
Group psychotherapy with people with dementia: lifting the curtain

Richard Cheston

Consultant Clinical Psychologist, AWP

Honorary Research Fellow, Bath University

A group session in the DVGP

Judith: I just wonder where it's going to end, that's my fear, you know where am I going to **end up**, just before the end you know

Robert: is it the dying, is that what you mean?

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

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

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

So how do we help people like Judith?

- As health professionals we need to think about the way in which we talk to people with dementia about what they're going through
 - Should we lift the curtain or not?
 - If so, then what's the best way to work?
 - What sort of therapy/counselling?
 - Group or individual work?
 - Exploratory or directive?
 - Are some people better suited to therapy than others?
-

Four different types of evidence

1. *Consumer satisfaction*

- ❑ asking people what they think of the intervention
- ❑ important but satisfaction rates tend to be high regardless of what happens in the intervention

2. *Clinical reports*

- ❑ Therapists drawing on their experience
- ❑ Important insights, but possibility of bias

3. *Process research*

- ❑ Looking independently at what happens during the intervention (e.g. changes in awareness)
 - ❑ Important, but doesn't tell us if people “*get better*”
-

4. Outcome research

- Compares standard measures at the start and at the end of the intervention. Sometimes includes a measure before the start (baseline) and a measure after the end (follow-up)
 - **Controlled trial** – compares one way of working with another in a structured and systematic way
 - **Randomised** – means that people placed at random in different ways of working
 - **Blinding** – individual and researcher do not know what way of working they receive
 - Often seen as the “gold standard” – but is it a better way of evaluating the effectiveness of drugs than of talking therapies?
-

Evidence for group therapy

- Little “hard” evidence for effectiveness, even for the most common forms of intervention
 - Validation Therapy - Neal and Briggs (2000) obtained data from just two studies and only found “*trends towards favouring VT for some outcomes*”
 - Robyn Yale (1991, 95) compared 7 people in a support group and 6 in a control group. No statistically significant changes in measures used, although support group participants and their carers reported many benefits
-

WARNING: Clinical work often precedes research evidence.

- Evidence for many interventions with older people with dementia is often not as strong as one might expect: *“with the exception of treatment of depression, drug efficacy is generally at a modest level...”* (Hopker, 1999)
 - *“one must remember ‘today's evidence can be tomorrow's myth’ and that medicine would not have advanced if the researchers and clinicians of the past had restricted themselves to the evidence available at the time”* (Purandare, 2000) .
 - *“Absence of evidence is not the same thing as evidence of absence”*
Donald Rumsfeld (2005)
-

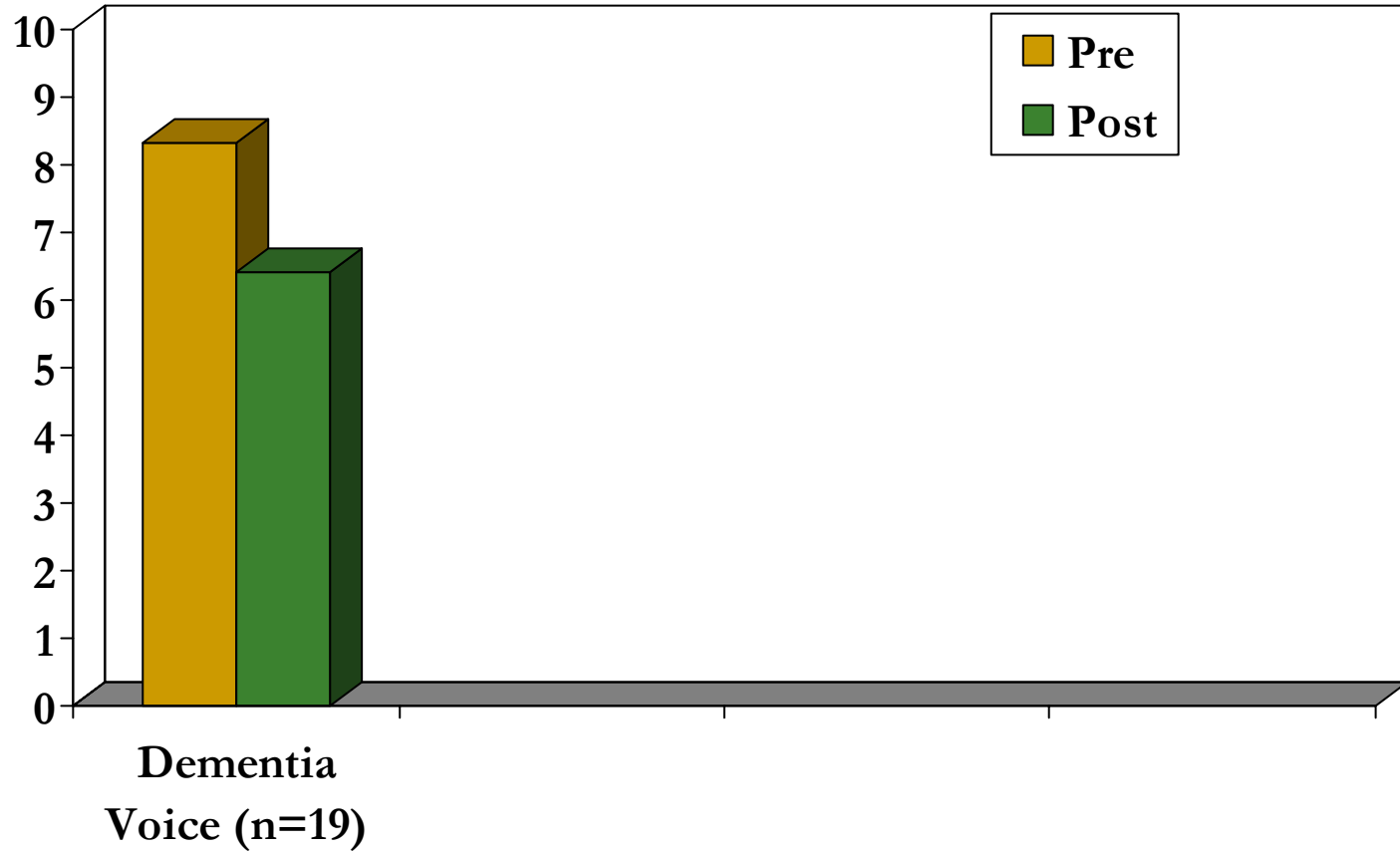
Dementia Voice Group Psychotherapy Project (Cheston, Jones and Gilliard, 2003)

- Six groups, each of which lasted for ten weeks
 - Task of each group was “*to think about what it’s like when your memory isn’t as good as it used to be*”
 - Predominantly exploratory approach – waited for participants to talk about dementia
 - 19 research participants from 6 groups. Data collected at 4 different points. Unpublished data from 8 additional participants
 - Measures of depression and anxiety collected independently
-

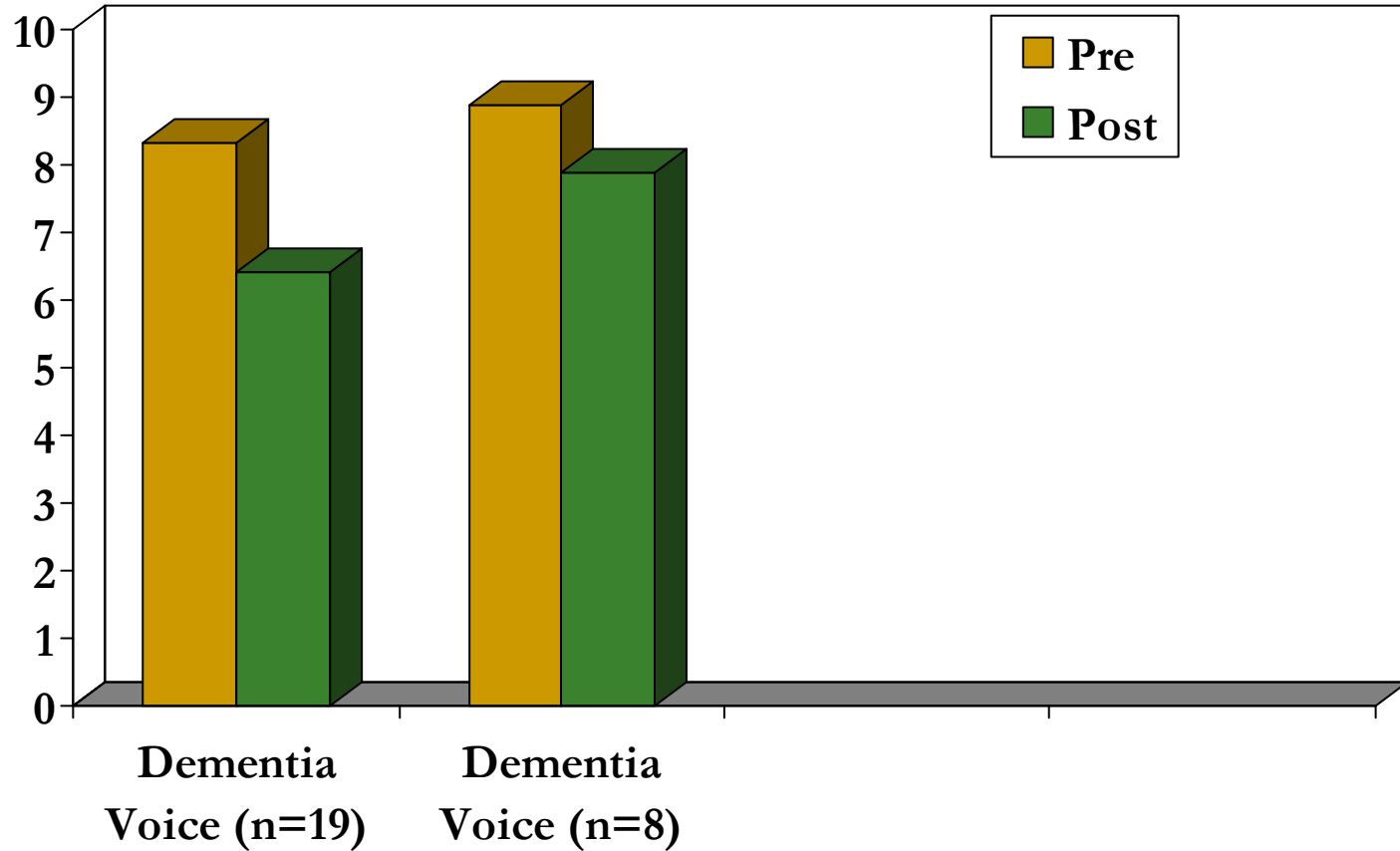
Feasibility study for RCT

- Recently completed research project comparing 10 sessions of exploratory vs. 10 sessions of psycho-educational therapy
 - **Exploratory sessions** again focussed on task of thinking about “*what it’s like when your memory isn’t as good as it used to be*”.
 - **Educational sessions** included talks from outside speakers, discussion of newsletter. Agenda and timetable
 - More sophisticated methodology - controlled, blinded, some randomisation
 - **Small numbers of participants!** Only 8 people with a diagnosis of Alzheimer's disease or similar completed each part of trial
 - Measures of depression, anxiety, quality of life and carer strain collected independently
-

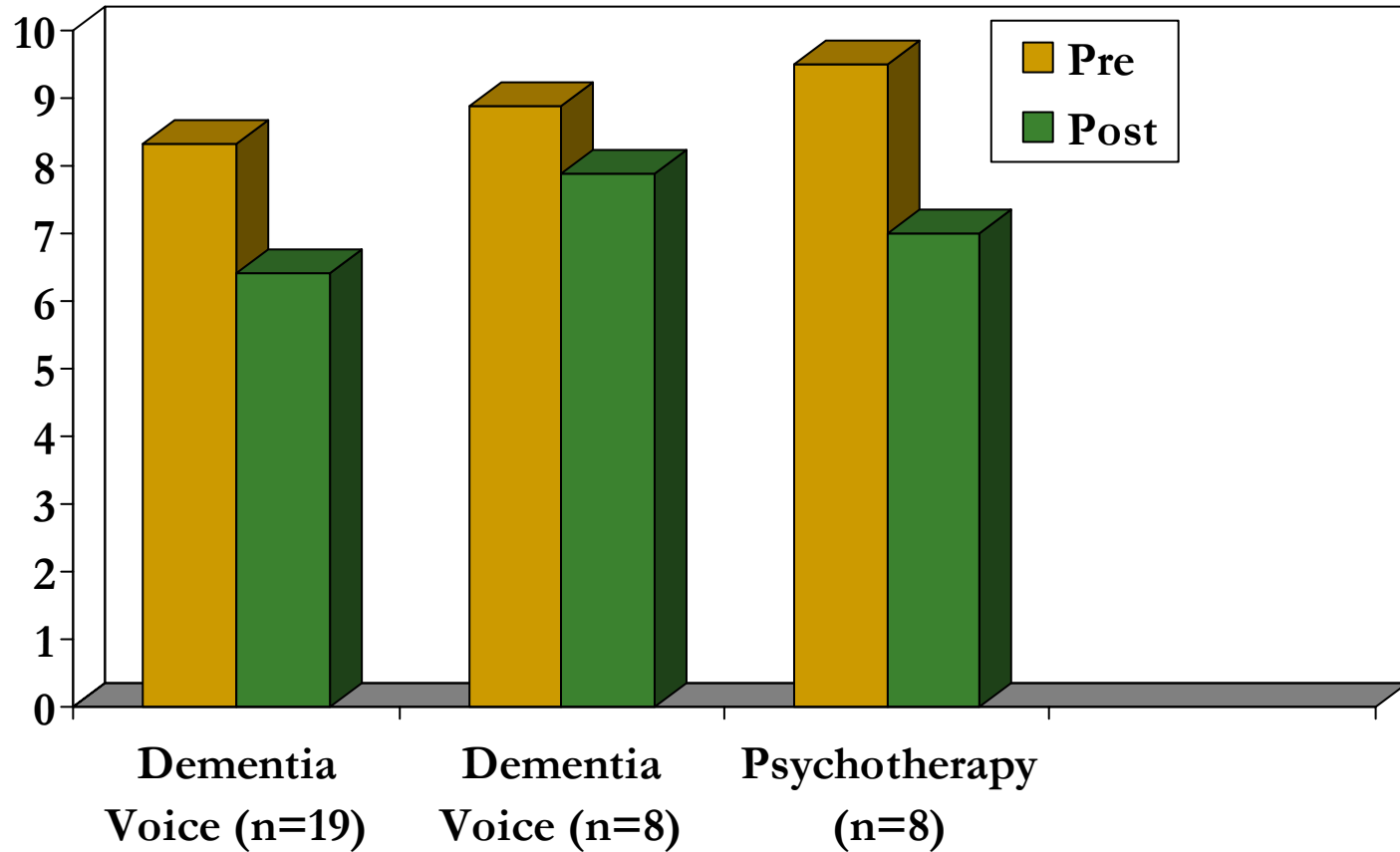
Depression (Cornell)



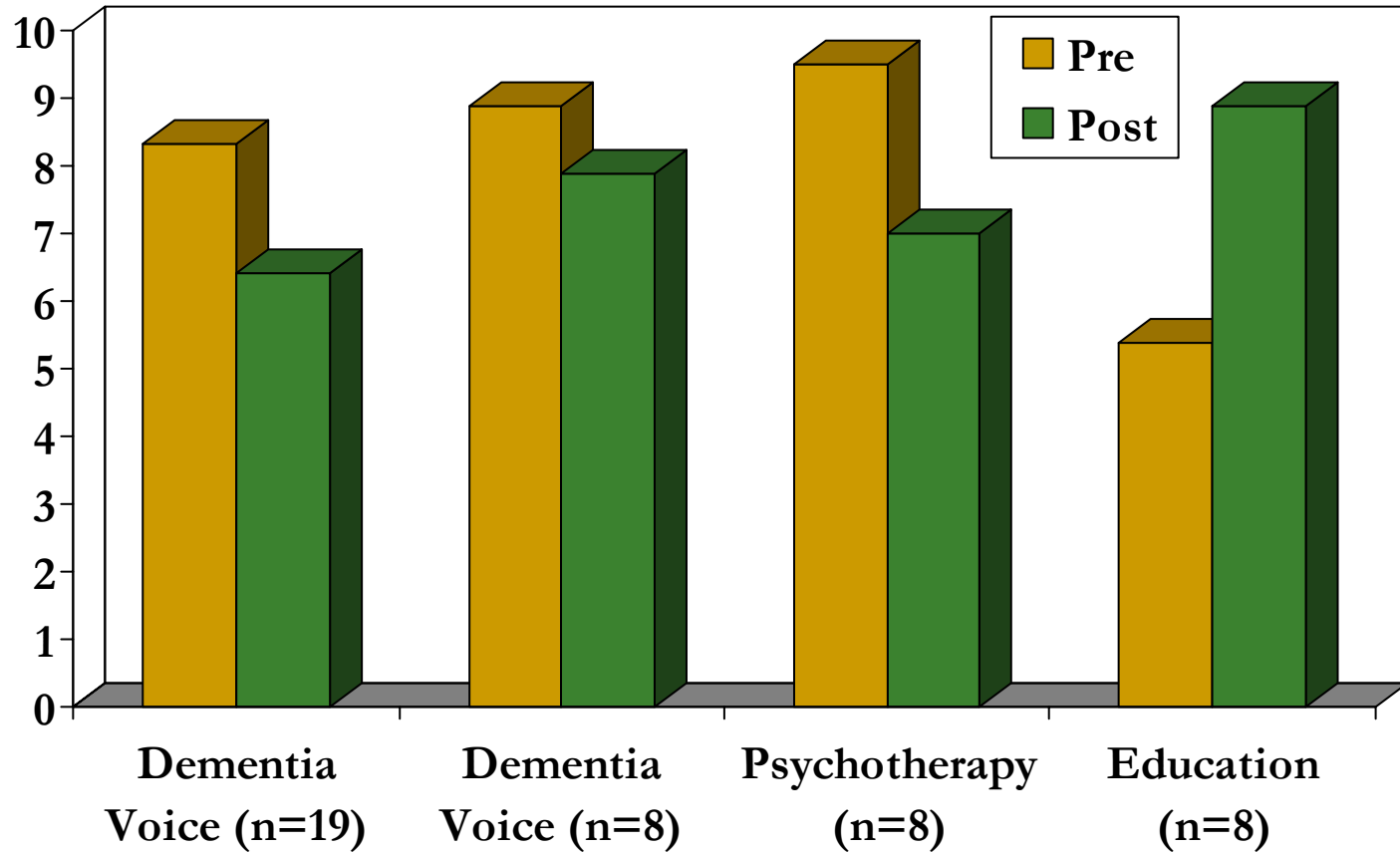
Depression (Cornell)



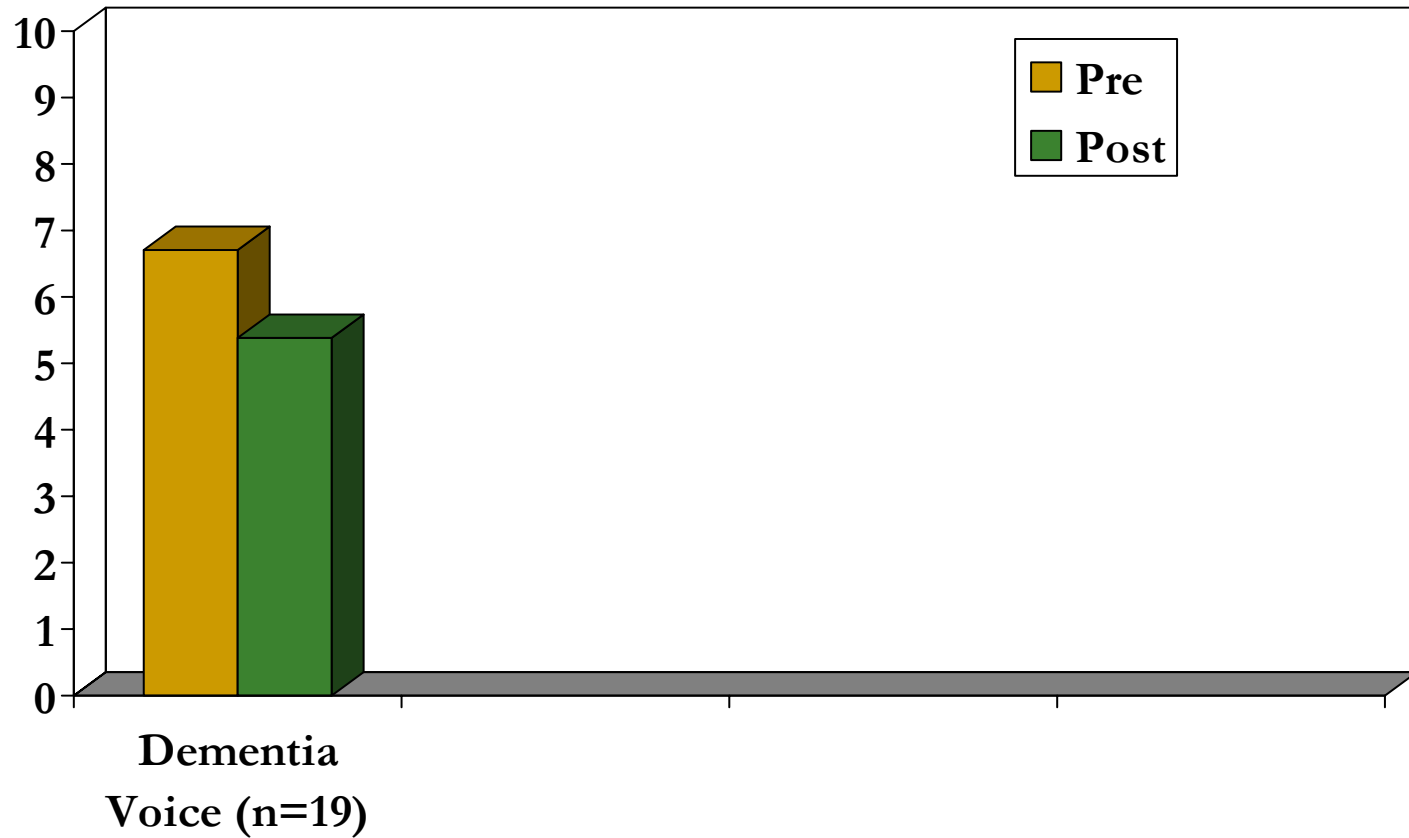
Depression (Cornell)



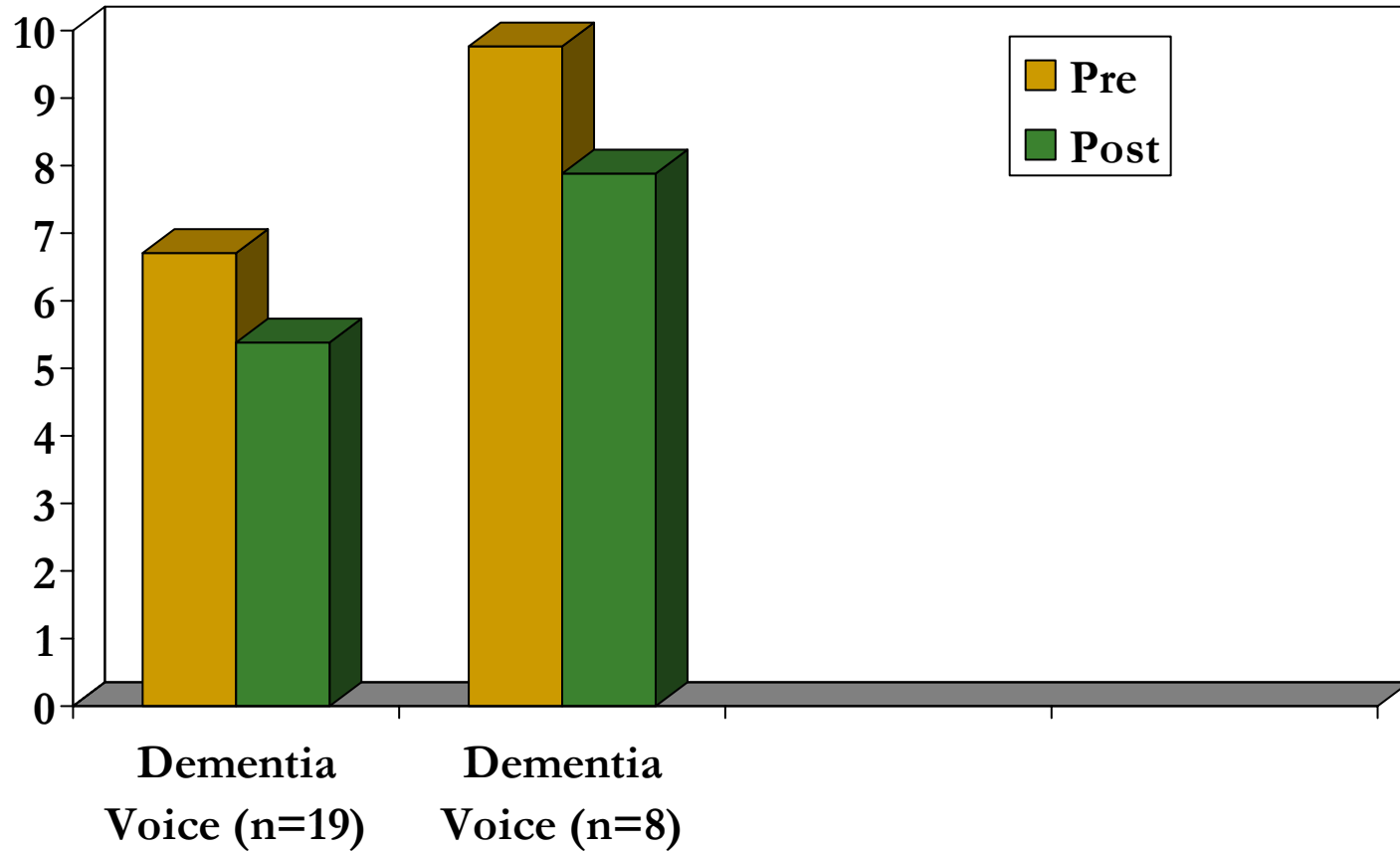
Depression (Cornell)



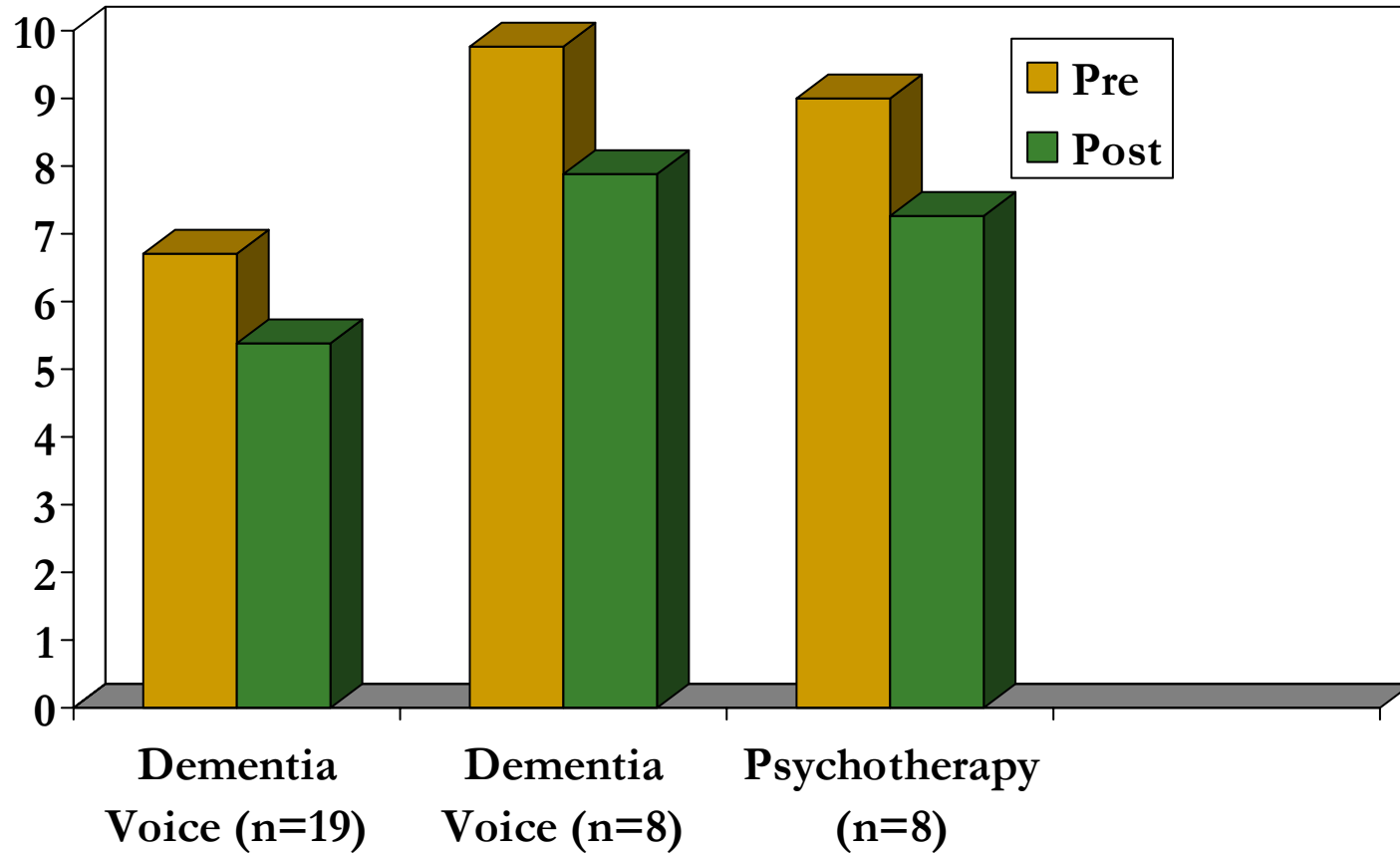
Anxiety - RAID



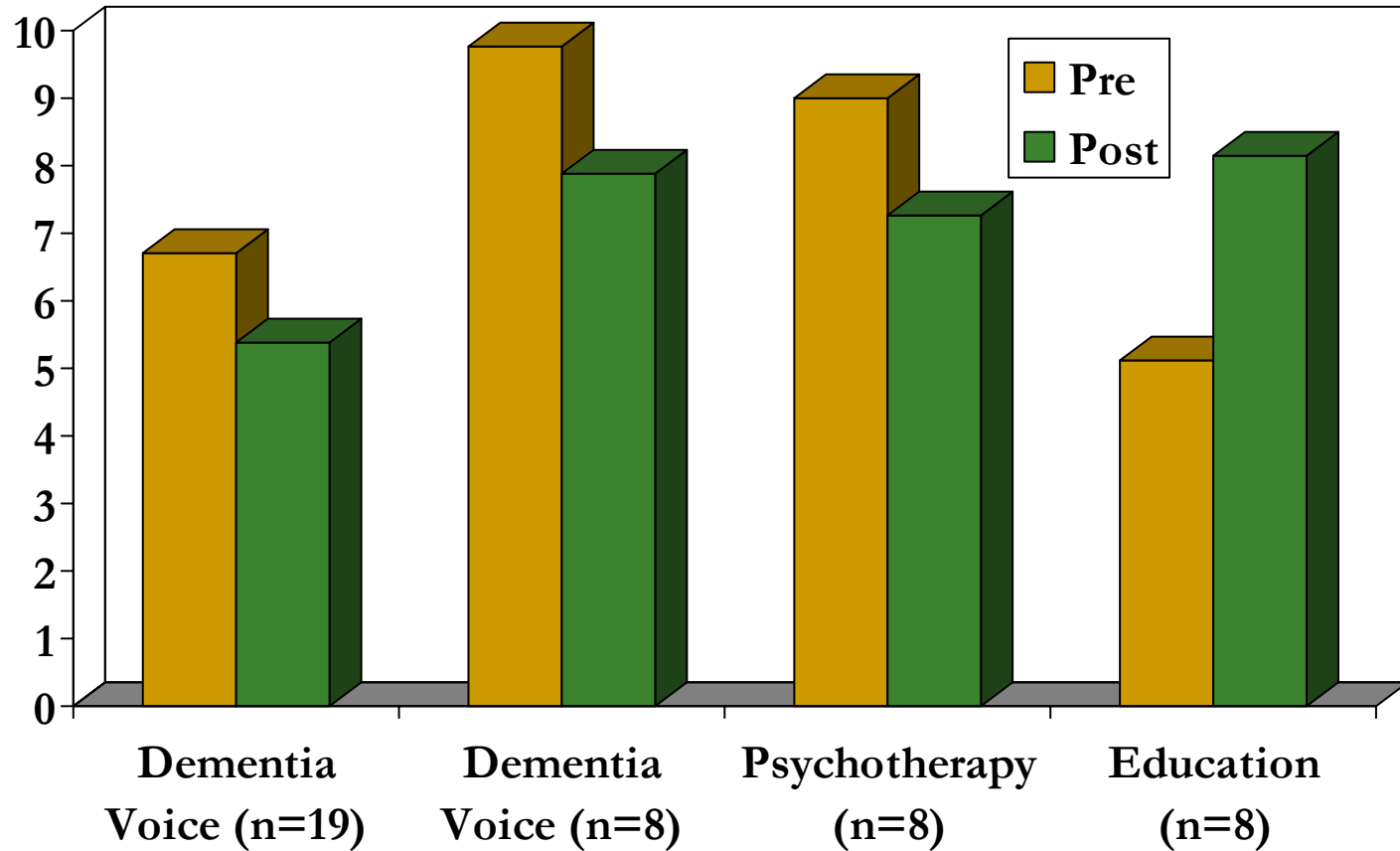
Anxiety - RAID



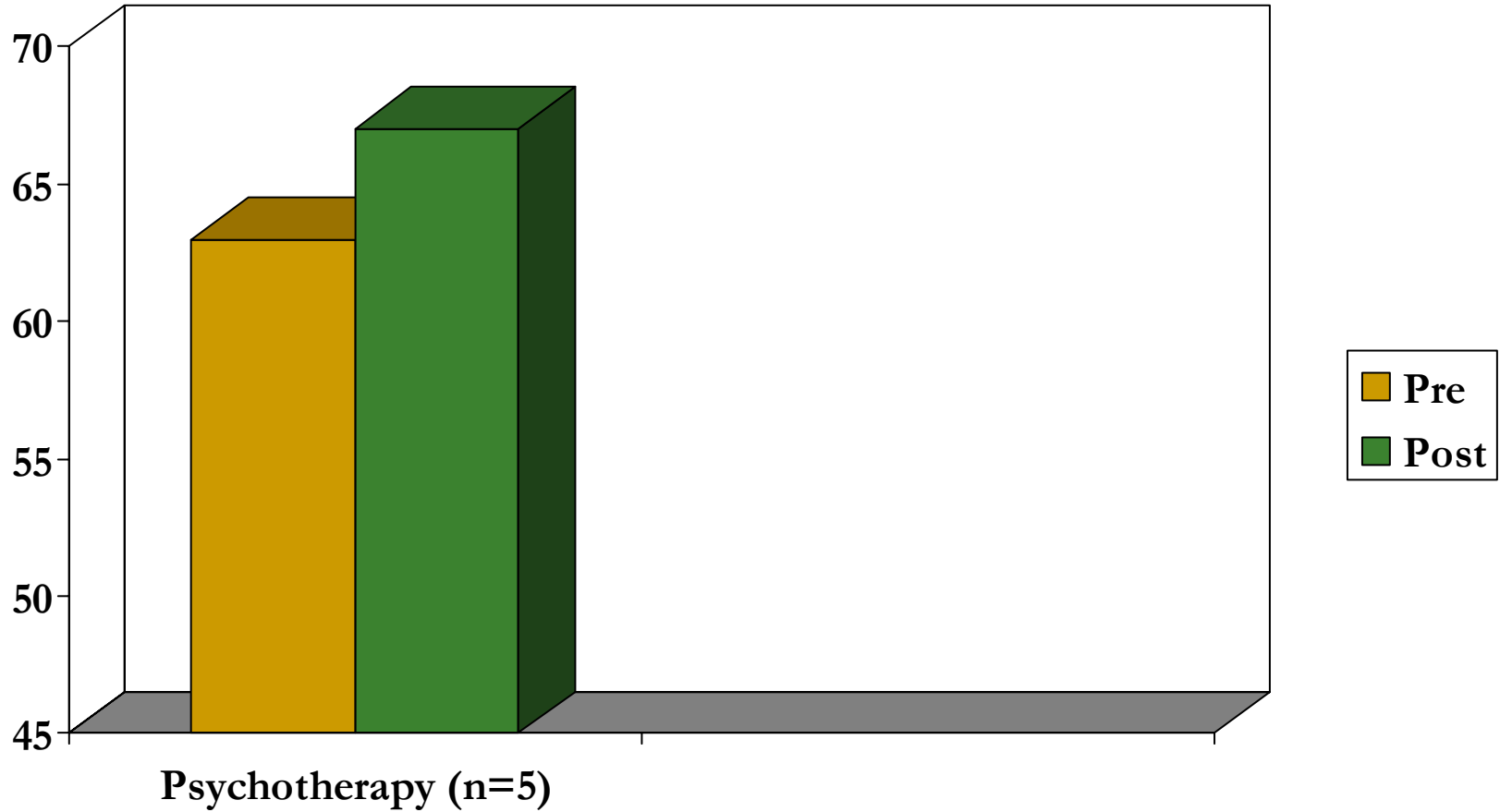
Anxiety - RAID



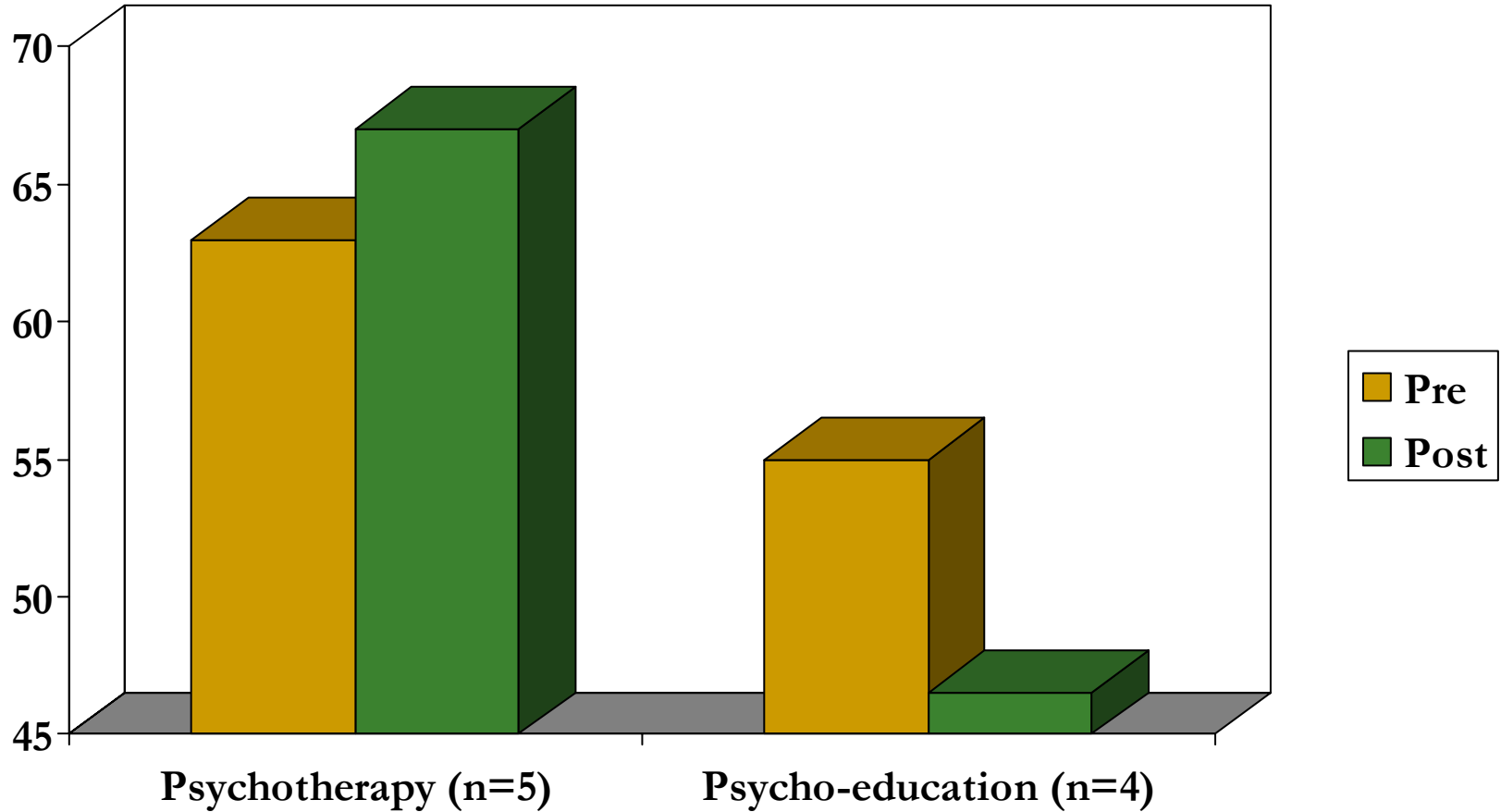
Anxiety - RAID



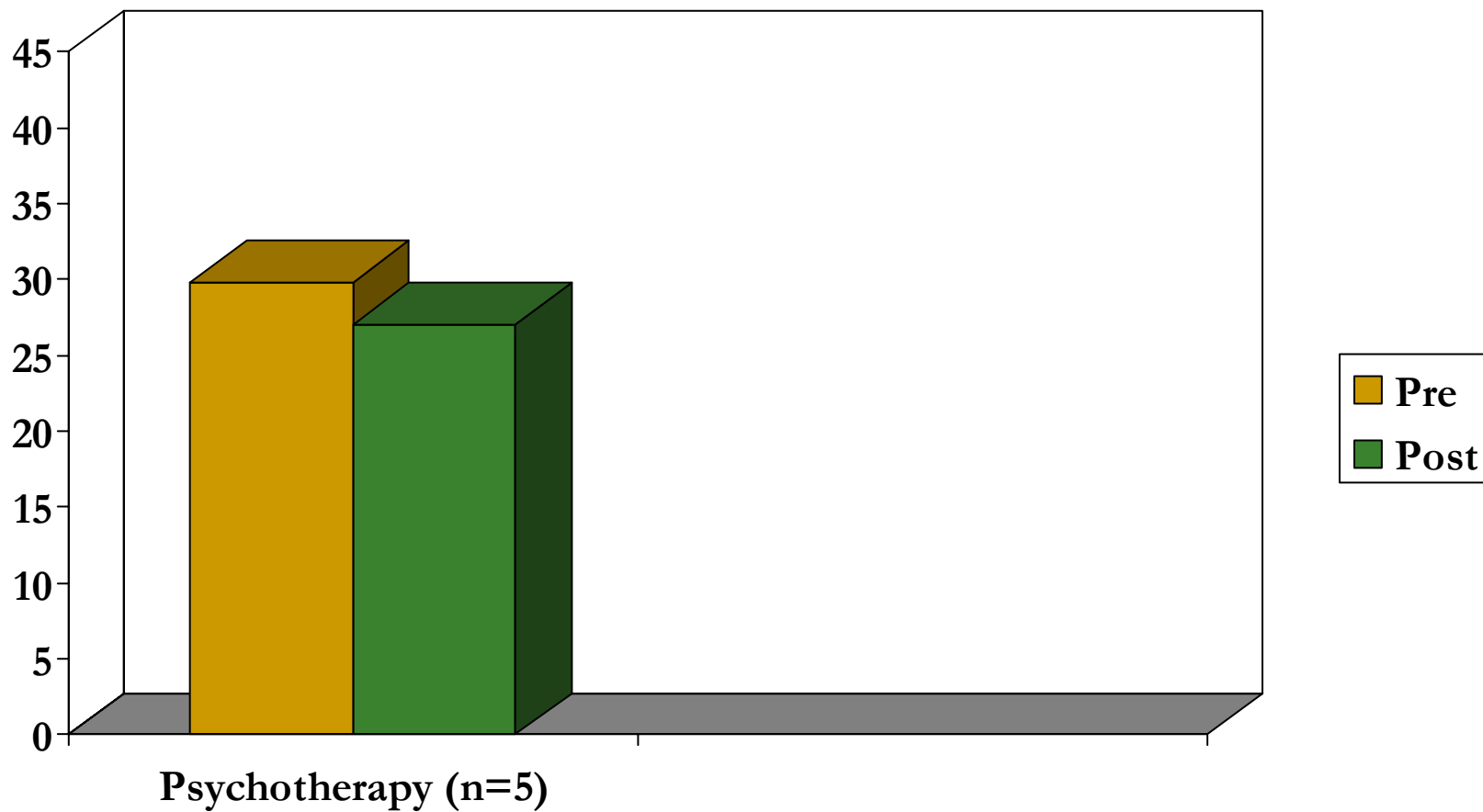
Quality of life



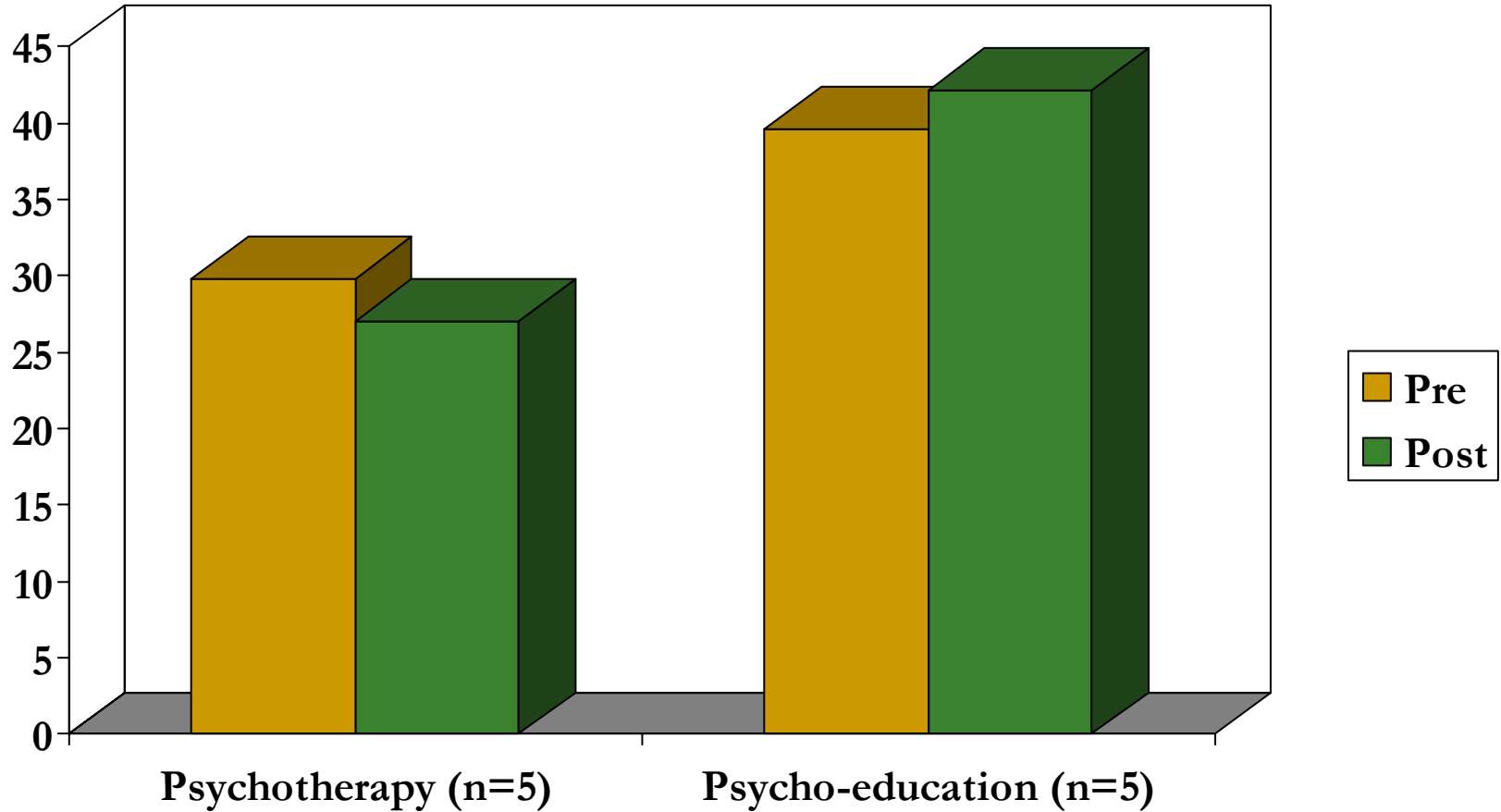
Quality of life



Carer burden



Carer burden



Why do groups work?

- The theory base of Group Analytic Therapy suggests that there are four steps within group therapy:
 - sharing of experiences
 - breaking isolation
 - lessening feelings of shame and abnormality
 - working to establish meaning
 - If we can do these 4 things, then this helps people to feel less hopeless and less frightened, and consequently their levels of depression and anxiety will improve
-

Conclusions

- 10 weeks of exploratory group psychotherapy can significantly reduce levels of depression and anxiety
 - These changes are still present at 10 weeks follow-up, and is consistent across two studies
 - Qualitative research also indicates that for some people, their ability to talk and to think about the diagnosis can be improved
 - A more directive and educational approach may not be as effective, and may, in fact be harmful
 - Problems with the data or too much too soon?
 - Possibly less opportunity to think through difficult feelings, particularly those around shame and embarrassment?
 - “Evidence” not just from outcome studies – important to be a reflective practitioner
-