Abstracts

Sociology and Social Policy

John Bond

Rodin, J. and Langer, E., 'Aging Labels: The Decline of Control and the Fall of Self-Esteem', *Journal of Social Issues*, 36, 1980, pp. 12–29.

This is the first of two articles which I have selected from the *Journal of Social Issues* for inclusion in this series of abstracts. The whole of the Spring Edition of this journal in 1980 was devoted to problems of ageing and is well worth looking at.

The usefulness of this first article is that it describes several studies which have investigated how negative labelling and stigmatization of the elderly confirms existing stereotypes of old age and leads to lower self-esteem and diminished feelings of control. This reinforcing characteristic of negative labelling has been termed *secondary deviance* by Lemert.[1] An old person placed in a psychiatric hospital ward with people suffering from dementia will have been given implicitly, whether or not they have the disease the negative label *senile* and may subsequently act in the ways expected of old people with dementia.

This article describes the extent and nature of the labelling process regarding the elderly and reviews studies which consider how stereotypes of old people affect interactions between the elderly and others. A prevalent stereotype of the elderly held by young, middle aged and elderly people included a fairly well defined conception of senility. In addition the article shows that the old have a real fear of senility. It would appear, from the studies reviewed in this article, that older people are more positive towards the elderly overall than younger people, but are also more negative than young people about the negative features of old age.

How have stereotypes affected interactions between the elderly and others? Although Strauss[2] maintains that those elderly people who perceive the environment as one that devalues them tend, as a result, to withdraw from involvement in their surroundings, Rodin and Langer state they they were unable to find data which could distinguish cause from effect. We must await their definitive study on this subject before we can accept or reject Strauss's hypothesis.

In the final part of this article Rodin and Langer describe studies in

which attempts have been made to reverse the effects of negative labelling. They argue that loss of self-esteem due to negative labelling results in a lack of motivation to engage in activities. They describe three studies which have attempted to motivate the elderly and these show that even in institutional environments the negative effects of labelling can be reversed.

COMMENT

Although this article contains a useful review of the problems associated with negative labelling I did not find it particularly easy to read. There is an over-reliance on the authors' own research at the expense of other relevant literature. Not withstanding these comments the article highlights some of the problems of ageing and their solutions which are associated with traditional stereotypes.

NOTES

1 Lemert, E., 'Social structure, social control, and deviation'. In *Anomie and Deviant Behaviour*, ed. Clinard, M. B., pp. 57–97, New York, Free Press, 1964.
2 Strauss, D., 'The relationship between perception of the environment and the retrenchment syndrome in a geriatric population', *Dissertation Abstracts*, 24, 1963, pp. 1975–76.

Estes, C. L., 'Construction of Reality', *Journal of Social Issues*, 36, 1980, pp. 115–32.

The second of the two articles from the *Journal of Social Issues* examines the perspectives and practice orientations of professionals who are either influential in making policy or provide services for the elderly. Professionals are not immune to the stereotypes that society constructs for the elderly and are likely to reinforce negative ones. They may also play an important part in creating such stereotypes through their definition of old people's problems.

This article reports data drawn from a study of the members of four community planning organizations in one locality who focused specifically on problems of the elderly. The data were obtained through 43 intensive interviews held with 'planning' members and 29 similar interviews held with 'service delivery' members. These data are supported by participant

observation of planning meetings held by the organization over a two year period.

In describing the different agencies and their members Estes categorizes agencies in terms of their orientation toward their clients. She contrasts two approaches: the accommodative and the restorative. 'The *accommodative approach* characteristically discourages older people from becoming independent, with emphasis to alleviating problems. . . rather than eliminating them. Such a program suggests a stereotype of the older person as one whose independence or improvement is unlikely. This construction of reality supports the *status quo* of the person's condition. In contrast, a *restorative approach* would focus on assisting older persons in helping themselves to fulfil their potential, to become independent. Programs that are restorative are likely to focus on rehabilitating elderly persons to become independent of their agencies'. (p. 125).

Estes concludes that the elderly are largely excluded from the planning of agency activities. She notes that the most powerful leaders in the agencies described have orientations which are predominantly accommodative. These same leaders have negative perceptions of old people and have been an important influence in the establishment of negative stereotypes. As a result the agencies have adopted and maintained an essentially accommodative approach to the provision of services.

COMMENT

This article is grounded in sound theory and provides common sense explanations of the way in which caring agencies approach the problems of old age. The analysis of data, however, adopts a statistical method which may not be suitable to the kinds of data available. I would have been happier if a more interpretative approach to the data had been integrated with the data analysis presented. The importance of this article must lie in the description of the way professionals influence the establishment of negative stereotypes.

Gubrium, J. F., 'Patient Exclusion in Geriatric Staffings', *The Sociological Quarterly*, 21, 1980, pp. 335–47.

This article describes the apparent movement toward the *restorative approach* in long-term care institutions as outlined by Estes in the previous article. It focuses on the inclusion of patients in the planning of their care and treatment during 'staffings'. 'Staffings are conferences where profes-

sional staff members of human service institutions deliberate over client care'. (p. 335).

Data were collected by participant observation in five nursing homes. The author observed more than 80 per cent of staffings which took place during the fieldwork period, noting in writing the organization of gesture, language usage, spacing, and timing in social interaction. From these data the strategic practice of 'doing staffings' with and without the presence of patients is described.

Gubrium identifies a number of exclusionary devices used by staff to limit the influence of patients participating in staffings. Planning ahead is the first device illustrated. Staffers may causally or conspiratorially share various means of handling or dealing with patients before they are present at a staffing, and throughout the meeting staffers make periodic use of patients' absence to plan or replan for managing the latter's presence.

Another device for excluding patients is to hold separate staffings, one to which the patient is invited and one to which she is not. One device for including patients at staffings but excluding them in the decision making process is to use them as a source of information. Where that information is corroborated by records or members of staff it is used in the planning of the patient's care. Information not confirmed is ignored.

Some issues normally dicussed at staffings may be too sensitive to discuss openly in front of patients. Gubrium discusses the notion of distancing whereby staffers avoid or treat lightly the issue until the patient is absent. A similar device is sub-plotting whereby staffers indicate – by means of gesture, intonation, and direct references – that only some of the apparent business at hand is meant for the patient. 'It is called "sub-plotting" because sub-plots are organized in the course of the staffing in which staff members selectively participate while the patient is held in dramatic suspension or in an audience role until the main plot is taken up again with the patient participating' (p. 343). Note passing is an example of one form of sub-plotting.

It is clear, even from this brief summary of exclusion devices, that what initially appears to be patient participation in the planning of their care is a façade. However Gubrium notes that nursing homes are not simply caring or otherwise client-serving organizations. The competing interests which such organizations inevitably experience are managed by staff in a way which limits the possibility of full patient participation in planning.

COMMENT

This article is well presented and well argued. Data are presented to illustrate and explain the phenomena under study. However, some indica-

tion of the perceptions of staffers towards the care of elderly patients would have increased its scope and usefulness. The two earlier articles in this series of abstracts have illustrated the importance of negative stereotypes. Such stereotypes, I imagine, have an important role to play in our understanding of the exclusion devices used at staffings and in explaining the failure of patient participation to endure beyond this embryonic form. Is it that staffers believe that patients are incapable of participating in the planning of their care?

Halper, T., 'The Double-Edged Sword: Paternalism as a Policy in the Problems of Aging', *Milbank Memorial Fund Quarterly – Health and Society*, 58, 1980, pp. 472–99.

One of the trivial problems of social science is deciding the boundaries between different disciplines. This article is an illustration of that problem. Written by a political scientist it clearly has sociological and social policy implications. Paternalism, the author argues, may be out of fashion as a word but paternalistic attitudes are still central to health and social policy. Paternalism is the right of those in authority 'to interfere coercively or deceptively in the life of the ordinary citizen for his own good'. (p. 472).

Halper introduces the four most significant criticisms of paternalism, focusing on the policies toward ageing, and follows these with four arguments that are mounted in defence of such strategies. These arguments are illustrated with reference to the decision to institutionalize an old person. In conclusion he attempts to indicate how paternalism can be used appropriately in the formulation and practice of social policy.

A widespread antipaternalist view is one which argues that although an old person may not always discern and pursue his best interest, he will do so more often than will public officials or even family members, because only he can really appreciate his wishes, anxieties, needs, and point of view. Some antipaternalists argue that by seeking to reduce the risks of existence a challenging life is denied old people. Perhaps, more importantly paternalism may serve as a convenient rationalization for a morally dubious self-interest. As our previous abstract suggested staff often play lip service to patient-participation. Greater patient participation involves extra work and, often, a challenge to the professionals' authority. Paternalism provides a rational justification for limiting patient participation. Finally Halper suggests that paternalistic social policies necessarily implies an official intolerance of the citizen's alleged shortcomings and a subordinate relationship that counter the presumption of equality.

In the face of these arguments Halper suggests that paternalists would reply that their opponents seek to maximize the freedom of the old person. But 'freedom is not the only road to happiness, and sometimes, in fact, freedom may lead in the opposite direction'. (p. 477). They would also argue that the distinction between the private and the public sphere is too sharp, particularly in relation to the elderly where it is difficult to find a pure case of paternalism independent of societal interest. Also, paternalists argue, the modern world is full of situations where an old person's ignorance or short-sightedness might itself have calamitous effects on the individual.

These responses have been made to the arguments presented by the anti-paternalists. Halper suggests that the major defence of paternalism lies in the fact that it is founded on the urge to help others. As long as this ethic dominates social policy thinking then paternalism presents no real danger. It is when professionals become arrogant in their assertions that 'we know best' that the double-edged sword becomes unsheathed.

COMMENT

In many ways the arguments rehearsed in this article for and against paternalism mirror an emerging debate in Britain and other industrialized countries about the role of the individual in influencing their own destiny in relation to social policy. However, this article is important also because of its relevance to my underlying theme in these abstracts. Paternalistic attitudes on the wrong edge of the sword lead to negative stereotypes. Rodin and Langer have shown how these affect the individual. But the unacceptable face of paternalism, it can be argued, has also influenced the development of ageism.[1] Ageism has three unacceptable aspects: prejudice, discrimination and the perpetuation of negative stereotypes and attitudes. In the sixties we saw the emergence of an attack on racism, in the seventies it was against sexism. Will the eighties be the decade when there is an outright affront on ageism?

NOTE

1 Butler, R. N., 'Ageism: A Forward', *Journal of Social Issues*, 36, 1980, pp. 8–11.

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Social Services

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Edwards, Carol, Sinclair, Ian and Gorbach, Peter, 'Day Centres for the Elderly: Variations in Type, Provision and User Response', *British Journal of Social Work*, 10.4, Winter 1980, pp. 419–30.

The development of day care, particularly for the elderly but also for other client groups such as the mentally ill, is one of the more significant movements in social services provision at the present time, and, in common with other such 'fashions' in service delivery, one which has been relatively little researched. This paper, drawing on data from the National Day Care Project recently undertaken at the National Institute of Social Work, is concerned to do three things: it develops a simple grouping of day centres for the elderly, it examines how far Local Authorities vary in the type of day centres they are providing, and how far these variations are reflected in the impact of these centres as perceived by their elderly users.

The grouping presented is based on three criteria each of which relates directly to decisions which have to be taken when agencies are planning new day care provision. These are the service provider (a voluntary body or a social services department), transport (whether or not the day centre organized transport for users), and location (whether the centre was based in the community or in an old people's home). The pattern of differences between the resulting types of centre was striking, the main one being between centres with transport and the others. 'Transport' centres were smaller, their users attended for fewer days per week, and reported much more disability.

The paper then compares 13 authorities in respect of the day provision they make and is able to show that authorities clearly pursue very different policies in terms both of the type of day centres provided and in the amount available, the most active authority catering for over 8 times as many users per 1000 elderly as the least.

Given that there are these stark variations in type and extent of provision an attempt is then made to relate statements made by users about the day centres they attended to the type of centre. Users' replies were classified under headings of improvement, prevention, maintenance, and negative. Few users expressed negative comments, most giving replies in the 'maintenance' category. However analysis suggests that those attending social services department run 'transport' centres were more favourably disposed towards the centres than were users of voluntary or residential-based centres.

COMMENT

Day care provision is becoming more extensive and it is time it was better understood. This paper, along with other material emerging from this study, are welcome additions to a rather thin literature. It raises a number of important issues and questions, even if, as the authors admit, the analysis can only be very tentative in parts. Does for example, transport act as a rationer of service with the effect that those in greatest need get least? Have those authorities with low rates of provision alternative ways of meeting need? Why is it that social service department centres in the community are apparently more acceptable than others? If the paper can prompt serious consideration of questions such as these it will serve an important purpose.

Simons, Kenneth R. and Warburton, R. William, 'A Sensible Service', *Clearing House or Local Authority Social Services Research*, No. 1, 1981, pp. 45–66.

In these times of great pressure on resources for the care of the elderly, considerable attention is being devoted to the role of the home help service. Some places have experimented with intensified home help whilst others have tried pilot schemes which involve combining the functions of care assistant and home help in an attempt to provide for more frail old people in the community. This paper is an account of a scheme of this latter kind in Cambridgeshire.

Domiciliary Care Assistants (DCAs) were appointed to provide a domestic help, personal care, and simple nursing care service to a group of elderly people in a sheltered housing scheme and to another group living in their own homes. The care provided to these clients is compared to that offered by the conventional home help service to those elderly people receiving the most intensive home help, living in the same areas as the 'DCA' groups. Additionally, the study compares the effect on the work of the DCAs when, in the sheltered housing group, existing home help is withdrawn with their work in the other scheme when home help was maintained.

Numbers in each of the groups compared in this study are small, but based on records of work undertaken and interviews with the DCAs, the home helps, and their clients, the paper offers an appraisal of the care provided to clients under these various conditions. It emerges that the comparison groups received a service through the conventional home help

service which was as intensive as that provided by the DCAs. Home helps, often acting beyond the limits of their duties prescribed by their supervisors, were able to meet many of their clients' needs through the day and could also give weekend cover. They were frequently the major form of support for the elderly person. In the DCA group without home helps, the DCAs found all their time taken up with domestic help despite their ambition of providing a broader befriending service. On the other hand, those DCAs freed of the need to provide basic domestic help by the continuation of home help to their clients were successful in mobilizing further community support to the elderly person. They were also able to fulfill many of the functions of the District Nurses who ceased to visit except when the DCAs were unavailable.

COMMENT

This paper, whilst it has some shortcomings as a piece of research, nevertheless should be read alongside the growing number of accounts of alternative patterns for the home help service. It draws attention to the overlapping areas of need of the elderly in the community for domestic help, personal care and simple nursing care, often thought of as the province of the auxiliary nurse. It suggests that much of this range of care is already being provided unofficially by individual home helps going beyond the formal limits of their official duties. Perhaps it is time this was officially recognized and acknowledged as a legitimate part of the role of the home help service.

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Psychology and Psychiatry — Mary L. M. Gilhooly

Wilkinson, I. M. and Graham-White, J., 'Psychogeriatric Dependency Rating Scales (PGDRS): A Method of Assessment for use by Nurses', *British Journal of Psychiatry*, 137, 1980, pp. 558–65.

This paper reports on the development of an assessment schedule for the elderly mentally ill which is intended for use by nurses. The authors argue that most previous scales have either concentrated on (a) mental abilities, or (b) physical abilities, and/or (c) disturbances of behaviour, but have not covered all three areas and, hence, are not comprehensive and do not give an overall assessment of the patient.

The Psychogeriatric Dependency Rating Scales (PGDRS) were, as the name suggests, designed to assess dependency. Dependency was defined as 'nursing time demanded by patient'. The items selected for inclusion in the scales were obtained through conversations with nursing personnel and were structured into the three areas mentioned above.

The Orientation items were two point scales (correct/incorrect response) and included items such as Name in Full, Age, Staff-Recognize, Bedroom, Belongings. The Behaviour items were three point ratings (Never, Occasionally, Frequently) and included behaviours such as Disruptive, Demanding Interaction, and Delusions/Hallucinations. The Physical Abilities subscale consisted of four-point ratings of hearing, vision and speech, a four-point rating of help required for dressing, and a six-point rating of mobility. Personal hygiene was scored for either verbal guidance and/or physical assistance and the Never/Occasionally/Frequently format was used for toileting, e.g., Urine-Day, Urine-Night. Space is also provided for nurses to specify special disabilities. The PGDRS format consists of a single case sheet, with instructions for completion in a small booklet. Nurses participating as raters attended two hour training sessions.

The methods of assessing reliability and validity of the PGDRS, plus obtained correlations, are as follows:

Two nurses rated each patient on all available wards (n was approximately 230) in order to compute inter-rater reliability. Weighted kappa (KW) was used and KW = 0.4 was taken as the lowest acceptable value. Items failing to reach this criterion were dropped from the schedule. For items retained in the final version of the PGDRS the mean item KW for the Orientation subscales was .61; for the Behaviour subscales the mean was .48; the mean item KW for the Physical items was .58. Reliability of the subtotal indices, derived from the division of the scales, was examined using Pearson correlation coefficients. The figures were +.86 for Orientation, +.71 for Behaviour, and +.87 for the Physical Subscale scores. All the values of KW and r were significant beyond the one in one hundred level.

The validity of the definition of the scales (dependency = nursing time required) was checked by obtaining independent judgements of required nursing time and correlating these judgements with the total PGDRS score on four wards. The weighted mean of the 4 wards was r = +.72.

The Orientation subscale was used to investigate the diagnostic validity of the PGDRS. It was assumed that patients with an organic diagnosis would score 2 or more, and that patients with functional disorders would score 0–1. On a subsample of 8 wards (n was approximately 100) the Orientation subscale was found to predict diagnosis at a level of KW = .71 ($P < .001$). This is equivalent for an organic diagnosis of a false positive rate of 22 per cent and a false negative rate of 4 per cent.

To further examine concurrent validity it was assumed that patients scoring 20 or more on the schedule were suitable for psychogeriatric (versus rehabilitation) wards. The KW for predicted allocation versus actual allocation was .75 ($P<.001$). For allocation of patients to psychogeriatric wards this represents a false positive rate of 9 per cent and a false negative allocation of 16 per cent.

Eighteen months after the original study patients were followed up to ascertain mortality rates. The total PGDRS score was compared with the mortality outcome. The analysis ($KW=.40$, $P<.001$) revealed a false positive rate of 41 per cent and a false negative rate of 19 per cent.

Finally, ratings were obtained from (1) a social service home for the elderly, (2) a group of elderly persons living at home alone, and (3) a group living in the community with relatives. The PGDRS scores reflected the difference that would be expected on *a priori* ground and hence provide, according to Wilkinson and Graham-White, further evidence of the validity of the scales.

In discussing their new assessment schedule Wilkinson and Graham-White state that, although statistically acceptable, the inter-rater reliability of the PGDRS is not as high as they had hoped. Unfortunately for the reader, the explanation for the low reliability is to be found in another paper (not referenced and presumably not published). Accordingly, they recommend that the PGDRS should be completed by a group of nurses, rather than individuals, and that it should not be used in situations where there are low staffing ratios. Recommended uses for the scales are (1) as an assessment of a patient's condition on admission, (2) to provide criteria to determine ward allocation, and (3) for comparisons of populations. The authors also suggest that the PGDRS could be used to determine staffing ratios within wards, to facilitate discussion of the aims and methods of psychogeriatric care and to stimulate nurses interest in patients.

COMMENT

Had this paper been sent to me to referee I would have suggested that portions of the results section be dropped altogether, namely the sections presenting statistics on the diagnostic and predictive validity of the PGDRS. These scales were, the authors claim, developed to measure dependency as defined by nursing time demanded. Wilkinson and Graham-White should, therefore, have concentrated on demonstrating that the scales adequately assess demanded nursing time. Whether or not the scales can differentiate patients with organic brain disorders from those with functional disorders, and whether or not the scales can predict mortality, is not a relevant test of the schedule's stated purpose.

Although patients in long-term care usually deteriorate, they rarely deteriorate so rapidly as to preclude examining the test-retest reliability of the PGDRS. Since the inter-rater reliability is not very high we are not provided with much evidence that this set of scales is a reliable measure of dependency. As anyone versed in basic statistics knows, a measure which is not reliable cannot be valid.

The PGDRS, even if considered reliable and valid, is a 'messy' assessment schedule. Some of the items are two-point scales, some three-point scales, etc.; some are frequency scales, some require indicating the type of care of assistance required of nursing personnel. What all of this means, of course, is that one cannot produce a total score, a single index of nursing time required. Because the PGDRS do not yield a single score, it is difficult to accept Wilkinson and Graham-White's assertion that '. . . as an assessment of a patient's condition on admission it provides a clear and concise general description. . .' (p. 563). In fact, I came away from this paper unconvinced that there is a need for this particular instrument. Compared to other scales currently available to the researcher or health practitioner, the PGDRS are not a great improvement, even though I accept the statement made at the beginning of this paper that 'There are few methods of assessment in the field of psychogeriatrics which are entirely satisfactory in their overall design and structure.' (p. 558).

Of what value is this new assessment schedule? In the last paragraph of their paper Wilkinson and Graham-White suggest that their instrument is of value in facilitating discussion among those involved in psychogeriatric care. Unfortunately, it is not uncommon to hear psychologists and psychiatrists say that this is the *only* value of such instruments!

Although unconvinced that the PGDRS constitute the valuable contribution that the authors claim, there probably is a need for a scale which reliably measures 'required nursing time'. Perhaps Wilkinson and Graham-White will alter and revise their instrument in the near future and give us a schedule which produces a single score reflecting an individual patient's demand on the psychogeriatric services.

Berg, S. and Svensson, T., 'An Orientation Scale for Geriatric Patients', *Age and Ageing*, 9, 1980, pp. 215–19.

It is argued in the introduction to this paper that existing orientation scales for use with psychogeriatric populations do not pay enough attention to patients' orientation to the long-term care or geriatric ward, i.e., to the 'immediate environment'. The study reported in this article was designed

to rectify this situation. Thus, the aim was to construct an orientation scale for patients in care, and to evaluate the psychometric qualities of the scale.

Berg and Svensson initially constructed a scale of 20 questions, with each correct response giving the respondent one point. The subjects for the study were 66 patients in seven geriatric wards in Jönköping, Sweden. The mean length of stay in these long-term care wards was 12 months, and the mean age of the patients was 77 years.

The responses to the 20 questions were analyzed using principal component analysis and varimax rotation. Five factors with eigenvalues greater than one emerged, with Factor I accounting for 37 per cent of the variance. The authors felt that Factor I constituted a general orientation factor. Factors II through V were difficult to interpret and questions for the final version of the orientation scale were, therefore, not selected from these four factors. The items chosen for the final version of the scale were as follows:

1. How old are you?
2. Where are you presently staying?
3. What day of the week is it?
4. What year is it?
5. What time do you eat lunch here?
6. What is the name of the patient lying/living next to you?
7. Have you heard the name (name of head nurse)?
8. Where is the office for the long-term care ward?
9. When did you come to the hospital?
10. How many patients are there in this ward?

Reliability of the new scale was examined by giving the scale to patients 14 days after initial administration; the test-retest reliability coefficient was .84 (n = 17). A test for homogeneity yielded a correlation coefficient of .83 (Kuder-Richardson formula 20).

Validation of the scale was provided by comparing the scores of the subjects with their diagnosed illness. Subjects with only a physical illness had a mean of 7.1 (SD = 2.7); those with a functional disorder a mean of 7.4 (SD = 2.3); those with a physical illness plus senile dementia and/or cerebral arteriosclerosis a mean score of 4.3 (SD = 3.2); and those patients with senile dementia and/or cerebral arterio-sclerosis only a mean of 3.7 (SD = 3.2). A comparison of the first two groupings of patients with the latter two groups indicated a significant difference ($p < .001$). Thus, the scale appears to be able to differentiate patients with an organic psychiatric disorder from those with a functional disorder or physical illness.

Further validation of the scale came from comparing scale scores with ratings by nursing personnel on Robinson's (1961) assessment scale.

The authors report correlations of .75 for the orientation and .67 for the communication subscales of Robinson's scale.

COMMENT

It seemed a little naive for the authors to argue that available assessment scales for use with the elderly give scant consideration to patient's orientation to the immediate environment, that is, to the geriatric ward. Post's (1965) Clinical Sensorium, for example, contains several questions relating to orientation to the hospital (E.g., What is the name of this place? Where is it located? How do you get here? Does anyone come with you? These questions are to be used with day hospital/centre people.) Whether or not the available scales have questions concerned with the immediate environment depends, also, on the purpose for which the scales were developed.

Berg and Svensson also suggest that it is better to recognize nursing personnel by name than know who the Prime Minister is. I agree. However, one asks questions like 'Who is the Prime Minister?' in order to examine the respondent's recent memory. Questions of this type have answers which are easily scored as correct or incorrect. One can ask what was eaten for breakfast, but the correct response may be unknown. Berg and Svensson should perhaps have spent more time discussing why orientation to time, place or person is investigated when assessing the elderly. However, this is a relatively short and concise report and the authors were, no doubt, correct in assuming that readers would be familiar with measurement of psychological functioning in the elderly.

Although one has to be somewhat familiar with the literature to understand this study, this paper provides an excellent starting point for anyone new to the field. There is a good, but brief, set of references, and one does not have to be a statistical wizard to understand the results.

Steuer, J., Bank, Olsen, E. J. and Jarvik, L. F., 'Depression, Physical Health and Somatic Complaints in the Elderly: A Study of the Zung Self-Rating Depression Scale', *Journal of Gerontology*, *35*, 1980, pp. 683–8.

The aim of this study was to investigate the validity of the Zung Self-Rating Depression Scale (SDS) for use with the elderly and, more specifically, to examine the possibility that among the elderly somatic symptoms may indicate real physical disease rather than depression.

The subjects were 29 male and 31 females suffering from a unipolor

depressive disorder; all were free of significant cardiac, hepatic and renal disease. The age range of these persons was 48–79, with a median age of 64.5 years.

Four hypotheses were tested. (1) physicians' ratings of health will not be significantly related to depression as measured by the total SDS score, (2) the relationship between physicians' health ratings and the Somatic Symptoms (SS) subscale of the SDS will not be significant in a group of healthy elderly persons, (3) a depressed older person in good health will respond to the SDS items in a way similar to depressed, healthy young people (in particular, intercorrelations betwen the Somatic Symptoms subscale and each of the other three subscales – Depressed Mood, Well-Being and Optimism – should be high and significant), and (4) there will be a significant association between the Somantic Symptoms subscale and depression.

The Zung Self-Rating Depression Scale (Zung, 1965) contains 20 items, rated on four-point scales. Examples are, 'I feel down-hearted and blue', 'I get tired for no reason'.

Abstracts from the medical charts of the 60 subjects were created and these were rated on a four-point scale for health, i.e., excellent, good, fair and poor.

The main findings were as follows:

Hypothesis 1 was supported, indicating that health may not be a confounding variable obscuring the measurement of depression in the elderly.

Hypothesis 2 was not confirmed. There was a significant positive relationship between health ratings and the SS subscale of the SDS.

The third hypothesis was given only partial support. It was expected that the intercorrelations between the SS subscale and each of the other three subscales would be high. However, only the association between SS and the Depressed Mood subscale reached an acceptable level of significance.

Finally, Hypothesis 4 was supported, but the fatigue item alone was responsible for the association between scores on the SS subscale and depression.

Because the relationships between each of the non-somatic scale items and the total SDS score were statistically significant, Steuer *et al.* argue that somatic symptoms contribute less to depression than lack of hope, decreased activity, problems in decision making, etc. This, they argue, is contrary to clinical lore which tends to emphasize the role of somatization in depression. They are, nevertheless, cautious in drawing this conclusion, pointing out that the subjects were volunteers who sought help for depression and, hence, less likely to disguise help-seeking behaviour in somatic symptoms.

Commenting on the high correlations found between the fatigue item and depression and physical health, the authors state that complaints of tiredness should be medically investigated and not discounted by health practitioners.

Results from a principal components analysis and varimax rotation are also presented. The most interesting finding to emerge from this analysis was that items loading high on Factor I were positively worded and those loading high on Factor II contained negative wording. Steuer and her colleagues suggest that the subjects in the sample may be responding to more than just item content, i.e., they are responding to the directionality (positive or negative) of the items. Furthermore, they speculate that acquiescence to negatively worded items may be part of the response style of depressed people.

COMMENT

The research reported here probably 'needed' doing, but the study itself and findings were not wildly exciting, nor are they likely to stimulate further research. Moreover, the article was rather difficult to read. It could have been simplified if the authors had discarded the four hypotheses, and merely explored, '. . . . the relationships between depression, somatic complaints and diagnosed physical illness in older persons.' (p. 683) There are times when it is better to examine relationships without predicting the directions – this was one of those times.

Gibson, A. J., Moyes, I. C. A. and Kendrick, D., 'Cognitive Assessment of the Elderly Long-stay Patient', *British Journal of Psychiatry, 136*, 1980, pp. 551–6.

The aim of the study presented in this paper was to explore the potential of the revised Kendrick battery (Gibson and Kendrick, 1979). To date the revised battery has been found to discriminate well between dementing and non-dementing psychiatric patients, as well as being sensitive to cognitive changes within individuals over time. Furthermore, the very simple nature of the revised battery has reduced the level of test refusals to virtually zero. Studies of the elderly long-stay psychiatric patient have in the past been plagued by incomplete results and outright refusals on the part of patients.

There were 20 male and 20 female subjects in the study; all were patients in a long-stay ward of an English psychiatric hospital, and all had

been diagnosed as suffering from a functional disorder. The subjects were aged 59 years or older and had been resident in the hospital for a minimum of three years. The subjects were divided into two groups matched for sex, age, social class, education, length of hospitalization and the proportion of schizophrenic to non-schizophrenic subjects. The experimental group received stimulation during the fourth and fifth week after assessment. All of the subjects were willing to do the battery of tests, indicating that the revised Kendrick battery can be used with long-stay elderly patients.

An analysis of variance of test scores, plus examination of means, revealed that the experimental group, in comparison with the control group, exhibited improved performance on both parts of the Kendrick battery, the Object Learning Test and the Digit Copying Test.

Besides investigating the use of the revised Kendrick battery in the detection of cognitive change, Gibson *et al.* compared the results of this study with results reported in previously published papers (Gibson and Kendrick, 1979; Kendrick, Gibson and Moyes, 1979). The performance of the long-stay patients selected for the study presented in this paper was compared with that of a 'normal' group of subjects, a group of depressed persons seen as acute admissions and out-patients, and a group of subjects diagnosed as dementing but not living in institutions. On both the Digit Copying Test and the Object Learning Test the long-stay group performed worse than the depressed and normal groups. However, on the Digit Copying Test the long-stay patients did not differ significantly from the dementing group. The long-stay patients performed at a higher level than the dementing group on the Object Learning Test.

The similarity in performance on the Digit Copying Test for the long-stay subjects and the dementing sample has, as pointed out by Gibson and his colleagues, interesting implications for the use of the Kendrick battery. If the battery had been used for *diagnosis*, 22 of the long-stay patients would be diagnosed as dementing; this represents a misclassification rate of 55 per cent. Gibson *et al.*, therefore, do not recommend the use of the revised Kendrick battery for detecting organic dementia in longstay psychiatric populations. Its use should be restricted to the types of acute patients upon which it was originally validated.

Interestingly, the authors recommend Pattie and Gilleard's (1979) Clifton Assessment Procedures for the Elderly (CAPE) when assessment of dependency needs is required and when management decisions are needed. They also recommend further studies of *both* techniques to elucidate the relative strengths and weaknesses of the two approaches.

COMMENT

Although this is an interesting article with several excellent references, there are parts which are likely to perplex the reader. For instance, we are not informed as to why the population under consideration (long-stay patients with functional disorders) would benefit from stimulation. The only allusion to this is made midway through the Discussion when Gibson *et al.* state 'That the elderly institutionalized are sensitive to a wide range of stimulation is well documented'. Even this claim is vague as we are not told in what way the elderly institutionalized are 'sensitive' to, or benefit from, stimulation. In other words, we are not presented with background material supporting the contention that stimulation procedures produce cognitive changes.

Another bewildering aspect is the presentation of results from two types of investigation. We are given results from (1) an intervention/stimulation study, and (2) a series of studies of the cognitive functioning of normal, depressed and dementing subjects. The latter set of findings were, as noted above, brought in from previously published papers. It is, of course, quite legitimate to present findings from published research, but the problem in this paper is that the reader is not informed that this was one of the objectives. The findings from the previously published studies are introduced in the middle of the results section and, hence, come as a bit of a surprise. One has to then refer back to the introduction and remind oneself that they are presenting findings on the ability of the revised Kendrick battery to assess cognitive *level* as well as cognitive change.

I was most intrigued by Gibson *et al.*'s recommendations concerning the Clifton Assessment Procedures for the Elderly (CAPE). It is so rare for those devising assessment schedules to say 'good' things about other schedules. (Deficiencies in available scales usually provide the justification for constructing or revising one's own scale). This is a refreshing development and inspires further confidence in the work of these three authors.

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Epidemiology and Community Medicine — John Bond

Yarnell, J. W. G., Voyle, G. J., Richards, C. J. and Stephenson, T. P., 'The Prevalence and Severity of Urinary Incontinence in Women', *Journal of Epidemiology and Community Medicine*, 35, 1981, pp. 71–4.

This article describes a survey in which 1060 women aged 18 or over, randomly selected from a defined geographical area in South Wales, were

interviewed at home about their urinary symptoms. Of the 1000 (95%) women responding 45 per cent reported some degree of incontinence during the previous 12 months.

The authors used a threefold classification of urinary incontinence: urge, stress and complex incontinence. 'Urge incontinence was recorded as positive response to the questions "Do you ever have to rush to the toilet to pass water?" and "If you have to rush to the toilet do you ever lose any water before reaching the toilet?" Stress incontinence was defined as a positive response to the question "Do you lose urine at any other time; for example, when you cough, laugh, or sneeze?" Complex incontinence was defined as any combination of the urge and stress types'. (p. 71). Data were also collected about the frequency of incontinent episodes and the volume of urine lost.

Stress incontinence was reported by 22 per cent of women interviewed, urge incontinence by ten per cent and complex incontinence by 14 per cent. Both complex and urge incontinence are reported to be more common in the older age groups but the prevalence of stress incontinence declined with age. Data about the severity of incontinence (frequency of incontinent episodes and amount of urine lost) indicated that stress incontinence, although relatively common, was usually a mild complaint, whereas the complex type was less common but more severe. Five per cent of all women experienced a loss sufficient to necessitate a change of clothes; in 2.6 per cent such loss occurred daily. Only three per cent of women reported that incontinence interfered with their social or domestic life and only half of these had sought medical advice.

COMMENT

There have been relatively few estimates made of the prevalence of urinary incontinence in the general population. This reflects the problems associated with asking questions about taboo subjects like sex, or death and dying and the reliability of the answers provided. It is known from studies, which have collected data about incontinence from both the subject and carers, that episodes and severity are under-reported by subjects. However, the extent of this under reporting is not well documented. One suspects that under reporting varies with age and social status, and as the authors of this article implicitly suggest they may vary according to the social significance of incontinence. Whatever the answer, surveys of this kind are an important beginning to our understanding of the distribution of this condition.

Snider, E. L., 'Awareness and Use of Health Services by the Elderly. A Canadian Study', *Medical Care*, XVIII, 1980, pp. 1177–82.

Yarnell *et al.* noted that about half of the women in their study with severe incontinence had not been in contact with medical services about the condition. This article describes the awareness and use of health services by a Canadian population and reviews some of the factors which might explain why women with incontinence did not seek medical help.

This article and two similar articles published elsewhere[1] are based on secondary analysis of information collected in a survey of the health and related needs of the elderly in the city of Edmonton, Canada from 428 retired, non-institutionalized family heads aged 65 years or older. The purpose of the research was to determine the level of knowledge about health services and to determine the extent to which awareness of services is related to the use of services.

Respondents were asked a number of questions about 35 health or social agencies and questions were also asked to determine the extent to which respondents used the services the agencies provided. Overall 54 per cent of respondents reported that they were aware of agencies. National agencies were more commonly recognized than local organizations. Demographic factors were not shown to be strongly associated with awareness of services with the exception of age which was inversely associated.

Multiple regression was used to explain the relationship between health service knowledge and health service utilization. Detailed analysis is described from which Snider concluded that the awareness of health agencies influenced patterns of use more than other factors.

COMMENT

At a common sense level the findings of this study are not remarkable. However, they are still important in our understanding of the use of health services. Not being a statistician I found the reporting of the multi-variate analysis difficult, which was not made any easier by the absence of a preliminary univariate analysis.

In particular the article did not provide information about the form of the variables used in the regression analysis nor the distribution of responses for these variables.

NOTE

1 Snider, E. R., 'Factors Influencing Health Service Knowledge Among the Elderly', *Journal of Health and Social Behaviour*, 21, 1980, 371–7; Snider, E. R., 'The Elderly and their Doctors', *Social Science and Medicine*, 14A, 1980, pp. 527–31.

Haug, M. R., 'Age and Medical Care Utilisation Patterns', *Journal of Gerontology*, 36, 1981, pp. 103–11.

Snider concluded that the awareness of health agencies influenced patterns of use more than other factors. In the present article Haug also shows the important influence of health knowledge on the use of physician services. The article uses data taken from a survey of 1509 people aged 18 and above (365 people aged 60 and above) which was undertaken to determine the effect of various consumer attitudes and behaviours on the use of different health services with particular reference to appropriate use.

A measure of appropriate use was developed by asking a panel of physicians to identify 10 common ailments; five of these for which the panel would expect contact with medical services to be made (serious conditions) and five for which such contact would not be expected (non-serious conditions). Three utilization measures were developed. In the first respondents who reported serious conditions in the last three months and who did not contact their physician were classified as under utilizers while people contacting a physician were termed appropriate utilizers. A small number of respondents were classified as mixed utilizers where the physician was contacted for some symptoms but not others. Similarly for the non-serious complaints a second measure of use was calculated. Respondents not contacting physicians about non-serious complaints were classified as appropriate users while those contacting were classified as over utilizers. Again a mixed category evolved where the physician was contacted for some non-serious complaints but not for others. The third measure of physician utilization used was the number of check-ups in the last three months.

Univariate analysis of physician use showed that age and gender were associated with all three measures. Race, respondent's own evaluation of their health and the presence of limiting chronic conditions were associated with age and the number of physician check-ups. Over utilization was associated with race, marital status, family social class, health knowledge and respondent's own evaluation of their health. Under utilization was only associated with age and gender.

Discriminant function analysis was undertaken to assess the joint influence of the variables identified in the univariate analysis. Discriminant analysis is a set of multivariate techniques which 'discriminate' between two or more groups. By knowing responses to a number of variables the technique enables the researcher to predict group membership.

Using these techniques Haug identifies the most powerful predictors of each of her three measures of service use. Whether or not an old person had a chronic condition was a good predictor of having regular check-ups. Being married was a strong predictor of being an under-utilizer for serious complaints. Over utilizers are identified as people with a chronic condition, feeling in better health and having less health knowledge than others.

From these data Haug bravely concludes that 'Since there is so little difference in over-utilization between groups with greater or lesser risk of out of pocket expense for care, flooding the system is not likely to occur... should economic barriers to utilization be lowered as a result of some form of American national health insurance plan'. (p. 111).

COMMENT

This article shows a sensitive use of univariate and multivariate statistical analysis. Given that traditional discriminant analysis is more effective when all the factors are well behaved quantitative variables some caveats of this analysis where non-quantitative variables are used should have been provided. However, the analysis allows some degree of speculation. It does not, though, support the final conclusion since this will depend on the way future cohorts of elderly people, who may have different expectations, use health services.

Garraway, W. M., Akhtar, A. J., Smith, D. E. and Smith, M. E., 'The Triage of Stroke Rehabilitation', *Journal of Epidemiology and Community Health*, 35, 1981, pp. 39–44.

Haug uses discriminant analysis to predict group membership. The concept of triage is also a method of predicting group membership which uses clinical judgement. When medical resources are scarce such as in developing countries, in military hospitals at the time of major battle and in civilian hospitals after a major disaster it is more rational to concentrate on the patients who are likely to respond more readily while providing less care for those who are likely to be poor responders or to those whose

condition is likely to improve regardless of medical intervention. Prediction of group membership, however, remains a clinical judgement.

This study used the concept of triage as a way of identifying patients for a controlled trial in which the effectiveness of a stroke unit is compared with that of medical units rehabilitating elderly patients with acute stroke. Patients with a first stroke referred by general practitioners in the target population were visited at home by medical staff in the study, who divided confirmed stroke presentations into a triage of three bands using selection criteria derived from previous studies of the natural history of stroke. Only patients in the middle band where prognosis was good for survival but spontaneous recovery of independence unlikely were eligible for the trial.

Outcome was measured at the time of hospital discharge using two measures of dependency. Patients recruited to the study were assessed using a purpose built Activities of Daily Living (ADL) unit designed to reproduce the home or other circumstances to which the patients were being discharged. Patients not recruited to the study, including those patients not referred were assessed from hospital records using the Rankin Disability Scale. Outcome at the time of hospital discharge suggested that clinical judgement in predicting group membership was fairly reliable.

This paper also concluded that 'The difference in functional outcome between the stroke unit and medical units enabled the hypothesis that a higher proportion of patients can be returned to independence after admission to a stroke unit rather than medical units to be accepted. The proportions of independent and dependent patients were similar among those admitted to the study who were allocated to medical units and patients with middle band strokes who were admitted to hospital without being referred to the study'. (p. 42). On the basis of this conclusion the authors provide an estimate for the size of the average stroke unit.

COMMENT

From the papers so far published[1] there can be no doubt that this has been a well executed clinical trial. However, conclusions drawn from clinical trials as with other kinds of research still rely on the judgements of individual researchers. In estimating the size of stroke units the authors assume a need for such units in each district general hospital. I was disappointed that the case for such a need was not argued in this article. I also regret that Garraway and his colleagues did not discuss their choice of a discharge outcome by referring to one of their earlier papers in which they concluded: 'Follow up of a controlled trial of the management of acute stroke in the elderly showed that the improvement in functional outcome

at the time of discharge from hospital that had been achieved through establishing a stroke unit had disappeared by one year'.[2] They attributed some of this change to the over-protection by the families of patients. Should stroke units be concentrating also on the rehabilitation of patients' families? If so could the concept of triage also be used to identify those relatives who are likely to respond?

NOTES

1 Garraway, W. M., Akhtar, A. J., Prescott, R. J. and Hockey, L., 'Management of Acute Stroke in the Elderly: Preliminary Results of a controlled trial', *British Medical Journal*, 280, 1980, pp. 1040–3.
2 Garraway, W. M., Akhtar, A. J., Hockey, L. and Prescott, R. J., 'Management of Acute Stroke in the Elderly: Follow-up of a Controlled Trial', *British Medical Journal*, 281, 1980, pp. 827–9.

Brocklehurst, J. C., Morris, P., Andrews, K., Richards, B. and Laycock, P., 'Social Effects of Stroke', *Social Science and Medicine*, 15A, 1981, pp. 35–9.

Once discharged from hospital – whether from a stroke or a medical unit – much of the support of stroke patients is provided by their relatives. This article focuses on the life and health of 97 'chief carers' and attempts to delineate the extent to which family members do look after stroke patients at home. Data is also included about a further 19 patients for whom no chief carer was identified.

Data for this article comes from a longitudinal study of all registered new strokes occurring in South Manchester and the surrounding areas during a period of 6 months in 1974–75. Patients were first seen 2 weeks after their stroke and were then followed up by six weekly visits for one year and survivors followed up annually for a further three years. Most of the data for this article is drawn from interviews undertaken at 2 weeks and one year after the patient's stroke with their chief carer.

The majority of chief carers (84%) lived with the patient and a further 5 per cent saw them daily. The largest group of chief carers were women, aged less than 60, and over one quarter of them had responsibility for other people. The authors report that 14 per cent of those carers in employment gave up their jobs as a result of the patient's stroke. During the course of the first year there was considerable increase in the number of chief carers who regarded their health as poor (from 10 to 28). This was matched by

an increase in the proportion receiving medical treatment (from 33% to 40%). At the end of the year 27 per cent of patients were totally dependent on their chief carer. The major problem reported by chief carers concerned patients' behaviour, in particular the need for constant supervision and loss of sleep.

COMMENT

This article adds to a number of studies which have highlighted the problems faced by relatives of elderly people with chronic handicapping conditions. Garraway and his colleagues have suggested a need for the development of stroke units in all District General Hospitals. This article illustrates the futility of such a policy without first increasing the level of community services to support relatives of stroke patients. Brocklehurst and his colleagues argue strongly for a variety of services: mobile 'stroke teams', more involvement of the relatives in rehabilitation and the continued development of day care facilities. Without this expenditure the successful rehabilitation of stroke patients in both medical and stroke units will be wasted.

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