Chapter 27

Psychological "Therapies" in Dementia

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INTRODUCTION

This chapter is concerned with psychological approaches to working with older people with dementia. The development of such approaches can be traced back over at least 35 years; Miller (1977) and Woods & Britton (1977) are good sources for much of the earlier work in this field. Are these approaches "therapies"? Certainly they have usually implicitly assumed that improvements in aspects of the function of the person with dementia are feasible and attainable; however, connotations of a curative model have often been avoided by describing these approaches as "management techniques". In fact, in terms of efficacy, it is not at all clear that the pharmacological therapies currently available are appreciably superior to the best of the psychological approaches (Orrell & Woods, 1996). These are not merely issues of semantics. Caregivers' expectations and the provision of resources are strongly influenced by how the various interventions available are viewed. Raising false hopes that cannot be fulfilled, leading to disappointment and disillusionment, damages the movement towards more positive approaches in dementia care (Woods, 1995a; 1995b). There must be realism as to what may be achieved; but emphasis must also be given to the value, to the person with dementia and to those who provide care, of those changes, however limited, in state and function that are achievable. Only then will the necessary resources of staff time, support and training be made available. We have come a long way from the days when the view that nothing could be done for people with dementia held sway. Now the priority is to define more clearly what can be achieved, and the most effective methods to bring about change.

PSYCHOLOGICAL APPROACHES: A FRAMEWORK

Before presenting information on some of the specific "therapies" that have been described over the years, it is worth discussing their place in the overall scheme of dementia care. Holden & Woods (1995) present an integrated approach which is of use in recognizing some of the general issues that are relevant to most approaches.

Attitudes, Values and Principles

The attitudes, values and principles underlying the implementation of any approach are of prime importance. Psychological and emotional needs must be addressed as much as the physical needs which often appear paramount. Attitudes which encourage individuality as an adult, dignity, self-respect, choice and independence are seen as providing the basis for any positive approach. Similar considerations emerge from the application of social role valorization principles to dementia care (see Chapter 20 in this volume and King's Fund, 1986). The converse of such attitudes is epitomized in the "malignant social psychology" around the person with dementia (see Kitwood, 1990 and Chapter 14 in this volume), which has been accused of reducing function in people with dementia, and perhaps increasing the rate of decline and neurological impairment.

A number of examples are to be found in the literature of dubious practices being carried out in the name of one "therapy" or another (e.g. Buckholdt & Gubrium, 1983). Several of these relate to reality orientation (RO), which seems particularly prone to being applied mechanically, in a depersonalized manner. However, the dehumanization, objectification and invalidation at the core of Kitwood's malignant social psychology are pervasive throughout dementia care; they distort and corrupt the therapies used, and must be dealt with before any approach can be applied appropriately. Why are negative attitudes so prevalent? Common sense and good intentions are not enough; understanding, empathy and imagination are required to acquire the insight needed to view the world from the perspective of the person with dementia. Reducing the pace of caregiving is not easy when other pressures compete. Possibly some features of dementia particularly make it difficult to recognize the person with dementia as being the same person as previously, and deserving of the same respect. Fears of developing dementia may lead some to maintain a distance, avoiding the empathy and closeness that would come from fully recognizing the personhood of the dementia sufferer. Aspects of attitudes and attitude change in dementia care are discussed elsewhere in this volume (Chapter 19); the key point here is that an explicit set of values and principles emphasizing the value and worth of the person with dementia are an essential prerequisite to the application of any psychological approach.

Individualization

Individualization is the second component of the integrated framework. It is important as a basic principle of personhood, with each person being unique, and, in addition, has strong pragmatic support. There are differences in neurological impairment: many different types and subtypes of dementia, many different stages in the progress of these disorders, a random element in some disorders as to which parts of the brain are particularly affected. Even greater are the differences in the person's interests, preferences, priorities, personality traits, lifestyle, ways of coping, health and life experiences which have influenced and shaped the person's life over many years to the present, leading to an enormous range of variation. Simply knowing the person has dementia is remarkably uninformative in the face of such diversity, which demands an individualized response. Lawton's model of "environmental docility" (Parmelee & Lawton, 1990) suggests that the lower the person's competence and level of function, the more likely they are to be shaped by and vulnerable to environmental contingencies. People with dementia are less able to modify and adjust the environment themselves; they therefore require input geared to their individual needs and abilities. They may show a lowered tolerance to variations from their uniquely ideal "person–environment fit", simply because they do not have the reserve capacity to adapt and accommodate. Those who work with the person with dementia must then "fine tune" their approach so that it is as close as possible to being spot-on for that individual.

Learning is Possible

The third key aspect of this integrated framework is the contention that learning is possible. Clearly, new learning is a primary deficit in most forms of dementia (see, for example, Chapter 12 in this volume); however, a great deal of experimental evidence has now accumulated to indicate that under the right conditions, some limited, but potentially valuable, ability to learn is identifiable (see Miller & Morris, 1993, pp. 113–115). This is apparent in at least four areas of learning:

1. Classical conditioning. For example, the eye-blink response that is elicited by a puff of air into the eye will in time be produced by a buzzer that was initially paired with the puff of air on a number of learning trials.
2. Operant conditioning. Patients with dementia have been trained to make a response (such as pressing a lever) contingent on a "reward"; thus four out of five patients with dementia learned to press a lever to obtain music (Burgess, Wearden, Cox & Rae, 1992).
3. Procedural and implicit memory. There are many examples of skills learning being preserved in dementia. In addition, there is evidence of certain aspects of implicit memory remaining relatively unimpaired. This is shown in situa-

tions where performance is enhanced without conscious or explicit recall of material, such as priming, where prior exposure to an item facilitates later processing of that, or a related, item.

4. Verbal learning and retention. Perhaps surprisingly, when information is adequately registered, rates of forgetting after the first ten minutes or so may be relatively normal in many people with dementia. For example, Little, Volans, Hemsley & Levy (1986) showed retention of information over a one- or two-month period by patients with a moderate degree of dementia. Backman (1992) concludes that support must be given at both the time of learning and the point of retrieval to maximize learning in dementia; the person with dementia may then need more learning trials, with fewer items at a time, and more guidance in encoding the material, as well as more retrieval cues.

These experimental findings provide some indications for cognitive rehabilitation (see below) and more generally refute the notion that no change is possible in the fundamental cognitive deficits of dementia.

Selection of Targets

The careful and creative selection of targets is essential; approaches such as RO have been criticized for emphasizing verbal orientation, which may be of limited clinical relevance. Does the person really need to know the day of the week or the name of the prime minister? When changes are inevitably fairly limited in size, and requiring considerable input for their achievement, it is essential that they address the key issues which will make a real difference for the person concerned. Learning to find the toilet on the ward might be important for one patient; for another, improving dressing skills may be the priority; for others, increasing social contact may be important. For some patients in the community who receive different services on different days, learning to keep touch with days and dates may be vital. In view of the often noted specificity of learning in dementia, with improvements not readily generalizing from one goal to another, targets have to be very carefully selected to be precisely and individually relevant and appropriate.

Maintenance of Benefits

Maintenance of benefits is a further major concern. There is a sense that the assumed natural history of decline in the dementias results in an uphill struggle to hold onto function against a backdrop of progressive deterioration. In reality, the clinical picture is considerably more complex, with great variation in rates of change, and some patients showing remarkable stability. Expecting any "therapy", psychological or pharmacological, to have lasting effects without any

further maintenance input is simply unrealistic; interventions need to be ongoing, with targets regularly reviewed as the person's condition changes.

Effects on Staff and Carers

Effects on staff and carers need to be considered alongside those on the people with dementia themselves; their attitudes, well-being and behaviour will have a major impact on the quality of life of the person with dementia. The consequences of any approach for those caregiving day by day must then be considered. If positive, staff or carers may be assisted in their difficult and demanding task—a worthy aim. Improved morale and less strain and burden are likely to lead to more positive interactions between caregivers and patients, and so will be of benefit for all concerned. The improvement in carers' mood reported by Greene, Timbury, Smith & Gardiner (1983), coincident with their relative with dementia attending RO sessions at a day hospital, is one of the most interesting positive indications. The increase in staff knowledge of individual patients related to reminiscence and RO reported by Baines, Saxby & Ehlert (1987) is also important. An integrated approach must take into account the needs, strengths, perceptions, commitment and abilities of caregivers if practicable, realistic care plans are to be developed. Simply to produce positive change in the patient's behaviour is not enough. As Tarrier & Larner (1983) report, staff may not perceive objectively measured change.

Realistic Expectations

Realistic expectations are important if caregivers are not to become disappointed when the latest "therapy" turns out to be no more of a cure-all than those that have preceded it. Changes are generally likely to be small and probably quite specific. Individualized targets for the achievement of change and development should be established, and set at a level where small successes may readily be achieved, so that staff do not become disappointed and the patient is not overpressured. Even when function does not improve, there can be valuable achievements in involving the person in a positive experience—a feeling of success, a moment of contact with another human being, a smile of appreciation. Kitwood & Bredin (1992) argue that it is possible to recognize indications of (relative) well-being in people with dementia when personhood is being maintained. These indicators are thought to be expressions of four "global sentient states": a sense of personal worth—a deep self-esteem; a sense of agency—to have some control over their personal life, to achieve something; a sense of social confidence—of being at ease with others; and finally, a sense of hope—feeling secure, trusting that all will be well. The expression of such states, however fleeting, is a worthy aim of dementia care.

Individual Programme Planning

These considerations lead naturally to an approach that has been described as "individual programme planning" (Woods & Britton, 1985) or "goal planning" (Barrowclough & Fleming, 1986). At the centre of this approach is the individual plan, covering all aspects of the person's life. Developing an individual plan begins with careful and thorough assessment of the person's strengths and needs, including any medical conditions and sensory deficits. As far as possible, the person with dementia and their family should be involved in this planning process. Discovering the wishes of the person with dementia may not be easy, especially when communication is poor. Information from relatives, friends of long standing and so on regarding the person's past life and experiences will be invaluable. Placing the dementing person in the context of their whole life is vital. Reminiscence-based activities may be a great help; preparing a life chart of the important events, people and experiences in the person's life is a good starting point (Woods, Portnoy, Head & Jones, 1992).

The assessment stage will include attempts to understand, as well as to define, the person's behaviour. The reasons for difficulties must be examined, including consideration of specific neuropsychological deficits. Generalized descriptions of behaviour such as "attention-seeking", "confused", "incontinent" and so on must be replaced by detailed descriptions of the person's behaviour, the exact circumstances, its frequency and intensity. Where particular specific neuropsychological deficits are identified, efforts should be made to find ways of overcoming the effects of the problems and ways of compensating for the disability.

Once the initial assessment phase is complete, the plan is drawn up. The strengths and needs that have been identified are used to form the plan. The person's strengths and resources are used to help meet particular needs selected for intervention. These are not selected simply for the convenience of staff, but in relation to the quality of life of the person. It may be that where a particular problem behaviour has been identified the targets will include the encouragement of activities that are incompatible with or which will reduce the frequency of the "problem". For instance, the target for a person who is frequently incontinent might be for the person to learn where the toilet is on the ward. This process in relation to challenging behaviour is discussed more fully by Stokes (Chapter 28 in this volume).

The various "therapies" contribute to the individual plan as possible approaches to some of the very common—almost universal—needs of people with dementia. Achieving success in valued activities, engaging in person-to-person contact and communication, finding important places and making sense of what is happening may all emerge in many patients' individual plans, and may all be addressed by one therapy or another. These approaches are then seen as subordinate to the individual planning process, but contributing significantly to the developing repertoire of methods of meeting individual patients' identified needs available to caregivers.

PSYCHOLOGICAL THERAPIES

Stimulation and Activity

These approaches arose from the notion that people with dementia are under-stimulated, receiving inadequate sensory input. Reduced sensory input may be experienced for several reasons; first, normal decline in sensory acuity; secondly, the monotonous environments in which some older people live; and thirdly, some patients withdraw and reject stimulation, cutting off from the environment, perhaps as a way of coping with perplexing, almost alien, surroundings. Support came from sensory deprivation experiments, showing that even young people suffered from confusion when deprived of sensory stimulation for a period of time (see Holden & Woods, 1995). Sensory deprivation results as much from monotony as from lack of stimulation.

A number of early studies reported positive effects from a range of social, physical and psychological stimulation, including occupational therapy and do-mestic and recreational activities (see Woods & Britton, 1977). Such activities have become a widely accepted aspect of good practice and are now offered in many care settings. More recently, different types of stimulation or activity have been evaluated, and ways of increasing the response of people with dementia, including those most severely impaired, to activity and stimulation have been explored.

For example, Norberg, Melin & Asplund (1986) evaluated the effects of music, touch and objects expected to stimulate the person's senses of taste, touch and smell (e.g. fur, hay, bread, camphor). Two severely impaired patients with de-mentia, who showed little, if any, verbal communication, were carefully observed whilst receiving the various forms of stimulation. A definite positive response to music was identified, but no differences in reaction to different objects or to touch were detected. Similarly, Gaebler & Hemsley (1991) identified a response to music in the majority of a group of six patients whose dementia was very ad-vanced and with whom verbal communication was impossible. These studies are particularly important in their focus on severely impaired patients and their painstaking use of observational methods to reliably detect a response that would be perhaps imperceptible to the untrained eye.

The effects of music have also been evaluated on a less impaired group of "Alzheimer patients" by Lord & Garner (1993). Groups of 20 nursing-home residents had either "big band" music from the 1920s and 1930s or puzzle exer-cises or the "standard" recreational activities of drawing, painting and TV over a six-month period in daily half-hour recreational sessions. The music group showed better recall of personal information, and their mood and social interac-tion also improved compared with the other two groups. "The subjects in the music therapy sessions always smiled, laughed, sang, danced and whistled while listening to the music." The other activities did not elicit the same degree of anticipation, enjoyment and pleasure, and were less effective as triggers of social interaction.

Pet animals are another popular source of stimulation. Several evaluative studies have been reported. Elliott & Milne (1991) and Haughie, Milne & Elliott (1992) evaluated the impact of a visitor with a dog in a psychiatric hospital ward where most patients had a diagnosis of dementia. In both studies interaction levels increased markedly when the dog and visitor were present. In the latter study, to control for novelty, photographs of the dog and visitor were also used as stimuli; they were associated with smaller, but still significant, increases in interaction. A number of aspects of the patients' behaviour, including mobility and dependency, were rated by nurses as improved when the dog was present. The improvements were not maintained on days subsequent to the visits of the dog. The presence of a stimulus is needed to elicit the higher level of interaction and other changes.

Most activity programmes have included some form of physical exercise, usually highly structured—light bending and stretching exercises whilst sitting in a chair, throwing a ball, knocking down skittles, brisk walking, rhythmical movements, movement to music, etc., all demanding task attention. Morgan (1991) reviews several studies on the effects of exercise in dementia. While there are some indications of limited benefits on aspects of cognitive function (e.g. Molloy, Richardson & Crilly, 1988), overall the studies have not been well controlled, so any benefits cannot be linked with certainty to the physical exercise component of the intervention. Also, diagnostic criteria have been weak in these studies.

Other sources of stimulation yet to be formally evaluated include visits by carefully prepared school-age children (Langford, 1993). There is much interest in "Snoezelen", an approach originating in Holland which seeks to increase the amount of sensory stimulation through changing coloured lights and visual effects, relaxing armchairs and cushions, pleasant smells and even a vibrating cushion and a soap bubble machine. The word "Snoezelen" is a contraction of two Dutch words meaning "sniffing and dozing". A positive evaluation has appeared (Benson, 1994), which suggests increased relaxation, improved mood and decreased agitation during Snoezelen sessions, although with little carry-over beyond the session. This article also suggests that conventional relaxation techniques—gentle music and one-to-one encouragement of slow, deep breathing—were equally effective in calming patients with dementia. Methods of providing tactile stimulation—hand or foot massage, aromatherapy, etc.—are also suggested as relaxing, enjoyable activities (e.g. West & Brockman, 1994).

Further support for the usefulness of relaxation techniques is provided by Welden & Yesavage (1982). Twenty-four matched pairs of patients with dementia attended either a relaxation training group or a current affairs discussion group for an hour three times a week over a three-month period. Relaxation instructions included progressive muscle reduction and a self-hypnosis technique. Subjects attending relaxation sessions showed improvement on ratings of behavioural function compared with the control group. In addition just over 40% of

those taught relaxation techniques no longer required sleeping medication; none of the control group was able to discontinue.

It has been argued that too much stimulation is unhelpful for people with dementia, and "reduced stimulation units" have been described (Cleary, Clamon, Price & Shullaw, 1988). Clearly stimulus overload is to be avoided; many care environments are too noisy, and too much happening around the person can be perplexing and can add to confusion. The emphasis in practice has been to devise stimulation and activity that will engage the person with dementia, that will be enjoyed and valued, and not act as an irritant. There will be individual differences, of course; some will not want dogs or children, and individuals' musical preferences must be respected. The growing interest in calming forms of stimulation suggests that some people with dementia are seen as over-aroused, having high levels of internal stimulation, emerging as feelings of anxiety and agitation. The sensory deprivation hypothesis is too simplistic to encompass all these strands, but has been a useful starting point.

Reality Orientation

This long-established psychosocial approach has been used with older people with dementia for over 30 years, and an extensive literature, both evaluative and descriptive, is available (see Holden & Woods (1995) and Woods (1992) for full reviews).

Two major components of reality orientation (RO) are described. Twenty-four-hour RO (or informal RO) involves a number of changes to the environment, with clear signposting of locations around the ward or home, extensive use of notices and other memory aids, and a consistent approach by all staff in interacting with the person with dementia. In its original form, staff undertaking 24-hour RO were intended to offer orienting information in each and every interaction; more recently, a modification has been described where staff are trained to take a more reactive stance, orienting the person only in response to his or her requests (Reeve & Ivison, 1985; Williams, Reeve, Ivison & Kavanagh, 1987). RO sessions (or RO classes) are structured group sessions, involving a small number of patients and staff, meeting regularly, often several times a week for half an hour or so. A wide variety of activities and materials are used to engage the patients with their surroundings, to maintain contact with the wider world and to provide cognitive stimulation. A typical session would go over basic information (such as names of those in the group, day, date, time and place), discuss a current relevant theme of interest, perhaps play a number or naming game, and finish with refreshments. Throughout there would be a tangible focus: a white-board for the current information; pictures or objects appropriate to the theme; personal diaries and notebooks for those able to record information for later use.

Holden & Woods (1995) identified 21 studies, meeting the criterion of report-

ing an evaluation of the effects of RO in comparison with either no treatment or an alternative intervention. There are many differences between the studies:

1. In the type of RO evaluated. Only a third of studies included 24-hour RO; just two of these evaluated the extent to which this intensive approach was actually being implemented.
2. In location. Hospital wards, residential and nursing homes, day centres and out-patients have all been the setting for one or more projects.
3. In the specificity of the diagnosis of dementia. Diagnostic criteria have not always been well described.
4. In measures used. A wide variety of brief cognitive scales (mainly orientation tests) and behaviour rating scales have been adopted.
5. In duration of the intervention period. The briefest period was three weeks, the longest a year. Frequency of RO sessions varied from twice daily to once a week; most studies had sessions five times a week.
6. In design and methodological adequacy. Whilst some studies have randomly allocated patients to groups, others have had comparison groups in different wards/homes/units. Each approach has its problems, the former especially where 24-hour RO is included, with inevitable "contamination" across the groups. Few studies have employed raters "blind" to group membership, and few have followed patients up after the end of the intervention.
7. In comparison groups included. No treatment has been most commonly used, but about a third of studies have offered an alternative group activity, sometimes as a placebo to control for the effects of attention, at times as a viable alternative to RO sessions.

Despite these variations between studies, some remarkably consistent conclusions have emerged. First, there is strong support for RO sessions being associated with increased scores on measures of verbal orientation, as compared with no-treatment control groups. Only one study to date (Williams, Reeve, Ivison & Kavanagh, 1987) has reported cognitive changes that could be attributed specifically to 24-hour RO, but, as mentioned above, few studies have actually demonstrated its implementation. With the emphasis in RO on verbal orientation, these findings may not seem so surprising, although given the severity of the learning problems in dementia, any indications of improvements are welcome. More controversial are suggestions that more general cognitive improvements may occur. Some studies suggest that only those orientation items specifically taught are learned; others that from a battery of cognitive tests, only the orientation items show improvement. More recent reports (e.g. Breuil et al., 1994; Zanetti, Bianchetti, Montini & Trabocchi, 1993) have tended to support the notion that more wide-ranging improvements in new learning ability may follow cognitive stimulation of this type.

The second main conclusion is that changes in function and behaviour are much more elusive than cognitive changes; in general they have been the exception rather than the rule. There are many possible factors in this difference

between the change in cognitive test performance and real-life function: behaviour rating scales used have often been less sensitive to the small changes envisaged; an environment encouraging dependence (as many have been shown to do) may counteract any benefits from group sessions; it is dubious whether verbal orientation has any influence on many of the areas of function, such as feeding and dressing, which comprise much of the content of the behaviour rating scales typically used. It may be argued that direct training of a particular skill will be required for behavioural change; several workers have shown this in relation to ward orientation—the person finding their way around the ward or home. Improvements in this domain have been shown in relation to specific training by Hanley, McGuire & Boyd (1981) and associated with 24-hour RO by Reeve & Ivison (1985) and Williams, Reeve, Ivison & Kavanagh (1987). These studies have in common a demonstrable intervention in the person's living environment, the former through direct training, the latter two through the monitored evaluation of 24-hour RO. The greatest range of behavioural improvement reported was evident in these studies.

The RO literature raises many questions, but does indicate that scope for cognitive management in dementia does exist. Further work from a more specifically cognitive standpoint is described below. RO has been much criticized in relation to its mechanical, inflexible, insensitive, confrontational application and its over-emphasis on cognitive aspects. Used appropriately, within an individualized framework, it still has an important part to play in dementia care.

Reminiscence

The use of past memories to establish a point of interest and contact has been often used in RO sessions, and has attracted much interest as an approach in its own right (Woods & McKiernan, 1995; Gibson, 1994). Reminiscence work with older people more generally developed from psychotherapeutic considerations, emphasizing the place of life review in adaptation (Coleman, 1986; Bornat, 1994). Reminiscence had been used extensively with patients who are depressed as well as those with dementia; it should be recognized that the aims and techniques may need to be different in each case. Norris (1986) provides an excellent description of the practical application of a variety of reminiscence techniques. There is an accumulation of evidence for the effectiveness of various types of reminiscence work in reducing depressive symptoms in older people (Scogin & McElreath, 1994).

Haight & Burnside (1993) draw attention to the way in which this psychotherapeutic use of life review has been confused with other reminiscence work, such as that with people with dementia. Whilst the terms "reminiscence" and "life review" have often been used interchangeably, they suggest that life review be used solely to describe an intervention where the therapist is seeking to assist the person in achieving a sense of integrity. This involves the older person

recalling and *evaluating* events and experiences throughout their life, usually in a one-to-one setting with the therapist, who acts as a therapeutic listener. Garland (1994) provides a useful account of life review therapy. Life review therapy, as described here, is much more likely to involve working through difficult and painful memories and experiences; it should be undertaken, like any other personal therapy, with the person's consent, with a clear aim, by properly trained and supervised workers. Generally speaking, it is a more appropriate approach for older people without cognitive impairment. "Reminiscence", on the other hand, is seen as having a variety of goals, including increased communication and socialization, and providing pleasure and entertainment. It may be individual or group-based; may be structured or free-flowing; may include more general memories than specific events or experiences; themes and prompts are frequently used; evaluation of memories is not specifically encouraged; and the focus is on a relaxed, positive atmosphere. Sad memories may emerge, but support is available from the group leader and other members, or from the worker in individual work, to contain any distress or pain associated with such memories. Reminiscence work *is* appropriate for people with dementia, but some caution is still required, taking into account Coleman's (1986) report of large individual differences in attitudes to reminiscence amongst older people and the need to avoid an intrusive approach that invades individuals' privacy. Particularly in a group setting, awareness of participants' life histories is important, to ensure appropriate support can be given if events that have traumatic connotations for certain individuals are being raised by other members.

The cognitive roots of using this approach arise from the apparent preservation of remote memory in dementia; the person appears to remember events from their childhood, whilst unable to recall what they had for lunch. Of course, when this area has been systematically tested, recall for specific events from many years ago is not relatively preserved (Morris, 1994); performance across the life span is depressed compared with age-matched controls. People with dementia, like normal older people, recall more memories from early life; such memories are often over-learned or well rehearsed, or have particular personal and/or emotional significance for the person concerned. Morris points out that studies of autobiographical memory indicate there is typically virtually no recall from the person's middle years; this disconnection must add greatly to the difficult of regaining orientation to the present time.

Reminiscence therapy has been used with individuals and in small groups (Norris, 1986; Thornton & Brotchie, 1987; Woods, Portnoy, Head & Jones, 1992; Gibson, 1994). Photographs, music and archive recordings, video tapes of newsreels and items from the past are used to stimulate a variety of personal memories.

Despite a number of positive anecdotal reports, empirical research on reminiscence with people with dementia remains in its infancy. Thornton & Brotchie (1987) and Woods & McKiernan (1995) provide detailed reviews. No changes in cognitive or behavioural function were reported by Goldwasser, Auerbach & Harkins (1987), who compared twice-weekly reminiscence and support groups

with a no-treatment control over a five-week period. The reminiscence group showed an improvement in depression, but this was lost at a follow-up six weeks post-intervention. It appeared that the less impaired patients showed most response.

Baines, Saxby & Ehlert (1987) compared reminiscence and RO groups in a residential-home setting, with residents having a moderate to severe degree of cognitive impairment. Staff involved in a reminiscence group acquired much more individual knowledge of the residents in the group than they did of residents in a control group who received no additional treatment. Residents were rated as deriving a great deal of enjoyment from the groups, both by staff taking part in the groups and by staff who saw the residents only outside the groups. Attendance at the reminiscence groups was consistently high. Some effects on cognitive and behavioural function following reminiscence sessions were apparent in a group of five residents who had previously responded well to a month of RO sessions. They showed a reduction in scores on a problem behaviour rating scale, as well as an increase in verbal orientation. A group who had a month of reminiscence sessions before going on to RO sessions showed far fewer positive changes in relation to the untreated controls.

Other studies have looked at changes within the group session. Head, Portnoy & Woods (1990) contrasted reminiscence work with alternative group activities in two day centres. In only one centre was there a clear increase in the contributions made by group members during reminiscence as opposed to other activities. The lack of difference in the second centre appeared to be related to it having a much more stimulating range of alternative activities, rather than any failure on the part of the reminiscence work to elicit communication. In an initially unstimulating environment, the results of any intervention will appear much more dramatic. Woods & McKiernan (1995) report the results of work by McKiernan, Yardley & Bender indicating increased engagement of patients with a moderate to severe degree of dementia during reminiscence groups in three different units, confirming "that it provides a meaningful, appropriate and stimulating activity for people with even a very severe impairment".

A larger-scale evaluation of a number of "general" reminiscence groups is reported by Gibson (1994), with a sample of four residential homes and two day centres. Some groups were specifically for people with dementia, whilst others had a mixed membership. People with dementia showed pleasure and enjoyment in mixed groups and rarely exhibited any behavioural disturbance within the group; outside the group some individuals were reported by staff to be less agitated and restless. In the dementia-specific groups interactions tended to be between leaders and members, rather than between members, as had more commonly been the case in the mixed groups. Small, structured groups seemed to be most effective for people with dementia.

Gibson (1994) has also been developing individual reminiscence work with people with dementia. Five cases were selected as the most "troubled or troubling" residents of nursing homes. For each person, a detailed life history was compiled, from which a care plan was evolved, including "special" reminiscence-

type work. The aim was to use "life-history as a working tool to enrich the quality of social exchange in the present". Trips and activities that related to the person's interests and experiences were planned, and the environment personalized and individualized according to the person's own style and preferences. Residents were reported to have shown increased sociability, decreased aggression and less demanding behaviour following the implementation of this individualized approach. Staff also responded positively, recognizing more of the "personhood" of each individual. This study illustrates the value of life histories as a major influence in care planning (see also Woods, Portnoy, Head & Jones, 1992; note what they describe as "life reviews" are better regarded as life histories). The aim is to help the care staff see the person in the context of their life span, and so assist in improving the quality of their interactions with the person with dementia.

Outcome research on reminiscence in dementia is inconclusive; there are clear benefits within group sessions, but the impact outside is less certain. Changes in staff perceptions are promising. Many questions remain regarding how best to run reminiscence groups and how to use one-to-one work most effectively. Reminiscence continues to offer exciting possibilities in dementia care. There is a pressing need for more sophisticated research which focuses less on overall outcome and more on how best reminiscence may be adapted to individual needs and circumstances.

Validation Therapy

Validation grew out of the dissatisfaction felt by Naomi Feil, a social worker in the USA, with approaches such as RO, which appeared over-confrontational. Feil found that insisting upon the person being oriented to the present reality often led to the person withdrawing and even becoming hostile (Feil, 1992a). Jones (1985) sums up the approach as "communicating with disoriented elderly persons by validating and supporting their feelings in whatever time or location is real to them, even though this may not correspond to our 'here and now' reality". Although Feil has been developing the approach since the 1960s, it was in the 1980s that the approach began to attract wider interest, initially in the USA and then further afield. Several publications describe aspects of the approach (Feil, 1992a; 1992b; 1993). Feil (1993) gives the most detailed description of the techniques involved.

At the core of the approach lies a recognition of the individuality of the person with dementia and respect for their value as a person, which fits well with the explicit values discussed above. There is an emphasis on what has gone on previously in the person's life influencing their current state; specifically, the person with dementia is seen as endeavouring to resolve "unfinished business" before the end of their life. Four stages of this "resolution" phase of life are identified: malorientation, time confusion, repetitive motion and vegetation. People with dementia are viewed as progressing through these stages, showing in-

creased physical deterioration and withdrawal inwards. The aim of validation is to restore dignity and prevent the deterioration into vegetation, through the provision of an empathic, non-judgemental listener who accepts the person's view of reality. Painful feelings from the past that are expressed, acknowledged and validated in this way are thought to decrease in strength, whereas if ignored or not expressed they are said to heighten.

Feil (1993, p. 31) acknowledges that people do not remain neatly in one stage or another, and that there is considerable fluctuation. However, by detailing different techniques for different stages she is offering some insights into what may be more or less helpful in particular types of situations. The specific techniques include many aspects of non-verbal communication—use of touch, eye contact, tone of voice—as well as using music and reminiscence. The loss of recent memory, combined with sensory losses, is seen as leading to the retrieval of earlier memories and familiar faces, and "the need to go back to mend torn relationships" (Feil, 1993, p. 30). There is thought to be a reason behind all behaviour, and an important technique is to link the person's behaviour with the unmet human need underlying it. Three needs are seen as universal: the need to be loved and nurtured, the need to be active and usefully engaged and the need to be able to express deep, raw emotions to an empathic listener.

The core technique is to recognize the person's communication of feelings and emotions, and to acknowledge and validate these, verbally and non-verbally. Whatever the person's current reality, whatever the facts of the matter, their feelings have their own validity. To respond to emotions at a cognitive level alone is to ignore an entire (and probably the most important) dimension of communication. For example, many people with dementia speak often about their parents as if they were still alive. To respond at a cognitive level, to correct the person, may well miss a key issue for the person with dementia. Miesen (1992; 1993) has shown the importance of attachment for many people with dementia, reflecting a need for security and safety in a perplexing and at times frightening environment; this need for attachment returns to the parents, the original attachment figures, in the person with dementia who develops a "parent fixation". This should then be seen as an expression of need, not simply as a sign of confusion.

Validation techniques are often applied in a group setting, but can be used effectively on a one-to-one basis. Even a few minutes several times a week is thought to be a worthwhile input; as with other communication-based approaches, much can be achieved during routine caregiving, although it may well be demanding work in its own right. More severely impaired patients in particular will require an individual approach. In group settings, there is an emphasis on comfort, and of the time together being "special". Music is used as a uniting activity, and every effort is made to minimize communication difficulties. Group members are encouraged to take on responsibilities within the group—song-leader, welcomer, giving out refreshments, and so on. The wisdom of group members is drawn upon, placing them in the position of having something to give from their extensive experience of life, e.g. "What advice would you give a young

couple thinking of getting married?". Issues for discussion are chosen to reflect real concerns and issues: there is no avoidance of controversial topics.

There are very few published studies documenting the efficacy of validation, although numerous anecdotal reports are referred to by Feil (1992b; 1993). Morton & Bleathman (1991) report an evaluation of a validation group which ran over a 20-week period in a residential home. Five residents with dementia participated; for ten weeks beforehand, their behaviour, mood and interaction levels in the day-room of the home were monitored. These measurements continued during the period of the group and for 10 weeks afterwards, when reminiscence techniques were used in the group. The group sessions were held for one hour, once a week. Three of the residents completed the study; the individual results suggested that for two residents verbal interactions increased during the validation therapy period, with a decline during the reminiscence period, while the remaining resident showed the opposite pattern, with an increase apparent during the reminiscence phase. It should be emphasized that these interaction measures were taken *outside* the group setting, in the home's day-room. There was a remarkable contrast between how little these residents interacted during any phase and the depth of interaction apparent during the group sessions (see Bleathman & Morton, 1992, for an illuminating selection of transcripts from the sessions). It is unclear whether this is attributable to the specific validation techniques, rather than to the more general influence of the carefully structured small-group setting.

Cognitive psychology is beginning to recognize the importance of emotional aspects alongside the cognitive components of models of human function. Williams (1994) suggests that the interacting cognitive subsystems model, developed by Teasdale & Barnard (1993), may be helpful in conceptualizing validation. The model proposes two meaning subsystems, propositional and implicational, reflecting cognitive and emotional representations respectively. If the implicational subsystem is intact, the propositional subsystem will not be able to make sense of its output in relation to recent events, as propositional event memory is clearly impaired in dementia. Instead, it will use material relating to events perhaps many years previously to complete the fragmented description emerging from the implicational subsystem. For example, the person's emotion of feeling lonely and abandoned, generated in the implicational subsystem, may be only interpretable propositionally, as "Where is my mother?". The task for the caregiver is to respond at a level that connects with the implicational content. Reframing validation in this way may assist in developing the approach from a theoretical foundation.

Validation has been subject to some criticism. Confusion has arisen as to whether or not it was intended to be used with people with dementia (Stokes & Goudie, 1990). This has resulted in part from the idiosyncratic and changing terminology adopted by Feil. Feil (1993) makes it clear that people with dementia are the focus. Younger people (i.e. under 70) with Alzheimer's disease are identified as generally continuing to deteriorate despite the use of validation, unlike older people with dementia (Feil, 1993, p. 24). However, the techniques are still recommended as having some transitory effect.

Kitwood (1992) cautions that the emphasis on past life, on unresolved conflicts and difficulties, means that current sources of devaluation and impoverishment may be overlooked. Each behaviour may well have a reason behind it, but it may be in the "here and now", rather than buried in the mists of time. Many people with dementia daily experience all manner of unhelpful, unsupportive interactions which may have as great an impact as past conflicts. By emphasizing the role of "unfinished business" an implicit assumption arises that if one could learn to cope with life's problems adaptively, dementia could be avoided. This implies that people with dementia have in a sense inflicted it upon themselves, by their lifestyle and ways of coping. There is no evidence to suggest that this is in fact the case, and there is a real danger of accentuating further the "them and us" divide between cared-for and caregivers, if dementia is attributed to the person's own actions.

Resolution Therapy

Resolution therapy is described by Stokes & Goudie (1990). It is similar to validation in that the aim is to tune in to the emotional communication of the person with dementia, adopting empathic listening skills. However, there is less emphasis on unresolved issues from the past, and more on the need for careful listening to identify feelings relating to making sense of the current situation, or expressing a current need. What the person says may, on the surface, not make "sense", but using counselling skills—warmth, acceptance, reflective listening, etc.—the concealed meaning may become apparent, reflecting the underlying feelings. The focus is on what the feeling is, not on why the person feels it; demanding explanations is seldom helpful in any context. Having identified the feelings, the next stage is to acknowledge them, verbally and non-verbally, and to modify the environment and the pattern of care to respond to unmet needs.

As well as counselling approaches such as this, there have also been exciting developments in the application of dynamic psychotherapy (Hausman, 1992; Sinason, 1992) and cognitive behaviour therapy (Thompson, Wagner, Zeiss & Gallagher, 1990) to older people with dementia. These developments reflect the earlier recognition and diagnosis of dementing conditions, resulting in a growing number of individuals with a much clearer awareness of what is happening to them. As yet, detailed studies of these approaches with these patients are not available; the application of a range of therapeutic listening techniques to people with dementia is long overdue. An important issue will be to consider to what extent such approaches have an impact on the overall process of dementia, or whether they are better seen as ways of enhancing communication with the person with dementia. The latter would itself be a very useful objective, and might facilitate short-term changes in function and well-being. As interest increases in this area, it may be that more attention will be given to what the person with dementia should be told about their diagnosis and prognosis: current

practice is usually to inform the relative rather than the patient, unless the dementia is mild (Rice & Warner, 1994).

Cognitive Management

From an analysis of cognitive deficits in dementia (Backman, 1992), it is clear that problems are more likely where performance depends on episodic memory or even semantic memory. Accordingly, to enhance function, cognitive load must be kept to a minimum, strong support provided for encoding *and* retrieval, with the use of retrieval cues where appropriate, and procedural memory and implicit memory utilized. So far little attention has been given to cognitive deficits other than memory and learning, and so the applications described largely emerge from this domain.

Reducing Cognitive Load

Alberoni et al. (1992) suggested that working with people with dementia individually rather than in groups would reduce their cognitive load. They demonstrated that in group conversations people with dementia have difficulty in remembering who said what, particularly when the group size was larger. Patients tended to use spatial location as a cue, and performance was particularly disrupted when group members changed places. It should be noted that these difficulties were elicited in relation to patients watching a video tape of a group conversation, rather than participating themselves. In an actual conversation, with familiar people, the problems might not be so marked. Morris (1994) suggests that these deficits mean group therapies "can degenerate into a monologue between individual staff members and patients". This is borne out by the finding of Woods, Portnoy, Head & Jones (1992) that in reminiscence sessions the majority of interactions taking place were between staff and patients; as would be predicted, they occurred more often between patients in a smaller group. Gibson (1994) similarly recommends small groups for people with dementia. In choosing whether to work with individuals or a small group, the advantages of working in groups—peer support, a social atmosphere, shared experiences—need to be weighed against their undoubted cognitive demands. Where groups are used, they should be as small as possible, with members retaining the same seating position from session to session; background noise and distractions should be kept to a minimum, and care taken to ensure that only one person speaks at a time.

External Memory Aids

External memory aids reduce the level of demand on effortful, self-initiated cognitive processes and provide support for the person in cuing and prompting

retrieval of information—key features of effective cognitive training approaches (Backman, 1992). Retrieval cues in dementia generally require a high degree of specificity in order to be effective. Non-specific external aids, such as an alarm clock or a kitchen timer, serve only to remind the person that *something* is to be remembered, leaving them with the frustration of not recalling what it was that had to be done. The effects of more specific aids have mainly been demonstrated through single-case studies. For example, a 68-year-old patient with a severe memory impairment successfully used a diary to prompt continuing awareness of personal information taught to her in daily individual sessions (Woods, 1983). Hanley & Lusty (1984) report a single-case study where an 84-year-old patient with dementia was able to achieve a higher level of orientation, using a watch and a diary as retrieval cues. Specific training was required in the use of the cues; without this, the patient did not spontaneously make use of them. During the training phase, the patient kept a far greater proportion of her "appointments" than previously, demonstrating an impact on everyday behaviour as well as on testing.

In a series of studies, Bourgeois (1990; 1992) has evaluated the effects of a prosthetic memory aid on conversational skills in people with dementia. The aid consisted of photographs and pictures of past and more recent events, important people in the person's life, and so on, in a convenient, robust wallet or book format. The person's spouse and other visitors were encouraged to use the aid when talking with the person. The results suggest that its use was associated with less ambiguous utterances and more statements of fact. The quality of conversation was assessed by independent raters as being significantly improved with the use of the aid as a focus for conversation. The aid is also reported to have proved useful in improving the quality of interaction between pairs of people with dementia. Although the aid is described as a prosthesis, its effects appear to be as much in prompting a number of memories related to each item, as simply acting as a replacement memory store for the specific information contained therein.

External memory aids have been explicitly used to reduce the load on the person's own memory and to support retrieval in daily living tasks by Josephsson et al. (1993). Four patients with dementia were evaluated on tasks such as preparing and consuming a drink or snack. Signs on drawers and cupboards indicated the location of required items. Physical demonstrations of task components were provided, for the patient to repeat. Verbal prompts and cues were also given. Improvements in task performance were shown by three patients; for two of these, continued environmental support and guidance were needed to maintain these gains. The remaining patient's lack of improvement was attributed to a high level of anxiety interfering with the learning process.

The need for staff input, at least initially, in reinforcing the use of the external aids is seen in the RO literature on signposting. Signs are usually more effective when combined with staff involvement, pointing out the signs and using them to orientate the person in training sessions (Hanley, 1981; Gilleard, Mitchell & Riordan, 1981; Lam & Woods, 1986). Such signposts may be viewed as retrieval

cues; certainly some people with dementia are capable of benefiting from them, with practice in their use, even though not using them spontaneously.

Enhancing New Learning

As discussed above, it is thought that once information is adequately registered, the rate of forgetting after the first ten minutes or so may be virtually normal. Several techniques to achieve this initial learning have been described.

In spaced retrieval or expanded rehearsal (see, for example, Moffat, 1989; Camp & Schaller, 1989) only one item at a time is learned. On each trial the retrieval period is adjusted according to whether the item was successfully recalled on the preceding trial; if it was, it is doubled; if not, it is halved. In this way, the item becomes fully registered, and subject to a relatively normal rate of forgetting, rather than the immediate decay of the memory trace usually associated with dementia. The next item is taught only when the first is fully established. Although this seems (and is) a laborious process, there is some evidence that learning may generalize to items not specifically taught in some situations. For example, Moffat (1989) indicated some generalization in retrieving the names of pictures of objects in a younger patient with Alzheimer's disease.

Several studies (see Backman, 1992; Martin, Browers, Cox & Fedio, 1985) suggest that encoding information in the form of a motor act (such as acting out a movement associated with the word to be learned) is helpful, even where the degree of dementia is severe. Bird & Kinsella (1996) have combined spaced retrieval and motor learning, and have shown both to make a useful contribution to learning. Sandman (1993) provides an interesting example of giving support at both encoding and retrieval. He showed that people with dementia improved their recall of a TV programme when they worked with their relatives on creating their own test question on it, i.e. they established their own retrieval cues at the time of learning. Self-generated cues are likely to be the most effective.

From the same study comes a further example of how support at the time of encoding might be given, by making the event more distinctive and memorable. A significant event was planned by the caregiver with the patient. It was chosen to stand out from the usual routine, and might be a picnic, a trip out or a meal at a special restaurant. Patients were subsequently asked about details of the day not directly related to the event, such as what they were wearing, who they met that day, and so on. Patients showed normal recall for items from these special days, whilst being significantly impaired on items from ordinary days. Caregivers are often encouraged to develop a routine, as this may reduce memory load; this should not, however, be at the cost of having nothing worth remembering. These findings suggest that to "de-emphasise memorisation as a goal" (Sandman, 1993) may itself be helpful. By making the experience as rich and meaningful as possible, memories associated with it will be enhanced. Helping the person to

work on the material (but *not* asking them to remember it) and using retrieval cues are probably the best ways of enhancing performance.

Implicit and Procedural Memory

An application of procedural memory is reported by Zanetti et al. (1994). Employing the time taken to perform various basic and instrumental acts of daily living tasks as the outcome measure, four patients were reported to have shown improvements after three weeks of daily one-hour training sessions. Improvements were noted on both the specific activities trained and control tasks not included in the programme.

An example of implicit memory is "priming", where exposure to an item enhances later processing of that, or a related, item. Morris, Wheatley & Britton (1983) report a study where the person was shown a list of words, then given the initial letters of the words to be recalled. Word-stem completion occurred more readily where the person had had prior exposure to the word; the effect in patients with dementia was near normal. Priming has had some practical application, for example in the use of word-stem cues to aid verbal orientation.

Making use of preserved implicit memory, by reducing reliance on effortful processing and building on more automatic, well preserved skills, is an approach with much to commend it. These processes could be seen as underlying several approaches described previously, e.g. spaced retrieval (Backman, 1992), retrieval cues (Josephsson et al., 1993) and ward orientation training (e.g. Lam & Woods, 1986). However, two caveats should be noted. First, the various forms of implicit memory may not all be affected in the same way by the person's dementia. Thus Heindel et al. (1989) indicate that people with Huntington's disease show an impairment on procedural memory, but not on lexical priming, whereas people with Alzheimer-type dementia show the opposite pattern. Parkinson's disease patients with dementia were impaired on both types of implicit memory. Secondly, it should not be assumed that such techniques help the person to achieve "normal" memory. The person in fact may have little or no conscious memory of the event (as is suggested by the definition); what is being accessed are more automatic processes, achieving the goal by a different pathway. Indeed the person may feel they are guessing the answer (Downes, 1987). However, to achieve a goal by a different route is a perfectly reasonable rehabilitation goal, but it is not "normal function" that is being restored.

CONCLUSION

The emphasis in this chapter has been on working directly with people with dementia on goals largely related to orientation, communication and achievement. A number of approaches have something to contribute to this work, within the framework of individual assessment and care planning that has been outlined.

Goals relating to challenging behaviour are discussed in detail by Stokes (Chapter 28 in this volume).

Training family caregivers to implement these approaches has not yet been given much attention (see Brodaty (1992) for a review). Some examples exist in the behavioural literature (e.g. Green, Linsk & Pinkston, 1986) and in the use of a prosthetic memory aid (Bourgeois, 1990) to enhance conversation. It is noteworthy that in the latter study, whilst independent raters confirmed improvements in conversational quality, the relatives involved did not perceive these changes. More attention needs to be given to developing approaches that family caregivers can make use of, without adding to their sense of strain, and which will target areas of value to both caregiver and care recipient. The added dimension of the existing pattern of relationship may well complicate the application of approaches such as RO, reminiscence, validation, etc., and a good deal of creative work is needed to find ways of implementing useful techniques in the family home.

Developing further cognitive models for rehabilitation and management may be particularly helpful, particularly when emotional and behavioural aspects are considered in the overall model, but these need to be extended beyond memory and learning to reflect the wide range of cognitive deficits to be found in dementia. As with all the approaches, the application of cognitive techniques must recognize the individuality of the person with dementia, and ensure that their perspective is recognized and respected. The increasing use of psychotherapeutic approaches in dementia is to be welcomed, and special issues arising in working with the person with a mild cognitive impairment need to be identified. Therapeutic listening may hold the key to relating to the person's implicational cognitive subsystem (Teasdale & Barnard, 1993). This affective subsystem perhaps increases its influence on the person's quality of life whilst the cognitive subsystem's integrity declines.

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