'The Remembering Group'; facilitating a cognitive stimulation group in an inpatient health and rehabilitation setting.

A submission for Clinical Psychology Forum

Summary

A trainee clinical psychologist and two occupational therapists reflect upon the experience of adapting a cognitive stimulation therapy group for an inpatient health and rehabilitation setting. The adaptations, benefits and challenges of implementing the group are discussed.

Introduction

Cognitive Stimulation Therapy (CST) is a brief group intervention recommended for people with mild-moderate dementia of all types (NICE, 2006). It is included in the British Psychological Society's guide to psychosocial interventions in early stages of dementia (2014).

CST is typically undertaken with a small group of people with a diagnosis of dementia who meet twice weekly for 45 minutes for 7 weeks (Spector et al., 2006). The group utilises reminiscence, music and singing, physical activities such as throwing a ball and mental activities such as matching sounds to pictures. It

encourages orientation to the month, year and season at the beginning of each group meeting.

CST has been associated with improvements in cognitions and quality of life in mild-moderate dementia (Spector at al., 2003). It appears to have particular effects in promoting language function which has been thought to lead to more generalised benefits (Spector et al., 2010).

Setting

The group was piloted in two older adult rehabilitation wards in an inner city hospital. As attendees of the group were simultaneously undergoing treatment for their physical health, they are referred to as 'patients' throughout the article.

Patients may have been treated in an acute ward prior to admission or admitted directly from the community. Patients are admitted with a variety of physical, mental and cognitive co-morbidities. The wards' physiotherapists (PT) and occupational therapists (OT) have already established groups, such as balance and breakfast groups, which are primarily focused on assessing and improving patients' physical functioning.

There are a number of patients on the ward who have cognitive impairment. Although the evidence-base for CST groups is primarily situated in community or residential settings, we wondered whether it would be beneficial for patients admitted for rehabilitation. As well as the benefits outlined in the literature, we hypothesised that through encouraging cognitive stimulation the group may increase psychological wellbeing and self-esteem and as such may increase motivation to engage in, and

benefit from, rehabilitative therapy. As such we agreed to trial a CST group for 10 weeks.

Aims

To provide:

- An intervention to strengthen communication skills, thinking and memory

- Opportunities for social contact between patients and therapy staff in order for patients to feel valued in their contribution to the ward and improve their quality of life

The group aimed to simultaneously support engagement in rehabilitation, particularly those who had previously declined other therapeutic groups. It also provided an opportunity for facilitators to observe patients in an unstructured setting. This contributed towards ongoing assessment of ability, rehabilitation needs and mental health.

Implementation

The group was inspired by Spector et al.'s manual for group leaders (2006). We maintained a person-centred approach which respected individual differences and diversity of views and opinions. The facilitation style was unstructured, with more socially active members of the group taking a role in involving and encouraging others. Patients named the group 'The Remembering Group'.

Facilitators were mindful to focus on opinions, not facts, encouraging questions which could elicit a range of responses, none of which could be thought of as correct or incorrect. The use of multisensory stimuli was also important; some themes allowed greater scope for this than others. For example, there were music and

photos available in every session and in the nature-themed group there were also blackcurrants to taste and lavender to smell.

As outlined in Spector et al.'s (2006) manual, facilitators completed the 'Monitoring Progress' record on a weekly basis which monitored patients' interest, communication, enjoyment and mood. Facilitators met at the end of each session to discuss and record these scores.

Adaptations

The ward setting of the group required some amendments to the model outlined in the manual (Spector et al., 2006), some of which are outlined below.

Frequency

Scheduling the group to take place weekly fit into the wider timetable of groups offered on the ward and was convenient for the staff facilitating the group. With greater staffing support it may have been beneficial for the group to run twice weekly as recommended by Spector et al. (2003). However we were mindful of possible burn-out for patients who simultaneously attended a variety of groups as well as individual physio-, occupational and psychological therapy.

Membership

Given the ward-setting and the frequent rotation of patients, the group was not pure in its application of CST and as such did not singularly invite patients with mild-moderate dementia. Some patients were invited as it was thought that social interaction would be beneficial for their mood or general presentation. Membership of

4

the group changed on a weekly basis; some patients would be on the ward for a short period of time and would therefore only attend for one week.

Reminiscence

Reminiscence therapy is recommended for people with dementia with depression or anxiety (NICE, 2006). The group predominantly focused on reminiscence and did not include a 'warm up' game, such as throwing a ball to one another, as outlined in the Spector et al. (2006) manual. This decision was made on the basis that patients were already regularly invited to exercise-based groups and we thought it may aid recruitment to the group that there was no expectation of patients to engage in physical exercise.

Themes

As a result of the weekly change in membership, and hoping to increase ownership of the group for those who were attending regularly, the following week's theme was decided by the group based on topics which had arisen from that week's group discussion. For example in the travel-themed group, many patients shared experiences of evacuation in the Second World War. Based on this we discussed the possibility of 'The War' being the theme for the following week. This was a thoughtful discussion, which acknowledged the difficult memories which may be brought up by the theme and the possible distress this might cause. Despite this, the group decided that these were important stories which they wished to share with one another; we therefore agreed 'The War' as the following week's theme.

Monitoring

Over the ten week pilot, 28 patients attended the group (15 female and 12 male). The average size of the group was seven; this ranged from five to ten and was most commonly six (50% of the total sessions). The average age of patients was 83.4 years with a range of 78 to 91 years. Sixteen patients were White British (57%), four were Black Caribbean (14%), and two were White Irish (7%). Other attendees were Black Mauritian, White Israeli, Black South American and Turkish Cypriot. The average number of sessions attended was two; though one patient attended eight of the ten sessions and eight patients attended only one session (though many of these have continued to attend following the ten week pilot).

For patients who attended more than one session in the ten week period (17 patients), the average and difference in scores in the monitoring progress record are as follows:

Measure	Mean Score (/5)	Difference between 1st and final score
Interest	3.8	Increased by 7.1%
Communication	3.9	Increased by 5.9%
Enjoyment	3.7	Increased by 8.2%
Mood	4.0	Increased by 2.4%

The measures are not self-report and are instead a reflection of the facilitator's perspective on the attendee's engagement. As such these measures were not used to demonstrate a positive impact of group attendance on patients, but were instead used as an opportunity to reflect on the patients' presentation and share this information with the multi-disciplinary team (MDT).

In the week following the end of the pilot, patients were asked what they thought about the group. Some of the comments from the group included;

"It's nice to remember"

"'I miss the days when I was young, things have changed too much now"

"'It feels like a trip down memory lane"

"I enjoy talking about the past"

Facilitators also observed benefits of attending the group. In the group setting, staff and patients were able to bear witness to life enhancing stories of patients which may have been lost or silenced through the patients' experience of being admitted and treated in hospital (Milton & Hansen, 2010). All stories were respected and listened to, without correction or seeking clarification, increasing exposure of attendees to success, something which Spector et al. (2006) refers to as 'maximising potential'. Given the time in the group to tell a different story about themselves, staff were surprised about what they learnt about the patient's histories. This changed how staff interacted with the patients outside of the group setting and allowed the, perhaps subjugated, stories of patient's strengths and abilities to be re-enacted in the interactions on the ward. These different relationships could then be utilised in engaging patients in their rehabilitation and placing them in the centre of the care plans for their discharge from the ward.

Challenges

Staffing

Working as part of a MDT can mean that staff groups have differing priorities. For

example when patients were unable to attend the group because the nursing team were supporting the patients in being washed and dressed or when the group was interrupted by staff preparing the patients' lunch. We sought to overcome these by providing multiple reminders of the group, such as recording it in the ward diary, placing signs around the ward and inviting all members of the MDT to attend. The timing of the group was also slightly amended so as not to interrupt the morning routine of the nursing team.

Environment

Utilising the dayroom in the ward for the group sometimes led to noise from the ward distracting the patients. The room is also used for lunch, which increased confusion for some patients on arrival. In upcoming groups we plan to create a banner which we will put up for each group to indicate the different use of the space for the Remembering Group. Despite the noise and some confusion regarding the multi-purpose use of the room, utilising the space on the ward allowed flexibility of attendance; with some patients encouraged to attend as they knew they could easily attend late or leave early. As such we will continue to use this space for the group.

Difference

Given the range in religious beliefs and nationalities of patients and staff, we consciously voiced our respect for diversity, particularly diversity of opinion, in the group. We hoped the patient-chosen themes represented patients' diverse interests and histories. We also ensured that photos used as stimuli featured a range of cultural groups and that the music played was diverse. Patients also presented with different sensory difficulties so it was important that patients had hearings aids, glasses and additional support from staff in order to engage.

Attendance

The health needs of patients meant that we over-recruited each week as we pre-empted a 'drop-out' rate of 2 – 4 patients when inviting patients on the morning of the group. This sometimes led to a larger number of patients in the group than anticipated. The range in attendance was at times problematic and on reflection the facilitators agreed that 6 was the optimum attendance number. Groups with 10 patients made it difficult to support the engagement of individuals in group discussion and as a result may have reduced the benefit for those who attended. It has since been agreed that patients will be invited to attend the group in order of priority with subsequent invitations offered based on the number of patients who accept.

Reflections

The opportunity for Occupational Therapy and Psychology to work closely on this group has been hugely rewarding and enjoyable. We have a better understanding of one another's role and believe working together on the group enabled further joint-working on the ward. Both OT and Psychology aim to adopt a whole-person approach and the opportunity to set up a CST group provided us with a great opportunity to make better use of our skills-base.

Through the group, we were able to gain a deeper insight into the lives and histories of our patients which is not always possible in the, often pressurised, daily assessments and interventions we carry out on the ward. This was invaluable in terms of increasing participation in functional tasks as we were able to employ a wide variety of strategies to engage patients outside of the group setting.

On completing the ten week pilot of the group, the facilitators agreed to continue the group with some ideas for improvement. To further encourage other staff members to co-facilitate the group, a flyer was created with basic information to pass onto new staff on the ward and the occupational therapists plan to deliver a training session to the therapy team to increase awareness of the group's aims. We also plan to include some more practical sessions; such as the creation of the group banner and introduction of activities, such as singing, dependent on the theme each week. In order for the group to be passed over between new trainee clinical psychologists on placement and occupational therapists on six-month rotation, a thorough protocol was written and shared with the team.

Further evaluation of the group is necessary and could explore any improvement in psychological wellbeing and subsequent engagement with rehabilitative therapy for patients who attend the CST group in comparison to those who may not have been asked to attend.

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