriculum?* Division of Physical Therapy, Georgia State University, Atlanta, Georgia; CaraVita Home Care, Roswell, Georgia; Second Wind Dreams, Marietta, Georgia.

Phinney, A., & Chesla, C. A. (2003). The lived body in dementia. *Journal of Aging Studies*, 17(3), 283-299.

Second Wind Dreams. (2013, April 5th). *ABC NIGHTLINE Tells America About the Virtual Dementia Tour*®. [Video File]. Retrieved from <https://www.youtube.com/watch?v=QEmBmokHU3Q>

A CASE STUDY



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Psychologist. Currently, she works as a Principal Psychologist in Inpatients Rehabilitation in Psychosis, Stepped Care services, Hopewood Park Hospital Sunderland, NTW NHS Trust. This case study is based on her work at the Older People's Services, Department of Clinical Psychology, Campus for Ageing and Vitality, Newcastle-upon-Tyne.

Does the word “Dementia” always imply end of growth? A case study

Abstract

People become more complex as they age, and providing mental health services for them requires a holistic approach. This case study looks at a person diagnosed with a mixed dementia, Matilda (Pseudonym). It tries to capture her journey from total despair to empowerment. The case study encourages adopting a holistic view in understanding the needs of Matilda and suggests that irrespective of the diagnosis, growth is possible within many areas of life. This commentary also emphasises the important role of establishing a strong therapeutic alliance. The latter feature can serve as catalysts in achieving the desired change and empowerment.

Introduction

In recent years there has been a trend to merge specialist older people's teams with working age adult services. This has led many manag-

ers and clinicians offering varying views on whether one can differentiate older people's needs from those of their younger counterparts. While notions of cognitive impairment have been relatively easy to articulate, the concept of 'functional frailty' has been more difficult. James (2013) attempted to capture some of this complexity in his 3-D model of impairment – see Figure 1.

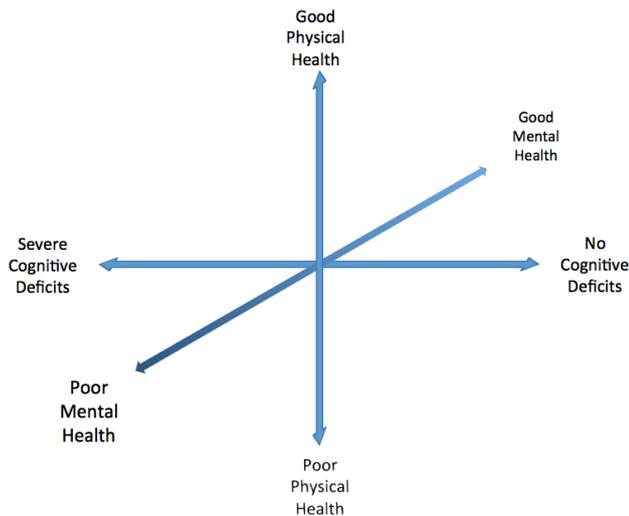


Figure 1: 3-D model of impairment.

Using this perspective, one can see that while some older people's (OP) profiles will map directly on to those of younger people's, many OP presentations can be highly complex and thereby require specialist training and support. The present case is designed to highlight a complex client, but of note the complexity is not related chiefly to her cognitive impairment. Indeed, focusing overly on Matilda's dementia would have been a red-herring and may have led a less experienced therapist to assume the person was unsuitable for psychotherapy.

The Northumberland Tyne and Wear NHS Trust policy to acquire a valid, informed consent to treatment was followed and elements of confidentiality were explained to Matilda. All the identifying information about the client, such as her age, socio-economic background was altered. Additionally, a verbal consent was acquired from Matilda for the use of her information for publication of the case study. She was keen to share her life story with the world.

Referral

Matilda was a 68-year-old Caucasian, married woman with two adult children. She was referred by a Consultant Psychiatrist from a Community Mental Health Team to receive psychological input for her psychosis, more specifically 'auditory and visual hallucinations'. Matilda suffered from chronic tinnitus (since the age of 16 year). During her adulthood, she talked about experiencing symptoms of panic attack for which Matilda had received counselling.

My first impression was of a woman who was 'attempting' to look at least twenty years younger than her biological age. Nevertheless, she was smartly dressed and wore light make up. Overall, she presented as a charming and intelligent person, clearly keen to please. Matilda was a logical and psychologically minded person. She enjoyed solving crossword puzzles and competitively participated in sports, such as golf and cards with her friends. At her first meetings, she gave me the following information about her current difficulties and their context.

Presenting difficulties

Three years ago Matilda received the diagnosis of "Dementia of Mixed type" (Alzheimer/vascular); a DaT scan had ruled out a diagnosis of Lewy body dementia. At the beginning, she had frequently experienced visual hallucinations mainly at dusk and dawn; these created panic in Matilda. For example, she sometimes saw a man sleeping in bed between her and Adam, her husband. On other nights, she saw all of her friends and their partners piled up in-between her and Adam in the bed.

Currently, Matilda continues to see miniature, cartoon like figures dancing on the walls of her bedroom. Soon after the diagnosis, Matilda also started hearing voices. The voices were benevolent in nature (90% of times). She heard two male voices ("Patrick" and his "Boss") who constantly offered intimate remarks on Matilda's physical appearance and actions; at times Patrick also offered sexually abusive remarks towards Matilda. The voices played constantly on

her mind and interfered with her Activities of Daily Living (ADLs - basic as well as instrumental). For example, while Matilda was bathing, Patrick would give personal comments to please her, or "Patrick" and the "Boss" would decide if Matilda could sleep well during that night. Patrick interfered when Matilda drove her car; she was not allowed to play the music of her choice. The voices interfered with Matilda's favourite activities; playing golf and bridge. Matilda felt depressed and anxious. At the time of assessment, Matilda did not pose any risk of harm to herself or to others.

Soon after the diagnosis of dementia, Matilda was prescribed with Citalopram (20mg OD), Donepezil (10mg), Lorazepam 1mg (1/2 tablet morning and 1/2 tablet in the evening) and Zopiclone 7.5mg. Matilda told me that she took her medication on a regular basis, and that these medications somewhat helped to keep her symptoms of anxiety and low mood at bay. She also expressed her decision against taking anti-psychotic drugs for her voice-hearing problem, owing to the recent publicity about their problematic side-effects.

History of difficulties

Matilda described her father as a quiet and kind person who came from a privileged background. Matilda described him as a "simple looking man". Matilda's mother used to work as a helper at Matilda's father's house, where they met and later married. Matilda's account of her early life experiences reflected severe maternal rejection. According to Matilda, her mother passed frequent nasty remarks about her children's physical appearances. Matilda further told me about her experiences of childhood neglect; she talked about feeling embarrassed wearing dirty underwear for days when she was young. She had witnessed parental emotional abuse. She also talked about receiving corporal punishment by her father at the age of five for being touched inappropriately by her female friend who was a little older than Matilda. After this incident, Matilda's mother became extra vigilant and made sure that Matilda did not touch herself, which remains an issue to date.

Matilda described her mother as a short tempered, disgruntled woman who initiated fights. Her mother also gave differential treatment to her children as a means of manipulation to satisfy her needs. Matilda and her siblings grew up witnessing parental discord. Therefore, Matilda had issues trusting others and learnt to keep emotions to herself. For example, while watching television soaps with her family members she would not shed tears over emotional scenes. Matilda had developed an anxious-avoidant attachment pattern. As a teenager, Matilda started to carry herself in a manner whereby she would be noticed and recognised. She told me that all her life she found herself surrounded by men, where she would be "fishing" for compliments from them. When Matilda grew up, she talked about getting attracted towards men who were unsuitable for her and hence she experienced a number of unsuccessful relationships.

When she was 18 years old Matilda got married to Adam who at the time was a renowned personality in the world of entertainment. Adam was always willing to go an extra mile to please her; for example, he would iron her bed to keep her warm during harsh winters. Adam had been a source of unconditional support in Matilda's life. Despite enjoying a glamorous lifestyle, she remembers feeling that Adam did not meet all her expectations. There was something missing from him, although she could not say what it was.

Matilda had two children. She described loving her children, but struggled to express affection towards them; for example, she had difficulty cuddling them. When her children were young, Matilda was romantically attracted to a man ten years older than her; she had managed to keep her affair a secret.

Adam told me that Matilda had always craved for attention from the others; nevertheless, she remained popular in their friendship circle. He also said that sometimes she could be 'vicious and extremely paranoid'. Matilda's children were supportive of her. Matilda had a spiritual

dimension to her personality. She talked about being actively involved with local church activities.

Prior to my contact with Matilda, a Trainee Clinical Psychologist and a Chartered Clinical Psychologist had supported Matilda with her voice-hearing problem. They had also sign-posted her to a voice hearing support group, which Matilda found intimidating and hence abandoned it. After an assessment, we established the following goals for therapy.

- To carry out psycho-education on dementia.
- To raise awareness, understanding and to offer support to live well with dementia.
- To reduce the influences of the psychotic voices.
- To address Matilda's low mood
- To perform psycho-education on the role of psychological strokes/complements- verbal/non-verbal/physical (Stewart and Joines, 2012) in one's life.
- To inculcate self-love.

Formulation

Through our discussions, I came to understand Matilda's presenting problem of voice hearing as a break-down of defence to her well-guarded emotions that was triggered by the diagnosis of dementia. Matilda's cognitions about her long-standing unmet need for recognition (verbal as well as libidinal) had popped out from the stream of her consciousness in the form of voice hearing. Guilt arising from her extra marital affair potentially contributed to her voice hearing and hallucinations.

According to DSM-V (2013), Matilda showed certain traits from Cluster B, with some borderline personality features. These became apparent through her life story, For example, since her early childhood Matilda had developed certain games, such as "Drawing figures in the cloud", where she used to project good and bad characters/things and spend hours thinking about them. Therefore, since a young

age she developed an early split in her perception about the self, others and the world in general and consequently, learnt to view the world in a "black or white" manner. Furthermore, Matilda's childhood experiences of maternal rejection, neglect and emotional abuse led her to develop a "damaged" self-image and hence the self-sabotaging patterns of behaviours, which helped her to maintain the internal psychological distress. This reflected through her unhappy relationships. Matilda frequently spoke about feeling intense jealousy and becoming excessively paranoid when any female tried to strike a conversation with Adam. She further reported extreme jealousy being a cause for frequent friction between her and Adam. However, her family injunctions did not allow her to express her feelings to its true intensity. At a conscious level Matilda disapproved of Adam for various reasons. However, at an unconscious level she was dependent on Adam and struggling very hard to cope with the underlying unconscious fear of abandonment and annihilation.

The purpose of Matilda's voice hearing appeared to be her unmet need for recognition; verbal as well as libidinal.

Interventions

Initially twenty sessions were agreed, but 6 sessions were later added to strengthen the achieved goals and to plan for the relapse prevention strategies. The initial 6-8 sessions were planned for alliance formation and introduction of relaxation techniques (containment).

Owing to Matilda's presentation a collaborative and person-centred integrative treatment approach was used. It included aspects of psycho-education on dementia and Cognitive Behavioural Therapy (Greenberger & Padesky, 1995), but adapted for people with dementia (James, 2010); Matilda was socialised to the use of thought diaries and homework assignments. Features of Acceptance and Commitment Therapy (ACT, Harris, 2009) were also employed, particularly in relation to her need to accept her dementia, her life stage, and to acknowledge

the ongoing support from her husband. The mindfulness elements of ACT, including the breathing techniques, were useful for dealing with her anxiety. Her auditory hallucinations seemed particularly responsive to the mindfulness based breathing exercises, because the voices seemed to be triggered by anxiety and tiredness, or following arguments with Adam. She was encouraged to practise these exercises on a regular basis (gradually building up to 20 minutes per day) as a control and relaxation strategy. Work on her spiritual/religious beliefs were undertaken (Gilbert, Merchant, Moss, 2008), which she felt enabled her to maintain internal balance.

The couple were introduced to the notion of “psychological strokes”. Strokes (verbal/non-verbal/physical) are a unit of recognition, which are thought to be vital for the healthy functioning of human system (Stewart & Joines, 1987).

Outcome

Despite her dementia diagnosis, Matilda showed evidence of growth in various areas of her life. At the end of the therapy Matilda stated that she had felt stronger and confident as she had accepted the diagnosis of dementia. She had managed to break free from the stigma attached with the condition and had taken up the role of voluntary spokesperson at a support group that assisted younger and older people with dementia who heard voices.

Her voice hearing began to reduce, and within weeks lessened to approximately 5 minutes a day, that too in a faded state (hardly audible to her). Matilda described this as a small window where she could share/acknowledge her well-being with the voice. She began to separate the voice from herself, referring to it as “Matilda’s voice”.

Matilda told me that when she felt tired her voice kept her awake for some time during nights. However, she managed to cope with these periods. Matilda identified therapeutic benefits extending to the other areas of her life, for example she talked about overcoming fears of undergoing dental treatments and using pub-

lic toilets. Matilda had grown in her awareness.

Interestingly, I noticed that Matilda’s face showed a more mature look. During the course of the therapy, she had grown; she became her own mirror and learnt to accept herself. I noticed that Matilda’s dressing style became rather conservative and she no longer desired compliments from men. She had “accepted” Adam and expressed her gratitude towards his unconditional support towards her. Eros was replaced by compassion. Matilda also expressed contentment with her life. She managed to “hug” me when she could control her voice hearing for the first time.

Reflections on learning

The case study suggests that the word dementia does not necessarily imply decline, and that the “self” remains dynamic; it continues to evolve, develop and grow. This case study highlights the importance of an in-depth understanding of an individual’s unmet developmental needs. It also emphasises the fundamental role of the catalyst; establishment of strong therapeutic alliance.

Matilda’s case study also supports the importance of providing psychological alternatives to medication. Banerjee (2009) has summarised the problems with antipsychotic medication in those with dementia, and thus effective non-pharmacological treatments need to be offered by competent therapists. The choice of such alternatives is particularly relevant when discussing treatment strategies with those PWD who have mental capacity.

The case demonstrates the importance of having a clear formulation of the person’s needs. With such an understanding a number of alternative approaches can be offered, but all seeking to address a set of core issues. Such ‘hub and spoke’ approaches are common in complex presentations, whereby the formulation is the focal hub around which the treatment are derived.

The case also highlights a number of key questions. For example, how frequently do we, as

clinicians, come across psychologically minded clients? Is it always possible to maintain reflexive stance over one's clinical practice while dealing with diverse range of clientele? Are we consciously aware about our ethical postures? How do we strike the balance between evidence-based practices in devising person centred interventions? Is it entirely down to the clinician's expertise and felt sense of empowerment that facilitates such interventions? And alternatively, is it the person-centred, collaborative work and less power imbalance in the therapeutic relationship that facilitates the desired change?

Why did I work integratively with Matilda? I had considered the CBT model for hallucinations (Sommer et al., 2012). It seemed to offer a detailed plan on dealing with "Command hallucinations", "Humiliating voices", "Critical voices" and "Reperceptive or Memory-Based Hallucinations". However, it did not deal with benevolent voices. Beck-Sander et al., (1997) suggest that people hearing benevolent voices comply with them regardless of its severity and those with malevolent voices are much likely to resist. Matilda's relationship with her voice explains her reluctance to disconnect with her voice hearing. Hence, after careful consideration of Matilda's needs and abilities, the integrative plan of treatment was planned.

It is positive news that people with dementia can be helped to continue to address core issues and schemas with the right kind of support offered to them at the right time. Dementia is a global challenge, which has been predicted to get worse. There is a dearth of research that focuses on growth of the "self" during dementia, but such work is warranted.

Acknowledgements

This work was undertaken while I worked as a clinical psychologist at the Older Adults Services, Campus for Ageing and Vitality, Newcastle-upon-Tyne, with Professor Ian Andrew James. I would like to extend my gratitude to Ian for his support and valuable contribution to this paper.

References

- American Psychiatric Association (Ed.) (2000). *Diagnostic and Statistical Manual of Mental Disorders: DSM-V-TR®*. American Psychiatric Pub
- Banerjee, S. (2009). *The use of anti-psychotic medication for people with dementia: time for Action*, A report for the Minister of State for Care Services, <https://www.rcpsych.ac.uk/.../Antipsychotic%20Bannerjee%20Report>.
- Barr, J. (1987). The therapeutic relationship model: Perspectives on the core of the healing process, *Transactional Analysis Journal*, 17(4), 134-140
- Beck-Sander, A., Birchwood, M., & Chadwick, P. (1997). Acting on command hallucinations: a cognitive approach, *British Journal of Clinical Psychology*, 36(1), 139-148
- Gilbert, P. (2008). Introduction to Spirituality, Religion and Mental Health: A brief evidence resource, Retrieved March 28, 2014 from <https://www.rcpsych.ac.uk/pdf/Gilbert%20Evidence%20Resource%20Doc.x.pdf>
- Greenberger, D., Padesky, C.A. (1995). *Mind over Mood: Change How You Feel by Changing the Way You Think*, The Guildford Press, New York.
- Harris, R (2009). *Act Made Simple: An Easy-to-Read Primer on Acceptance and Commitment Therapy*. Harbinger Press: London
- James, I. A. (2010). *Cognitive Behaviour Therapy for People With and Without Dementia*. Jessica Kingsley: London.
- James, I. A., & Hope, A., (2013). Relevance of emotions and beliefs in the treatment of behaviours that challenge in dementia patients, *Neurodegenerative Disease Management*, 3(6), pp 575-588

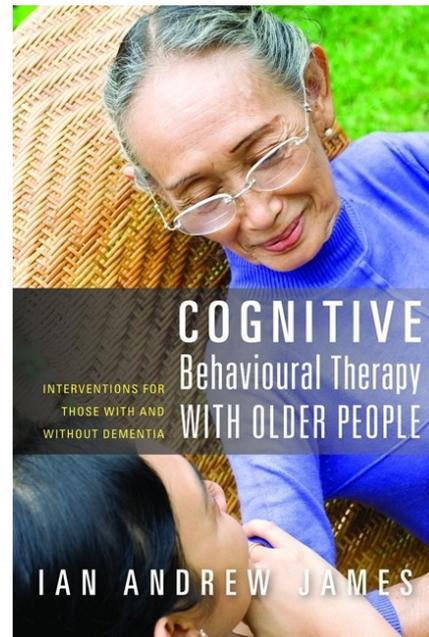
Kabat-Zinn, J., Chapman, A., Salmon, P., (1997). The relationship of cognitive and somatic components of anxiety to patient preference for alternative relaxation techniques, *Mind/ Body Medicine* (2), pp. 101–109

National Collaborating Centre for Mental Health UK (2007). Dementia: A NICE-SCIE guideline on supporting people with dementia and their carers in health and social care, British Psychological Society www.bps.org.uk

Sommer, I. E., Slotema, C. W., Daskalakis, Z. J., Derks, E. M., Blom, J. D., & Van der Gaag, M. (2012). The treatment of hallucinations in schizophrenia spectrum disorders, *Schizophrenia Bulletin*, 38(4), 704-714.

Stewart, I., & Joines, V. (1987). *TA today: A new introduction to transactional analysis*. Life space Pub.

Book Review



Cognitive Behavioural Therapy with Older People: Interventions for those with and without dementia.

Author: Ian Andrew James

Publisher: Jessica Kingsley Publishers, 2010 (256 pages)

ISBN: 978-184905-100-2

RRP: £24.99

This book outlines how to tailor and adapt Cognitive Behavioural Therapy (CBT) for older people with and without dementia.

Early in the book, the idea of conceptualising older people presenting for psychological intervention into four quadrants, based on two continua: cognitive impairment (none to a high level) and physical impairment (fit and active to unwell and inactive) is introduced. Four quadrants are proposed: Quadrant 1 includes older people in good health without cognitive changes; quadrant 2 encompasses people with physical health challenges without cognitive impairments; quadrant 3 represents fit and active people living with dementia and quadrant 4 describes people living with dementia and co-morbid health challenges.

This conceptualisation is useful for both service developers and clinicians alike. In terms of service delivery and education of therapists, this matrix adds to the debate about age-blind versus needs lead services and to what extent, non-specialist older peoples' CBT trained staff can work with the different client groupings, with some basic adaptations, such as pacing of therapy; supportive literature in the form of mini formulations and written summaries of key concepts from individual therapy for clients. The book provides in-depth coverage of the types of CBT/psychological formulations that can be applied or are developed specifically for older people or people living with dementia and refers to the literature on CBT and other psychotherapeutic trials with older people.

The strength of the book lies in discussing cognitive therapy for clients in quadrant one and two. Coverage of cognitive therapy includes the main aspects of standard cognitive therapy and more latterly developed adjuncts such as continua work, with adequate referencing to more in-depth key texts. The basics are covered in terms of assessment, collaboration, Socratic questioning, automatic negative thoughts, dysfunctional thought records, homework etc. and these ideas are developed and expanded through an example case report and a chapter on rating cognitive therapy skills, which will be of use to trainers and trainees alike.

An omission might be that the book offers less coverage of behavioural therapy. Whilst reference is made in passing to the use of the California Older People's Pleasant Events Schedule and research on behavioural activation, the book does not go into any great detail on the practical application of these techniques. As such, this is not a catch all CBT book and people wanting information on behavioural experiments and exposure based therapies will need to look elsewhere. The appendices contain

some cognitive models for common psychological problems, but these may be misleading for fledgling clinicians, for example, a cognitive model of OCD is reproduced, whereas NICE guidelines would suggest exposure response prevention as the treatment of choice.

The chapter on cognitive changes outlines neuropsychological changes such as executive dysfunction and working memory changes and how therapy may be adapted to accommodate these. The problem is that sometimes, CBT therapists and referrers may not be aware when people presenting for psychological therapy are experiencing early cognitive changes, until progress may not be apparent and so a section on cognitive screening, using non specialist measures such as the Addenbrooke's Cognitive Examination (Third Edition) and the Frontal Assessment Battery may have been helpful in assisting therapists to correctly assign people to either quadrant 1/2 or quadrant 3/4. I feel that more reference could have been made to the use of behavioural therapy and co-therapists for quadrant 3 and 4 clients. Behavioural therapy is also useful for quadrant 1 and 2 clients in that people with severe depression do well with behavioural activation and well designed and personalised behavioural experiments are good mediators for both behavioural and cognitive changes.

Turning to quadrant 3 and 4 (clients living with dementia); staff supporting people with behaviours that challenge, will find the chapter outlining the Newcastle Model valuable. This is a person centred, needs lead, team formulation based model, which draws upon personal history and personality, social environment, functional analysis of behaviour informed by CBT and an understanding of the neurological and physical changes and medication side effects that a person may be experiencing, in order to inform person centred care planning to meet

the unmet needs hypothesised to be driving challenging behaviour. This chapter is detailed and outlines the process of assessment, team formulation, care planning, intervention monitoring and evaluation in detail.

The book will be of interest to many people for different reasons:

Service managers and clinicians will enjoy the clearly elucidated matrix classifying people along the continua of no physical impairment to severe and no cognitive impairment to severe, which not only guides therapeutic choice but also service delivery models.

Trainees in CBT and Clinical Psychology will derive benefit from the case studies outlining the process of assessment, formulation, treatment strategies, reformulation and therapy outcome evaluation.

Experienced CBT therapists will find the explanations of the impact upon cognition upon the application of CBT useful.

Trainees, trainers and supervisors will find the chapter on the Cognitive Therapy Scale – Revised of interest.

In-patient staff and those working into and in care homes will find the chapter on the Newcastle Model valuable.

In summary, this is an informative book for people with some prior knowledge of CBT, looking to gain insight into developing their skills in assessment, formulation and adaptation of CBT for older people. The book is more of a cognitive therapy than a behavioural therapy text, but does have the added value of detailing the Newcastle Model, which is a valuable approach for working with people with behavioural problems associated with dementia. Ian Andrew James has kept to his word regarding his philosophy for therapy with older people, “KISS – keep it simple and slow” and has written a book that is both accessible and conveys complex ideas in an easily readable format.

This is a book that I always recommend to Trainee Clinical Psychologists coming on Older People’s Psychology placements and colleagues new to CBT with older people.

Dr Helen Barker

Professional Lead for Psychology (Mental Health and Learning Disabilities)

Abertawe Bro Morgannwg University Health Board

About Me

Reflections on a summer volunteering Placement in Sri Lanka



My name is Samantha Staite and I am a Psychology undergraduate at Cardiff University. I recently completed a placement year in Mental Health Services for Older People and am about to commence my final year of study. On completion of my degree I hope to work in mental health services.

This summer I spent 6 weeks in Sri Lanka with an organisation called SLV Global where I volunteered on a mental health placement. Myself and other volunteers from across the world ran therapeutic activity sessions in psychiatric facilities for individuals with a range of mental health issues. In addition to our time at hospitals, we also worked at social initiatives for children and adults with disabilities and taught English in



government run schools as well as extra classes in the local community. My time in Sri Lanka has made such a lasting impression on me. It gave me the opportunity to see the im-

pact of culture and society on mental health and allowed me to appreciate a different way of working.

Before I set off to Sri Lanka, I was apprehensive about what this placement would offer and how I would be able to help people when I did not even speak their language, however, I soon realised what a difference I could make by simply offering company and creative therapy activities to the service users. We may not have always been able to understand each others spoken word but we could communicate through art, music and games. This helped to alleviate their mood, providing much needed stimulation that, in many settings, they did not have the staff or resources to provide otherwise.

One thing that particularly shocked me during my time in Sri Lanka was the lack of Psychologists across the country. During one mental health talk I listened to whilst out there, it was scary to hear that there are only about 90 psychologists in the whole of Sri Lanka. This is surprising considering the size of the country and I was even more shocked to here that for the whole of the Sri Lankan army, they only had one Psychologist. It was these sorts of realities that really make me appreciate the accessibility of services in the UK and the amount of staff and resources that we seemly take for granted when compared to countries such as this.

Due to the lack of staff and resources, it was very common to see a heavy reliance on medication to treat service users. Counsellors and psychologists work only in the private sector in Sri Lanka, so in the government sector they rely on doctors providing therapy such as Cognitive Behavioural Therapy (CBT). Thus the majority of service users have no access at all to one to one therapy sessions or even therapeutic groups which are common interventions used as part of treatment in the UK. Medication alone is consequently used, rather than being part of an overall treatment plan incorporating therapeutic activities. This is where our work, as volunteers, became very important as we were of-

ten the only people other than nurses or doctors that service users would interact with during the week. The activities and interactions we offered were one of few meaningful activities that service users engaged in. This made it particularly rewarding to know the long term benefits our work may have with service users.

I knew before leaving for Sri Lanka that it would be different from mental health services in the UK and had expected the hospital conditions to be substantially poorer than those you would see here. I had prepared myself for what the conditions might be like, however, seeing first-hand how service users in mental health services live was still very difficult. At times it became difficult to provide psychological care when I could see that the standards of living on hospital wards were so much poorer compared to the UK. The wards were crowded, with fairly small spaces between each bed and hygiene standards appeared lower than I had expected. The resilience of the service users did however surprise me, as such living conditions were just part of normal life for them. There was the sense that everyone tried to make the best from any situation and keep positive.

Although some of what I've said may depict a negative side of mental health services in Sri Lanka, they have and do continue to improve their services. Sri Lanka do not yet have Community mental health teams set up as we do in the UK but this is something they are hoping to introduce over the next few years. Projects such as the SLV Global volunteering placement that I took part in really do help to make a difference and provide much needed meaningful activity for service users. One thing that did also stand out to me was the strength of community in Sri Lanka and how many people seem keen to help others in their community. Their collectivist society seemed like a positive thing for mental health as individuals would usually have the support of their family or community members to help them if they were struggling.

All in all, my time in Sri Lanka was a very unique experience that I will not forget. It

helped to put in to perspective, how advances mental health services in the UK are and made me appreciate all the services that are available to us. The work that I did with those who mostly could not speak English also really highlighted to me that words, although important, are not always necessary to communicate with others and sometimes positive body language and meaningful activity alone can help to lift someone's mood. This is something that is very relatable in the later stages of dementia care when communication in words becomes difficult. It really emphasised that the biggest thing in mental health care is being able to empathise and show compassion. The whole experience really helped me to be able to relate to people who are from such a different culture and background.

Samantha Staite
Psychology Undergraduate
Cardiff University

Signpost Information

Anyone Can Contribute to Signpost

Including those who are living with mental or physical difficulties, or the care partners of older people with mental health needs in hospital, residential homes and in the community.

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Contributions

All contributions must demonstrate a positive attitude towards this group of people and their care partners. Contributions can be made in the form of an article, case study, letter, question, announcement, review or other appropriate proposal.

Books Available for Review

We currently have a number of books that require reviewing, if you are interested in providing a review please contact us. Thank you.

- Mind Clearing: The Key to Mindfulness Mastery, Alice Whieldon
- Dementia: Support for Family and Friends, Dave Pulsford and Rachel Thompson
- Telling Tales about Dementia: Experiences of Caring, Lucy Whitman
- Losing Clive to Younger Onset Dementia: One Family's Story, Helen eaumont
- Can I tell you about Parkinson's Disease, Alan M Hultquist
- People with Dementia Speak Out, Lucy Whitman
- Counselling Older People with Alcohol Problems, Mike Fox and Lesley Wilson
- Spirituality and Personhood in Dementia, Albert Jewell
- Life Story Work with People with Dementia, Polly Kaiser and Ruth Eley
- Embracing Touch in Dementia Care, Luke J Tanner

Signposts Editorial Panel

Dr Julie Wilcox is a Consultant Clinical Psychologist and Joint Head of Specialty for MHSOP, Neuropsychiatry and Clinical Gerontology within the Mental Health Services for Older People in Cardiff and Vale of Glamorgan.

Annette McLean (Dunne) is a Clinical Specialist Dietician in Eating Disorders and the Mental Health Clinical Dietetic Lead for Cardiff and Vale University Health Board.

Paul Bickerstaff is a Lecturer in Mental Health, Learning Disabilities and Psychosocial Care at the Cardiff School of Nursing and Midwifery Studies.

Johannes Gramich is a social worker working within Mental Health Services for Older People in Cardiff.

Dr Natalie Elliot is a Senior Specialist Speech and Language Therapist with the Cardiff Memory Team and Mental Health Services for Older People in Cardiff and the Vale of Glamorgan.

Dr Rachel Brewer is a Specialty Doctor with the Cardiff Memory Team.