

to be asked by providers. Curriculum appears as an issue in the two American articles. Not only the published curriculum, which in itself is often delimited by ageist misconceptions, as Brian Groombridge argues, but the hidden curriculum. The hidden curriculum of institutional and cultural barriers confines older learners either to the margins of younger people's learning, as Ivan Moyer and Dan Lago argue, or it sets limits on the personal development and learning trajectories of older people. The Massachusetts programme suggests that there may be ways of opening up the curriculum to innovation and inbuilt change.

While some providers, as all these articles demonstrate, are well versed in the first generation issues of rights and entitlement, they also confirm that second generation work is only in its earliest stages. There are now well attested examples of the success of fee-waived and institutionally encouraged provision in the UK and in the US. Now required are debate and evaluation of what is provided, by whom and with what outcomes over time? Sadly this is the least propitious moment to be initiating such reflection. The current education debate in the UK is almost wholly focussed on schools. Adult education is non-mandatory, and if the ability of local government to act as the funder and sponsor of initiatives and longer term sources of support and evaluation is curtailed or, at best, fixed at present levels, then opportunities for more self-critical and open processes in the development of older people's learning will virtually disappear.

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D. Arber, 'Aids to awareness and communication'. *Computer Applications in Social Work and Allied Professions*, 3, 3 (1987), 6–11.

In the last few years there has been a great deal of interest in techniques of reality orientation and the principles of this approach have been used to a greater or lesser extent in a number of hospital wards and residential homes. Woods and Britton describe three major types of reality orientation (RO).¹ Informal or 24 hour RO involves staff presenting current information to patients/clients in each interaction, commenting on what is going on and reminding them of the time, place and people about them. A second type, often described as classroom

RO, consists of group sessions focussing upon current information or activities which permit an individual to retain a topic despite their memory difficulties. The third variant is individualised and requires staff to maintain a particular attitude or pattern of response to each patient according to their personality and needs.

One problem with the first two of these approaches is that a number of aids are required to provide people with suitable visual cues or to maintain interest and attention during a group session. Often those which are hand written may become less legible with use and as further information is added. This paper describes the use of computer technology as a part of the repertoire of reality orientation. The uses described include the capacity to vary the size and colour of background and foreground text displays so that they are readily accessible to all and may be easily read on television screens. Similarly the speed of scrolling of enlarged words could be controlled to make possible participation in group activities such as community singing.

A number of other possible uses are described, including the display of different types of information on television screens at particular times, such as a reminder of a meal which is due or other relevant communal information. More creative programmes are described as well as basic 'notice board' functions. These include combinations of pictures and words that can be used in 'classroom' or group sessions through which people can attempt to understand their current environment. The author suggests that the presentation of material through the medium of a television screen may reduce the discomfort experienced by some staff when imparting very mundane information in a didactic fashion. Another benefit which is indicated is the capacity to edit displays so that out-of-date information can be erased and new material inserted, avoiding the total rewriting of a hand produced display.

COMMENT

This is an interesting descriptive paper which indicates some of the ways in which, at relatively low cost, modern technology might be utilised in the care of elderly people suffering from dementia. Many similar arguments could also be deployed for the use of such facilities in reminiscence therapy with the elderly. Perhaps we have been slow in considering the potential of how relatively inexpensive computer aided activities could be beneficial for elderly people suffering from intellectual impairment.

NOTE

- 1 Woods, R. T. and Britton, P. G. *Clinical Psychology with the Elderly*. Croom Helm, Beckenham, Kent, 1985.

S. H. Ferris, G. Steinberg, E. Shulman, R. Kahn and B. Reisberg, 'Institutionalisation of Alzheimer's disease patients: reducing precipitating factors through family counselling'. *Home Health Care Quarterly*, **8** (1987), 23-51.

We know little about the causes of and prevention of admission to institutions of patients suffering from dementia. The authors of this paper report two studies. The first was designed to determine the circumstances which were related to the admission of Alzheimer's disease patients, and the second to identify whether provision of a programme of family counselling could reduce those circumstances identified as precipitating admission. The two studies were thus logically interlinked.

In the first study, concerned with the identification of precipitating circumstances, 109 family members of patients already in nursing homes were interviewed in depth. Most patients who had been institutionalised exhibited a severe degree of impairment and had been ill for more than four months. The most common behaviours which were associated to admission to institutional care were agitation and violence, incontinence and wandering. Nearly one-third of care-givers had no auxiliary help, but on the other hand, one-fifth had assistance at night through a helper sleeping in their home. It was noteworthy that despite equal numbers of male and female patients of equivalent severity in the sample, more wives placed their husbands in institutional care than husbands placed wives. This was attributed to the greater likelihood of male carers hiring auxiliary help at home.¹ Financial difficulties were reported by nearly half the care-givers, most frequently with medical home care and health related expenses. This affected the utilisation of auxiliary help in about 20 per cent of cases. A very high proportion of care-givers reported help from children or siblings although very little support appears to have been available from wider social networks such as friends and neighbours. Although most care-givers reported good physical health there was a high prevalence of emotional complaints, 39 per cent reporting depression, and in 17 per cent of cases existing illnesses were exacerbated. Overall, about 60 per cent of carers believed that if help of a suitable kind had been available they could have kept the elderly person at home.

In a second study these problem areas were built into the counselling programme which was provided for 41 family members who were contemplating institutional care for their intellectually impaired family member. In particular, as a result of the study, a number of additional factors were built into the existing family counselling programme: (1) knowledge about and access to medication and treatment for the management of problem symptoms such as agitation, violence or incontinence; (2) individual counselling and/or group support for coping with present and future problems, and continuous education about the nature and course of the disease and advice about appropriate coping techniques; (3) advice and assistance to enhance the availability and utilisation of social networks; (4) information about auxiliary help at costs which were affordable by the family; and (5) advice and referral for legal and financial guidance.

The authors noted that over a six month period only one patient was institutionalised and that a marked reduction occurred in both caregiver emotional complaints and practical problems such as financial matters and difficulties in coping with patient agitation. As a conclusion from this study, albeit a small-scale intervention, the authors argue that a programme of individual counselling and support groups can improve and mitigate the factors which are associated with the decision to admit patients to institutional care.

COMMENT

Our knowledge is relatively sparse of appropriate and effective techniques of intervention in the community with the sufferers of dementia. This paper should therefore be seen as a welcome contribution alongside studies of the factors associated with breakdown and techniques of management.²

NOTES

- 1 Charlesworth, A., Wilkin, D. and Durie, A. *Carers and Services: A Comparison of Men and Women Caring for Dependent Elderly People* Equal Opportunities Commission, London, 1984.
- 2 Argyle, S., Jestic, S. and Brook, C. P. B., Psychogeriatric patients: their supporters' problems. *Age and Ageing*, 14 (1985), 355-360; Berman, S. and Rappoport, M. B., Social work and Alzheimer's disease: psychological management in the absence of medical care, *Social Work in Health Care*, 10 (1984), 53-70.

M. Fitting, B. Rabins, M. J. Lucas and J. Eastham, 'Care givers for dementia patients: a comparison of husbands and wives' *The Gerontologist*, 26 (1986), 248–252.

Although it is recognised that families provide most of the care for dementing elderly people, it is not clearly understood how care-givers of different ages and sex respond to the role of care giving. Thus it is sometimes assumed that women, with stronger social supports than men and a greater 'ethic of caring', adjust to this role more readily and therefore that male care-givers will feel greater burden and have more difficulty adjusting to a new role.¹ Alternatively, it could be argued that women might resent the return to full-time care giving whereas men might enjoy a new role.² With regard to age, it is not clear whether younger care-givers are more likely than older care-givers to be stressed due to resentment with their own problems of poor health.

This study examined spouses caring for people suffering from a dementing illness. Some 67 potential respondents were identified, seven of whom refused to be interviewed, and six were not seen since their physician judged them to be greatly overwhelmed by their current problems. Twenty-eight husbands and 26 wives were seen. A structured interview was used with a range of measures designed to assess burden, family environment, psychological stress, social networks and the degree of impairment of the elderly person. The median age of the carers was 67 years; for the purpose of analysis the group was divided between those who were less than 67 years and those of at least this age.

No dichotomised age or sex differences were found in the relationship between the influence of perceived family environment, such as openness of expression within the household, and the level of burden. However, the levels of burden for the younger wives and older husbands who were caring for more severely impaired elderly persons were significantly higher than others. Female carers were found to exhibit more psychological stress than male carers, and more women reported a deteriorating relationship with their spouse following the onset of the illness. This extent of apparent depression in women was seen by the authors as a reflection of the carers demoralised state rather than a major depression in itself. They suggest that dementia care-givers may feel powerless to change the outcome of the condition and are therefore suffering various states of despair. They conclude that support from professionals might alleviate this sense of hopelessness and thereby benefit care givers even though the progress of dementia *per se* is not changed.

Younger care givers appeared to be more lonely and resentful of their plight, in part because of a wider range of competing responsibilities. Surprisingly, one quarter of husbands reported an improvement in their relationship with their spouse since adopting the care giving role, whereas women tended to perceive themselves as more constrained. It appeared that men valued the opportunity to reciprocate the care that they had received earlier and the adoption of a new role on retirement, whereas many women saw caring as a return to a role they had moved away from as their children had grown up. Another possible compounding factor suggested by the authors was the difference in the way that the care giving role may be perceived by husbands and wives. It could be that women caring for dementing husbands adopt a parent/infant model, whereas men adopt a work-organisation model involving the delegation of responsibility and the recognition of limitations. These different models of coping strategies may relate to past role patterns and thereby to the degrees of satisfaction for the care-giver.

COMMENT

This study is important in that it examines differences in responses and therefore by implication the requirements of care-givers in different situations. There are some interesting suggestions about factors which influence the carer/cared-for relationship, which any successful service intervention should consider. This study should be read in conjunction with those few other studies of family relationships in the care of the dementing elderly.³ It is heartening to see that we are moving away from the rather simple approach to the problem of relieving carers, such as the standard response to provide day care, to an awareness of the important differences in carer characteristics, degree of client impairment, degree of burden and their inter-relationship which necessitates much more sensitive and flexible service responses to the enormous variety of different requirements.

NOTES

- 1 Gilligan, C. *In a Different Voice*, Harvard University Press, Cambridge, Massachusetts, 1982.
- 2 Lowenthal, M. F., Thurnher, M. and Chirboga, D., *Four Stages of Life: A Comparative Study of Men and Women Facing Transitions*, Jossey-Bass, San Francisco, 1975.
- 3 Bergmann, K., Manchee, V. and Wood, R. T., 'Effect of family relationships

on psychogeriatric patients', *Journal of the Royal Society of Medicine*, 77 (1984) 840–844.

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Medicine in Society

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J. Harris, 'QALYfying the value of life'. *Journal of Medical Ethics*, 13 (1987), 117–23.

Medical care has always been unlimited for those who can pay for it. When costs have to come out of the public purse politicians become concerned about value for money and allocating priorities between different services and categories of patients. These priorities have traditionally been held to be matters for political decision, but politicians are attracted by arguments that offer to turn difficult political issues into technical ones soluble by the application of plausible formulae. The present fashion is for American politicians to seek formulae from ethicists, the British from economists.

One traditional form of economic argument in health care, which has spawned many variants, is to weight priorities in proportion to the number of years of life expectancy saved for the recipients of specific interventions. On this reckoning a scarce life-saving treatment should be given to younger patients in preference to older since younger patients will, on average, have more years of life expectancy left. One of the more pernicious variants of this approach is to count only those years preceding compulsory retirement age on the premise that the worth of man is to be equated with the potential value of his labour to the state.

Recently, British health economists have imported the American concept of the Quality Adjusted Life-Year (QALY) in a laudable attempt to incorporate some assessment of quality as well as length of life into the evaluation of care outcomes. The QALY aims to weight years of life gained or modified by a health service intervention on a scale of zero to one. Thus one year of perfect fitness, weighted at 1.0, would be regarded as worth two years each weighted at 0.5 because of some disabling or painful condition. It is even possible to envisage negative values to certain states of existence that match the Victorian heroine's concept of 'fates worse than death'. A simple refinement would make it possible for the QALY to reflect outcome probabilities,