Nursing Staff Attitudes to Older People and Dementia

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This thesis is submitted to the University of Edinburgh in part fulfilment of the degree of Doctorate in Clinical Psychology.

DECLARATION

'I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification'.

Signed: Date: 11/9/2011

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ABSTRACT

Aims: Demographic trends indicate that the world's population is ageing. Given the increased prevalence of chronic illness and dementia with advancing age, the proportion of patients with dementia in general hospital settings is also expected to increase. Research has suggested that nurses in general medical settings can often lack specialist training, both in the care of older people and in the management of patients with dementia, as well as holding negative attitudes towards this patient group, which can impact both on the quality of care provision and the well-being of care providers. This study aims to explore whether nursing staff attitudes towards older people with dementia, the illness of dementia and older people differ across psychiatric and general medical settings. Given that increased knowledge and contact can support the development of positive attitudes, it was proposed that psychiatric nursing staff, who tend to have more specialist knowledge about dementia and more frequent contact with this patient group, were likely to hold more positive attitudes than general medical staff.

Design/Method: A qualitative methodology was used and a cross-sectional between groups design was employed to compare the responses of nursing staff across psychiatric and general medical settings on a series of self-report questionnaires assessing attitudes to older people, older people with dementia, and the illness of dementia. 73 completed questionnaire packs were received (45 psychiatric; 28 general medical).

Results: Nursing staff across the sample held positive attitudes towards both older people and older people with dementia; however, no significant difference in nursing staff attitudes between the psychiatric and general medical groups was reported. There was a significantly positive correlation between the attitudes nursing staff held about older people and older people with dementia across the whole sample. No significant difference was reported in nursing staff attitudes towards the illness of dementia between groups.

Conclusions: Positive attitudes towards older people and older people with dementia may be considered as reflecting the advent of a downturn in ageist attitudes in some respects; however, more research is needed to explore the manner with which such attitudes translate into practice, as well as the potential barriers to promoting positive views about older people in practice. The role of potential confounding variables in the lack of attitudinal variation between groups, such as the level of training and experience, also merits further investigation.

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1 INTRODUCTION

1.1 Overview

Demographic trends indicate that the world's population is ageing (United Nations, 2009). Despite an increasing proportion of older people living longer and healthier lives than ever before, those aged 65 and over remain the heaviest users of the health service (Scottish Executive, 2002). The proportion of older patients admitted to general medical wards is consequently expected to increase in coming years. As the prevalence of dementia is also known to increase with age (Alzheimer's Society, 2007), the proportion of people being admitted to hospital with a diagnosis of dementia secondary to the illness for which they were primarily admitted is also expected to increase (Kirby, 1998).

Research has suggested that nursing staff in general medical settings can often lack specialist training in the care of older people and the management of patients with dementia, which can impact both on the quality of care provision and the well-being of care providers (Higgins *et al,* 2007; Marshall, 1999; Pritchard & Dewing, 2001; Schell, 2001; Tolson *et al*, 1999; Zimmerman *et al*, 2005).

Ageist attitudes, which are prevalent both amongst health care professionals and society in general, can further compromise the care that is provided to this patient group (Age Concern, 2007; Azjen, 1989; Courtney *et al*, 2000; Helmuth *et al*, 1995; Hope, 1994). It is therefore imperative that these issues are addressed to ensure that services can evolve

to meet the growing needs of older people in the future through improvements in staff support and training.

Attitudinal theories suggest that knowledge and contact have an impact on the development of prejudice and the application of discriminatory behaviour (Azjen, 1989; Allport, 1954; Baltes & Wahl, 1992; Cuddy & Fiske, 2002; Vaughan & Hogg, 2005). The current study aimed to assess the attitudes nursing staff hold towards older people, older people with dementia and the illness of dementia, both in psychiatric and general medical settings. As psychiatric nursing staff are likely to have more specialist knowledge about dementia as a consequence of their training requirements (Royal College of Nursing, 2008), as well as more contact with dementia patients, it is proposed that they will hold more positive attitudes towards this patient group than nursing staff in general medical settings. Relationships between participants' attitudes, age range and training will also be considered.

1.2 The Demographic Context

The composition of the world's population is changing. Improved living standards and advancements in health care have resulted in an increasing number of people living longer and healthier lives than ever before. The proportion of people aged 60 and over is consequently growing faster than every other age group; so much so that the number of people in this age range is expected to rise from 473 million in 2009 (21 per cent of the total population) to 1.6 billion (33 per cent of the total population) by 2050 (United

Nations, 2009). At a local level, estimates suggest that this demographic shift will result in the proportion of Scottish residents aged 65 and over increasing to one in four by 2030, whilst one in twelve will be over the age of 80 (Scottish Executive, 2005).

Although population ageing can be regarded as 'one of humanity's greatest triumphs, [it is also] one of its greatest challenges' (WHO, 2002 p.6). Many fundamental questions have arisen regarding the wider implications of this changing demographic, including its potential impact on the provision of health and social care, whereby increasing demands are expected to be placed on a decreasing pool of formal and informal carers (Laidlaw & Pachana, 2009; Wolf, 2001).

As the incidence of fall-related injuries and the prevalence of chronic and long-term conditions, such as arthritis, coronary heart disease and diabetes tend to increase with advancing age (Scuffham *et al*, 2003; Wannamethee, 2005; Wilson, 2006), it is not surprising that older people are the heaviest users of the health service in NHS Scotland, with two-thirds of hospital inpatients reported to be aged 65 or over at any one time (Scottish Executive, 2002). According to the National Audit Office (2007), it is likely that a large proportion of these patients will also have a diagnosis of dementia, as around one million bed days in acute hospitals are reportedly utilised by dementia patients each and every year. This figure may only scratch the surface, however, as it fails to account for patients who have symptoms of a dementing illness but remain undiagnosed.

As the prevalence of dementia is noted to increase with advancing age, a further consequence of the changing demographic is an exponential rise in the number of people with dementia. According to recent figures, the number of people with dementia in the U.K. is expected to rise from over 700,000 to over a million by 2025 (Alzheimer's Society, 2007). Between 58,000 and 65,000 people in Scotland currently live with a diagnosis of dementia. In keeping with national trends, this figure is expected to rise to between 102,000 and 114,000 people across Scotland by 2031 (Alzheimer's Scotland, 2008).

Given the increased prevalence of chronic and long-term conditions in the older adult population as a whole, the proportion of hospital inpatients that also have dementia is expected to increase as well (Alzheimer's Society, 2007; Kirby, 1998). As older people tend to be admitted to hospital more frequently and require longer than average hospital stays than their younger counterparts, such changes are likely to impact on the capacity of the health service, whilst those working within it reportedly lack sufficient gerontological training to manage the impact of these changes effectively (Health Advisory Service 2000, 1998).

Such difficulties are further magnified by the fact that older patients can often remain in hospital until suitable community care or nursing home placements are arranged. According to a recent survey of Scottish hospitals, 40 per cent of the patients in Older Adult Psychiatry wards and 37 per cent of the patients in Geriatric Medical wards had their discharge from hospital delayed for up to and over a year (JIT Scotland, 2009). One

might therefore argue that healthcare professionals in acute medical settings who are likely to care for a number of older patients (e.g. geriatric medical, cardiac, orthopaedic and stroke wards), as well as those in older adult psychiatry settings, are likely to bear the brunt of the demographic shift.

Challenges are likely to present in these settings, not only for older patients and those with dementia, but also for the health professionals required to support them. According to attitudinal theories and some research evidence, the attitudes that are held about this patient group can arguably influence the manner with which health professionals behave towards them, which can in turn have an impact on the quality of care provision (Ajzen, 1989; Baltes & Wahl, 1992; Cuddy & Fiske, 2002; Vaughan & Hogg, 2005).

Before exploring the attitudes health professionals hold towards older people, older people with dementia and the illness of dementia in greater depth, it is firstly important to put these views into context by defining old age, whilst later considering the factors within this definition which can contribute to the development of ageist stereotypes and their application.

1.3 What is old age and when does it start?

Old age can often be defined by social and cultural norms, the nature of which can arguably influence the way in which older people are viewed, as well as the way they view themselves. In Western society our lives are defined by our chronological age in

many respects, for example, whether or not we are old enough to drive, vote, work or retire (Age Concern, 2000). Despite the fact that the official retirement age of 65 years old is merely a social construct, it has become by association, a chronological marker that is widely used to define the advent of old age. Within this age bracket, older people are popularly characterised into three different chronological categories, including the young-old (65-75 years), old-old (75-85 years) and oldest-old (85 years and over) (Laidlaw *et al*, 2003).

Although the classification of individuals as being in their old age can be largely influenced by chronological age and physiological aspects of ageing, the issue of when old age *begins*, is however, much more complex than age categorisation alone; it is also a subjective construct which can be influenced by a number of factors, such as whether or not an individual is considered to meet specific criteria for group membership (which may include the presence or absence of negative ageing stereotypes), as well as how individuals might feel about being categorised as belonging to that particular group.

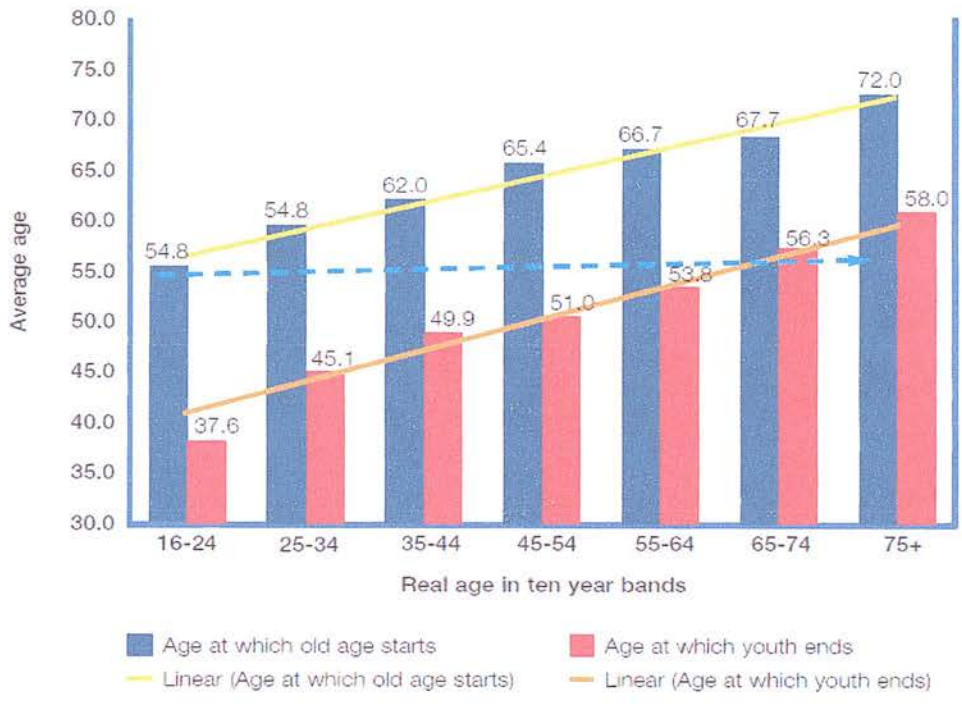
'To me old age is always fifteen years older than I am' (Bernard M. Baruch, 1940)

As illustrated in the statement above, when it comes to people's perceptions of their *own* ageing, what constitutes old age can also vary greatly in accordance with one's own chronological age.

According to Coleman (1996), for example, older people are more likely to reject the negative connotations of old age than their younger counterparts, which suggests that one's own chronological age can have an impact on the acceptance or rejection of negative ageing stereotypes.

Figure 1.1:
Results of survey by Age Concern (2000): When does youth end and old age begin?

Source: Age Concern. (2000). How Ageist is Britain? London: Age Concern England.



This is further illustrated in Figure 1.1, which depicts the results of a survey held by *Age Concern*, in which 1834 participants were asked to provide their opinions on the ages at which youth ends and old age begins (Age Concern, 2000). The stages at which participants perceived youth to end and old age to begin tended to increase with

advancing age, as those aged 16-24 considered youth to end in one's late thirties, whilst those aged 75 and over considered youth to end much later in one's late fifties.

These results ought to be interpreted with a degree of caution; however, as although the report suggests that the number of subjects in each age band was spread equally, the actual number of participants within each band was not provided. As a consequence of this, the results may be subject to bias or misinterpretation.

In spite of these limitations, it is interesting to compare the pattern of these findings with current research. As both the advent of old age and the departure of youth was consistently delayed across the age bands of those surveyed, one might argue that the results highlight a tendency for people to distance themselves from their own ageing by viewing it as a process that happens to other people but not to themselves. On the other hand, however, it might be that older respondents did not *feel* old or consider themselves to fit the mould of what it means to *be* old when surveyed.

The latter statement was highlighted in a recent study by Laidlaw *et al.* (2007), in which older people's views on the age at which they considered themselves to be old were explored. On the whole, participants considered ageing to be more about one's mindset than one's chronological age per se, as they responded with phrases such as 'you are only young as you feel' and 'ageing is a state of mind'. Participants were asked to provide views on their own ageing in this study; however, it may have been useful to examine their views of ageing stereotypes or what it means to be in one's old age. Without this

information, it is difficult to assess whether the results highlight a positive view of ageing or the tendency for individuals to reject the label of old age (with reference to themselves), as it serves to represent a wide range of negative connotations (Levy, 2003).

As highlighted in a review paper by Levy (2003), older people were the only in-group to reject identification with a negative age stereotype. One might suggest that these results go against social identity theory, which states that members of the in-group ought to see each other more positively than the out-group (Taijfel & Turner, 1979). On the other hand, however, this could arguably highlight the magnitude of the negative connotations associated with old age, as not even people within that age group wish to be associated with it.

This is a complex issue; however, as the widely negative global views that people hold about ageing are often not the ones that they hold true for themselves. In spite of this, people may continue to apply their global views about ageing to people other than themselves, whilst holding the belief that everyone else shares their opinion. This can be considered as a form of pluralistic ignorance; defined as a situation in which the majority of group privately reject a norm, but assume (incorrectly) that others accept it (Katz & Allport, 1931).

This begs the question of what it actually *means* to be old. In some respects, it may be that being classed as 'old' has different connotations to being classed as an 'older person'. Perhaps being old or classifying oneself as old might require the acceptance of

or the identification with negative ageing stereotypes. As the nature of such stereotypes may differ greatly from the reality of actually *being* an older person, people in this age group may be more likely to reject identification with negative age stereotypes than younger people.

There are differing views as to why this may be the case. In rejecting identification with negative age stereotypes, Coleman (1996) reported that older people may also be distancing themselves from aspects of ageing that may be deemed threatening, such as facing their own mortality. This reflects the views of Levy (2003), who theorised that 'the more negative the aging stereotype, the more resistance there [is likely to be in] identifying [oneself as] old' (p. 205).

According to Erikson (1997), the rejection of negative age stereotypes could theoretically signify two very different things. Firstly, it could suggest that the person in question has attained 'wisdom' and 'ego integrity', as they have been able to come to terms with their past, thereby facing and coming to terms with the end of their life. In doing so, one could argue that death is not feared, but is considered to be a natural part of life and is not a subject that is avoided. If this were the case, older people may simply reject negative age stereotypes as they either do not consider themselves to fit the mould, or they have maintained crucial aspects of their identity in spite of illness or other life events (Erikson, 1997).

Secondly, a person may presume ego integrity without facing the difficulties of old age, which Erikson described as 'presumption'. As this can make it harder for a person either to face or come to terms with the end of their life, people in this category may reject negative age stereotypes or avoid seeing themselves as an older person, as a means of avoidance (Erikson, 1997).

As these views are chiefly founded on Erikson's lifespan development theory (Erikson, 1997), as opposed to being the outcome of research that has grown out of his theory, one might argue that further research is required in order to support or contest these points of view.

Given the importance of stereotypes and prejudice in the development and maintenance of attitudes towards one's own ageing and the ageing of others, the following section aims to explore these issues in greater depth.

1.4 Attitudes, stereotypes and prejudice: an overview

An attitude can be described as a 'relatively enduring organisation of beliefs, feelings and behavioural tendencies towards socially significant objects, groups, events or symbols' (Hogg & Vaughan, 2005, p.250).

This definition fits within the tripartite model of attitudinal development (Azjen, 1989), which states that there are three categories of responses to any particular object, group,

event or symbol (otherwise known as the 'attitude object'). These include cognitive (positive or negative stereotyping), affective (positive or negative prejudice) or behavioural responses (verbal or non-verbal action or inaction which can result in positive or negative discrimination) (Allport, 1954; Ajzen, 1989; Vaughan & Hogg, 2005).

The cognitive element of the tripartite model encompasses the range of cognitive constructs individuals hold with respect to attitude objects. On the one hand, the development and application of such constructs is considered to be an essential way of categorising the world efficiently and effectively. On the other hand, however, some of these constructs can be founded on hearsay or prior assumptions, as opposed to first-hand experience, which can result in the development of standardised or simplified conceptions of particular groups or individuals (Ajzen, 1989; Vaughan & Hogg, 2005). The application of such 'faulty' constructs to an attitude object is commonly known as stereotyping. Depending on the nature of the preconceptions that are held about a particular attitude object; be it positive, negative, or a mixture of the two, this can purportedly influence one's behaviour towards it (Cuddy & Fiske, 2002; Pratkanis *et al*, 1989; Vaughan & Hogg, 2005).

The affective element of the model relates to the feelings an individual holds about a particular attitude object, which are noted to be influenced and maintained by the nature of the cognitive constructs. As prejudice can be defined as 'an antipathy based upon a faulty and inflexible generalisation' (Allport 1954, p.9), this element relates to the

expression of feeling towards an attitude object and its potential relationship to one's behaviour.

The behavioural element of the model relates to ones 'behavioural inclinations, intentions, commitments and actions with respect to the attitude object' (Azjen, 1989, p.244). This purports that an individual's behaviour towards a particular attitude object is influenced by the nature of the cognitive and affective constructs that are held towards it. In other words, an individual might exhibit either positive or negative discrimination towards a particular attitude object, as a consequence of their underlying thoughts and feelings about it; regardless of the basis or foundation of those beliefs.

In a similar vein to the cognitive-behavioural models that are employed in therapeutic settings (e.g. Beck, 1976), the tripartite model purports that cognitive, affective and behavioural responses to an attitude object can both influence and be influenced by one another. In other words, one's thoughts and feelings about a particular attitude object can influence the way one behaves towards it, whilst also serving to confirm or disconfirm pre-existing cognitive responses to it.

This principle underpins Allport's hypothesis that improved knowledge and contact with a particular attitude object can also influence the way an individual behaves towards it by challenging the nature of the stereotypical views which serve to maintain discriminatory behaviour (Allport, 1954). It is important to stress, however, that the *nature* of contact with an attitude object can play a vital role in determining whether or not stereotypical

views are actually challenged. With this in mind, one might argue that contact with an attitude object in some contexts can actually serve to *reinforce* a stereotypical view as opposed to challenging it.

Given the nature of their work, healthcare professionals are more likely to come into contact with older people who are chronically ill, frail and cognitively impaired, as opposed to meeting healthier older people who do not present with these difficulties. Furthermore, many of these older patients do not recover from their illness and are more likely to die in hospital than younger patients (Basnett, 2001). With this in mind, contact in the context of healthcare can arguably lead to the development of a skewed global view that *all* older people are dependent, ill or cognitively impaired. This can consequently serve to reinforce pre-existing negative ageing stereotypes, as opposed to challenging them (Basnett, 2001).

Developing biased views of certain patient groups through prolonged training and practice is also known as professional socialisation (Basnett, 2001). According to Norman (2006), professional socialisation can also impact on the nursing role, as in order to 'fit in and muck in', nursing staff may have to adopt attitudes or behaviours that apply to their role and particular ward environment as opposed to their own personal stance (p.11). If negative stereotypes are overridden via professional socialisation, this is likely to be positive; however, if positive approaches are repressed to meet the needs of a busy ward, this can not only be detrimental to the patient, but can also increase levels of stress for the nurse and increase the likelihood of staff leaving the profession (Norman, 2006;

Zimmerman *et al.*, 2005). In some circumstances, professional socialisation contradicts the view that increased knowledge and contact will reduce prejudice and promote the development of positive attitudes (Allport, 1954; Hope, 1994), as one could argue that contact under certain conditions may actually increase it.

As illustrated above, although cognitive and affective constructs can theoretically *influence* behaviour, they cannot always *predict* it, as unlike the tripartite model suggests, one's thoughts and feelings about a particular group are not always congruent with the way in which one behaves towards them.

Early attitudinal research has suggested a weak to moderate link between attitudes and behaviour (Dugan, 2004; LaPiere, 1934; Wicker, 1969), however, outwith the exploration and development of attitudinal models discussed above, little research has explored this link in depth.

According to Burns (1992), who assessed the attitudes of oncology nurses towards cancer, the nature of attitudes that are held towards a particular illness or patient group can have an impact on the treatment and care received. Of those questioned, respondents with positive attitudes towards cancer were noted to place higher value on patients receiving treatment and psychological care than those with negative attitudes. As a consequence of this, Burns (1992) proposed that the attitudes held towards cancer might influence the treatment and care they were offered or provided.

Like a number of studies in this field, however, respondents' *attitudes* towards the provision of treatment and care were examined, whilst the *actual* quality of care provision was not.

The direct causal relationship between attitudes and behaviour has frequently been put into question. Such a relationship does not appear to account for an individual's ability to choose whether or not to act upon his or her feelings or for the impact of external factors on whether one chooses to exhibit or inhibit a particular behaviour.

Given the fluid nature of attitudes and the propensity for people to hold diverging attitudes simultaneously, the relationship between attitudes and behaviour is therefore particularly complex and difficult to assess. Attitudes can be fluid in response to a kaleidoscope of factors; all of which can serve to influence their development and application. Such factors include knowledge and understanding and the context within which this is applied, cultural influences and beliefs, and a person's view of their role within a particular group (Allport, 1954; Azjen, 1989; Hazan, 1994). With this in mind, one might argue that attitudes have a role in influencing behaviour to varying degrees, depending on the particular relevance of these external factors to each individual (Smith & Mackie, 2007).

Whether or not a behavioural *intention* becomes an *action* may also be contingent on more than the cognitive and affective elements of the tripartite model. In accordance with the theory of planned behaviour, for example, this may relate to a number of issues

including an individual's attitude towards their intended behaviour, subjective norms and whether their behaviour is perceived to be within or outwith their control (Ajzen, 1989). Within this model, it may be that a nurse intends to spend some time talking to their patient, but that this behaviour is inhibited due to the number of patients on the ward who also require care (perceived control) and the notion that this is not an integral part of his or her role (subjective norm in relation to nursing).

The theory of planned behaviour also fits within the premise of social learning theory, which purports that a nurse's behaviour towards a patient could be influenced by whether or not their colleagues agree or disagree with their practice (Norman, 2006; Taijfel & Turner, 1979). Behaviour that is reinforced and accepted by other nurses is therefore more likely to be practiced than behaviour that is considered to be unacceptable. Nursing staff may consequently have to inhibit certain attitudes (or the behavioural intentions and actions that might arise from them), in order to meet the expectations of their colleagues. This also fits with the notion that professional socialisation via prolonged training and contact with a patient group could be positive if it encouraged the dismissal of negative aging stereotypes, but that it could just as easily be detrimental to patient care if it promoted the reverse.

As evidence suggests that stereotypical cognitive constructs can operate without intent and outside of one's conscious awareness (Levy, 2003), it is clear that professional socialisation is only part of the picture. Both the tripartite model of attitudinal development and the theory of planned behaviour fail to account for this finding.

According to Levy (2003), an individual can be unaware of their behavioural intentions towards a particular attitude object, or of the fact that the actions they have carried out are discriminatory. One might argue that professional socialisation might promote this notion to some degree, as behaviours that are considered to be common practice and carried out automatically may indeed by discriminatory without intent. This process of unconscious stereotyping can occur both amongst older people and those who support them. More importantly, the application of such stereotypes has been noted to have implications for the way older people behave, as well as the way healthcare professionals behave towards them (Baltes & Wahl, 1992; Levy, 2003; Stockwell, 1972).

For example, following exposure to negative primers of ageing, such as 'ageing is a time of decrepitude and ill-health', Levy (2003) reported that older people displayed changes in their physical behaviour, such as shuffling or stooping, whilst their younger counterparts did not. When the same respondents were provided with positive primers of ageing, such as 'ageing is a time of wisdom', such behaviours were no longer observed. This suggests that when older people are placed in ageist categories by others, that they may unconsciously react accordingly; even though they may *consciously* reject any association with the label of old age or the negative connotations that can be associated with it (Age Concern, 2000; Coleman, 1996; Laidlaw *et al*, 2007)

According to a behavioural observation study, the inadvertent operation of negative ageing stereotypes in healthcare settings can lead to nursing staff supporting dependent behaviours and ignoring independent behaviours (Baltes & Wahl, 1992). The results

suggested that older patients were often automatically fed and dressed by healthcare professionals, even though they were capable of doing so independently. On the other hand, patients who attempted to care for themselves were considered awkward or stubborn, whilst those who were carrying out a task with difficulty were either left to their own devices or had the task done for them, instead of being supported to do so correctly. This can have an adverse impact on rehabilitation, as the culture can develop that it is quicker to do things on behalf of this patient group than it is to encourage their independence. As older people are likely to be in hospital for longer than their younger counterparts and to have their discharge from hospital delayed (JIT Scotland, 2009), a culture of 'dependency-support' could also have an adverse impact on their ability to return to their own home and live an independent life. In fact, reports have suggested that patients in this age group can often be discharged with lower levels of functioning than they had on admission, not as a result of their illness, but as a result of encouraged dependence as a consequence of their hospitalisation (Courtney, 2000).

Bearing in mind the flexible and duplicitous nature of attitudes, the factors which can influence them and the likelihood that those of a stereotypical nature can be administered outwith conscious awareness, the measurement of attitudes can be a complicated business. According to Azjen (1989), as attitudes are 'latent variables [which are] inaccessible to direct observation, they must be inferred from measurable responses [which] reflect the positive or negative evaluations of the attitude object' (p.242). As a consequence of this, a large proportion of the studies which explore the attitudes

healthcare professionals hold towards older people opt to use validated self-report questionnaires (Hope, 1994; Kearney *et al*, 2000; Tierney *et al*, 1998).

Many of the issues discussed can complicate the measurement of attitudes, as it can be difficult to tell whether the particular response provided by an individual is representative of their personal opinion, or the view that they are required to hold in their professional role. This can make it challenging to measure attitudes with consistent degrees of accuracy, as their measurement not only relies on valid screening tools, but also on respondents reporting their views with honesty. As a consequence of this, it can be difficult to compare and contrast different studies effectively.

According to Bowling (2001), for example, factors such as social desirability bias can impact on the measurement of attitudes, whereby participants respond with information that places them in a positive light, or pays lip service to political or managerial guidelines, instead of sharing information which reflects their true feelings. Similar difficulties can arise in observing behaviour, as those being observed may opt to change their regular practice, in order to be seen in a more positive light. In order to assess behaviour correctly, one must have understanding and experience of the role being observed. According to Norman (2006), this can make it particularly difficult for those outwith the nursing profession to provide a credible account of nursing staff attitudes on the basis of behavioural observation. As a consequence of these issues, the current study did not endeavour to examine behaviour directly.

As the current study aims to explore the attitudes nursing staff hold towards older people, older people with dementia and the illness of dementia, the remainder of the chapter will consider these issues in turn; alongside the potential links between ageist attitudes and care. Before doing so, however, it is firstly important to explore the concept of ageism and its foundations in greater depth, as well as the potential impact of these attitudes on older people.

1.5 Ageism: an overview

Ageism can be defined as a 'process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender' (Butler, 1975, p.35).

Negative attitudes towards old age and older people have long been in existence and are known to develop from a young age. In spite of improvements in healthcare leading to increased longevity and a healthier old age, a raft of negative stereotypes such as mentally declining, ill, frail, decrepit, disabled and depressed continue to be applied to people aged 65 and over; purely on the basis of their chronological age (Cheston & Bender, 1999; Levy, 1996; Palmore, 1990).

In some respects, one could propose that the vast improvement in life expectancy across the Western world has contributed to ageist views, as according to Blythe (2005), 'old age has become the only *'normal'* death age' (p.96). With this in mind, negative views

about ageing may be partially driven by internal fears and anxieties about death and dying, as old age is generally considered as a time at which one begins to face the boundary between life and death (Blythe, 2005; Erikson, 1997).

As a consequence of this, old age has become synonymous with a loss of health, strength, independence and cognitive functioning (Blythe, 2005; Hazan, 1994; Laidlaw *et al*, 2003). Old age and ill health have, therefore, become inextricably linked; to the extent that old age *itself* is perceived as an illness (Wilson, 2000). Universally negative stereotypes of older people can develop from this assumption, whereby those aged 65 and over are automatically perceived as being less physically or mentally capable than their younger counterparts. This can result in the view that both physical illness and cognitive decline are normative within this age group, which is also known as the 'understandability phenomenon' (Blanchard, 1992).

In accordance with the tripartite model of attitudinal development (and the theory of planned behaviour), the application of such views can also can serve to promote and maintain corrosive misattributions about older people, as well as influencing the way in which individuals behave towards older people to varying degrees (Ajzen, 1989; Vaughan & Hogg, 2005). This is particularly relevant when considering the attitudes healthcare professionals might hold towards older people in their care, as viewing a person as being incapable, incompetent or ill, not as a consequence of a disease, but as a consequence of their chronological age, may well have implications for the treatment and care that they receive.

The attitudes of healthcare professionals towards older people and those with dementia will be explored in greater depth in the following sections, with an emphasis on those in the nursing profession. It is firstly important to briefly examine the ways in which knowledge and contact with this patient group might serve to influence attitudinal development given the focus on psychiatric and general medical nursing groups in the current study.

1.5.1 The role of knowledge and contact in the development of ageist attitudes

According to Hazan (1994) 'rather than [simply] consisting of data at our disposal, [knowledge can be] shaped by perceptions, beliefs and rationalisations' (p.2). As knowledge about ageing and issues that are relevant to the care of older people can be founded on a wide variety of negative stereotypes or prejudicial views, these can arguably serve to shape the way in which information about older people is internalised and utilised. With this in mind, one might argue that knowledge about older people can serve either to dispel or maintain negative ageing stereotypes, depending on the manner in which the knowledge is attained and whether or not barriers exist to prevent its application.

Some studies have suggested that the advancement of gerontological knowledge via training and further education serves to promote positive attitudes towards older people and older people with dementia, however, this has not always transferred directly to the quality of care they receive (Ballard, 2002; Hope, 1994).

Researchers have used a wide variety of methods to measure knowledge, including validated questionnaires (Hope, 1994; Tierney *et al*, 1998), years of experience in working with older people, as well as the participants' level of gerontological training (Hope, 1994; Tierney *et al*, 1998). According to Hope (1994), who explored the potential difference in nursing staff attitudes to older people across general medical and acute geriatric settings (see p. 40), there was a positive correlation between the level of post-basic gerontological education and the attitudes that were held by respondents in the general medical group ($p = 0.04$). It is important to note, however, that this correlation was not particularly strong. Furthermore, as only two out of the 38 respondents in the general medical group had actually undertaken this level of education, this result ought to be interpreted with a degree of caution.

Some studies have also measured the advancement of knowledge via the specialist advice and support of ward-based geriatricians and liaison nurses, which is considered to be instrumental in shaping nursing staff attitudes and improving practice (Ballard, 2002; Tierney *et al*, 1998)

In conducting a 9-month observational study in a care home setting, Ballard (2002) noted that the presence of liaison nurses significantly reduced the administration of neuroleptic drugs, however, the capacity in which the liaison nurses supported this change (e.g. the promotion of behavioural methods) was not fully explored. According to Ballard (2002), there was no significant difference in the quality of care received between the setting which had liaison nurses and the setting which did not. One might argue that this fails to

acknowledge the importance of the reduction in drugs administered, as the prevention of over-medication ought to be considered as an improvement in care.

This highlights issues with the validity of tools which purport to measure quality of care, as they may fail to recognise changes which make a real impact on patient care. Furthermore, as this study used Dementia Care Mapping (DCM), a process which requires the continuous observation and coding of nurses' behaviour towards their patients, the influence of social desirability bias may have been overlooked (Bowling, 2001). As baseline measures of quality of care were not provided it is, however, difficult to assess if the lack of change relates to the low impact of liaison nursing input on quality of care, or if it simply reflects a high standard of care across both settings prior to their introduction.

Given the wide variation in measures of knowledge, it can often be difficult to make adequate comparisons across individual studies; whilst as reflected above in relation to quality of care, the validity and relevance of existing measures of knowledge has frequently been called into question.

Although several studies have used the *Palmore Facts about Aging Quiz* (Palmore, 1977) in order to assess respondents' knowledge about older people (Hope, 1994; Palmore, 1977; Tierney *et al*, 1998), one might argue that this is not a valid measure of gerontological knowledge. Many of its items appear to have a theoretical, as opposed to a factual basis. For example, in answering true or false to the statement 'rarely does

someone over the age of 65 produce a great work of art, science, or scholarship', the answer provided is clearly based on the individual opinion that the respondent holds, which one might argue does not constitute a gerontological *fact.*

Similarly, measures of knowledge about dementia, such as the *Dementia Quiz* (Gilleard & Groom, 1994) and the *Alzheimer's Disease Knowledge Test* (Zarit *et al*, 1988) are considered to be somewhat outdated in terms of today's practice. In the *ADKT,* many of the questions relate to aetiological, diagnostic and pathological aspects of dementia, as opposed to behavioural elements and their management, which are arguably more relevant to nursing staff required to provide this patient group with care and support. Although the *Dementia Quiz* improved on the *AKDT* by adding sections on knowledge about coping and knowledge about the services that are available for people with dementia, it is aimed at informal carers and does not reflect issues that would arise in a hospital setting.

Although knowledge is considered to be an important factor in the development and maintenance of attitudes, it can be difficult to measure its impact; particularly given the potential influence of barriers on its application. For example, nursing staff may have a great deal of knowledge about managing behavioural difficulties that can arise as a consequence of dementia, but it may be difficult to apply this knowledge effectively due to restrictions with the ward environment itself, such as the ward layout or reduced staffing levels.

Research has suggested that both knowledge *and* contact are essential in the reduction of prejudice and the promotion of positive attitudes (Allport, 1954; Cummings & Galambos, 2002; Desforges *et* al, 1991; Levy & Banaji, 2002). Although knowledge and training may have a role to play in the promotion of positive attitudes towards older patients to some degree, knowledge alone is not considered to be sufficient to challenge ageist stereotypes (Cummings, Galambos & DeCoster, 2003; Hinrichsen & McMeniman, 2002).

As discussed previously, the *type* of contact is of particular importance in determining whether negative ageing stereotypes are challenged or maintained. This deduction has been 'linked to the tripartite model of attitude formation (Vaughan & Hogg, 2005), in which increased knowledge about a group experiencing discrimination [only serves to address] the cognitive component of the attitude, thereby addressing stereotypes rather than addressing prejudice (the affective component) or discrimination' (Koder & Helmes, 2008, p.276).

This was highlighted by Cummings, Galambos and DeCoster (2003), whose study with social work graduates indicated that frequency of contact and rewarding interactions were the most significant predictors of opting to work in an older adult speciality compared with level of gerontological training. On the contrary, however, Koder and Helmes (2008) reported that clinical psychologists who had more contact and/or rewarding contact with older people were no more likely to choose to work with older adults than those who did not.

Both of these studies failed to consider the role of contact within a professional context, however, as they used measures which assessed the nature of their contact with family and friends in this age bracket. As a consequence of this, neither study measured the impact of prolonged professional contact with older people, who are likely to be considerably frailer and sicker than their healthy counterparts.

Upon further investigation, Koder and Helmes (2008) noted a relationship between participants' attitudes to ageing and their level of specialisation in older adult care, whereby those with a specialisation in older adult care were more likely to have negative attitudes to ageing than those who did not. This challenges the notion that increased contact with older people has a positive impact on the attitudes of healthcare professionals towards them (Allport, 1954; Cummings, Galambos & DeCoster, 2003; Desforges *et* al, 1991) as in this case it was purported to have a detrimental effect.

These findings were mirrored by Moniz-Cook *et al* (2000), who reviewed the factors associated with the perception of behaviour as challenging in residential and nursing home settings. A total of 326 nursing staff across 14 residential and nursing homes were assessed with a battery of tests, which measured variables such as experience, stress, burnout, job satisfaction, anxiety, knowledge of dementia and staff support. High levels of staff anxiety, a lack of supervisor support and difficulties in relating to residents as individuals were predictors of perceiving behaviour as challenging. Interestingly, it was found that qualified members of staff were more likely to perceive behaviour as

challenging than their unqualified colleagues, which has implications for the impact of training and experience on attitudinal development.

This also supports the view of Hochschild (1983) who theorised that increased clinical contact with older patients can raise awareness about death and dying; raising anxiety about the ageing process and strengthening negative ageing stereotypes as a consequence. Furthermore, it may be that increased exposure to a skewed population of older adults in a health care setting serves to perpetuate negative ageist stereotypes about frailty and ill health throughout the older adult population.

According to a recent report, ageist attitudes do not only persist towards older people amongst society in general; they are also evident in the attitudes healthcare professionals hold towards older patients in their care. These views were felt, not only to 'reflect negative ageist stereotypes existent in wider society', but were also considered to be a product of professional socialisation within a structurally ageist environment. Although its role in addressing ageist views has been widely debated, a lack of knowledge and training about the specific needs of older people in the health service was also considered to be a factor (Courtney *et al,* 2000, p. 63).

The following section therefore aims to explore the attitudes healthcare professionals hold towards older people and the potential foundations of these attitudes. Factors which may serve both to influence and maintain these views will be explored, whilst continuing to explore the potential impact of ageist attitudes on behaviour throughout.

1.6 ATTITUDES OF HEALTH PROFESSIONALS TOWARDS OLDER PEOPLE

According to Higgins *et al.* (2007), the perception that ill-health is a natural part of ageing can lead to the notion that the effort of providing medical care is unfounded, as it is unlikely that an older person with multiple conditions will be 'cured' following an intervention. It follows that such underlying attitudes can impact on the way these patients are perceived and cared for by healthcare professionals:

'Perhaps you would probably work a little bit harder to get, say a sixty-year old up and moving and to become more independent. You wouldn't necessarily spend as much time on an elderly [sic] patient that you know is going back to a nursing home that probably wasn't walking very well before' (Higgins *et al*, 2007, p.232).

According to Hochschild (1983), the sense of powerlessness and the inability to cure reflected in this statement can increase levels of objectification and dissociation towards this patient group. As healthcare professionals often come into contact with people who are seriously ill and may have to deal with a number of deaths as a result, Hochschild (1983) noted that frequent contact with chronic and terminal illnesses might result in health professionals considering aspects of their own mortality and of those close to them. Such anxieties were purported to lead staff to distance themselves from certain types of patients as a means of self-protection.

Hochschild (1983) argued that this may be particularly common in those working with older patients, given the thinning boundary between life and death with advancing age.

With this in mind, it was theorised that some healthcare professionals may be fearful of becoming emotionally involved with older patients, keeping them at a distance and treating them accordingly.

One might argue that this also contradicts the view that increased contact promotes positive attitudes towards older people. As very little research has been carried out in order to explore the validity of Hochschild's theoretical framework in professional settings, however, it is difficult to comment on the potential impact of these issues on either attitudinal development or quality of care (Hochschild, 1983).

Although pervasive, stereotypes that are held towards older people are not always negative; in fact research has suggested that older people 'face a more complex brand of [ageism which comprises of] *both* negative and subjectively positive beliefs, feelings and behaviours' (Cuddy *et al*, 2005, p.271).

By using the stereotype content model (SCM), a model that is used to describe and predict both the way in which groups are 'sorted' in any given society and how this relates to the nature of the discrimination its members may encounter (e.g. positive or negative), research has suggested that mainstream society stereotypes older people as warm (positive) but also as incompetent (negative) (Cuddy & Fiske, 2002). Although this research was mainly based on the views of undergraduate students, it fits with the dependency-support literature, which suggests that older people are likely to be treated as if they are incompetent in healthcare settings (Baltes & Wahl, 1992).

Interestingly, Cuddy & Fiske (2002) also suggested that older people who conformed to the stereotypes to which they were assigned were *treated* better than those who did not. This mirrors Baltes and Wahl's findings, as those who were dependent (and arguably perceived as incapable or incompetent) were theoretically provided with more support than those who attempted to be more independent (Baltes & Wahl, 1992).

According to Schell (2001), 'patients are...commonly perceived by nursing staff in terms of mental and physical dependence', as these factors can determine a patient's ability to accomplish or assist in a variety of tasks, such as attending to their own personal care (p.367). Whether or not patients can accomplish these tasks can not only influence the level of demand placed on nursing staff, but it can also contribute to their popularity on the ward.

If older people are frequently considered to be incompetent (consciously or unconsciously), simply as a consequence of their age, this clearly has implications for the manner in which they are treated, as well as the quality of care they receive. For example, reports have suggested that incidences of delirium are frequently under-diagnosed, as a consequence of the belief that all older people lose their memory or are somewhat incompetent due to their age (Alzheimer's Society, 2007; Wahid, 2004). The promotion of dependency can also lead to reduced physical rehabilitation, as these patients are neither encouraged nor expected to regain their independence (Baltes & Wahl, 1992). As all of these factors can influence the length of time an older person remains in hospital,

this also increases the risk that they might contract hospital based infections, or that they no longer return to their own homes following their admission.

There is also an expectation that older people ought to adhere to ageing stereotypes; so much so that those who *do* are likely to be treated better than those who do *not* (Baltes & Wahl, 1992; Cuddy & Fiske, 2002) This has interesting implications for the older person as patient, as one might argue that in order to have a positive experience in hospital, they are not only required to conform to ageing stereotypes, but are also required to adhere to the role of the patient (Stockwell, 1972).

By studying patient-nurse relationships on general medical wards, Stockwell (1972) found that good humour, expressing the determination to co-operate with medical procedures and the ability to communicate well with nursing staff were all deemed to be characteristics of a popular patient. In a sense, those who assumed their role as a patient and allowed nursing staff to perform theirs were often the most popular on the ward. This may partially account for Baltes and Wahl's findings, as dependency may be encouraged to promote co-operation with ward rules and regulations (Baltes & Wahl, 1992).

On the other hand, aggression, mental health difficulties, complaining, feigning symptoms, and 'demanding excessive attention' from nursing staff were characteristic of an unpopular patient. Patients who found it difficult to communicate for a wide variety of reasons such as those with post-stroke aphasia or those with hearing difficulties were also less popular with staff (Stockwell, 1972). If nursing staff did not feel equipped to deal

with certain patients, such as those considered to be better supported in a specialist unit or alternative hospital, it also had a negative impact on their popularity, particularly if they were admitted for several months or more.

Although Stockwell's study might be considered dated in some respects, it is nevertheless interesting to explore the parallels between older patients and unpopular patients. As discussed previously, older people are more likely to have longer than average hospital stays (Health Advisory Service 2000, 1998), whilst those aged 65 and over are at increased risk of having conditions that can interfere with their ability to communicate, such as poor eyesight or hearing, stroke or dementing illness (Scottish Executive, 2002).

As all of these factors are also present in the profile of the unpopular patient, one could argue that older people are most vulnerable to becoming unpopular with health care professionals; those with dementia even more so, as popular patients 'were uniformly defined as mentally intact' (Stockwell, 1972).

This provides an interesting contrast to the 'warm but incompetent' stereotype (Cuddy & Fiske, 2002); as according to Stockwell (1972), patients with an increased level of competency – those described as 'mentally intact' – were considered to be more popular with nursing staff than those who did not fit into this category. In other words, those who are deemed to have a greater level of competency are likely to be treated better than those who do not.

As the actual *level* of incompetence applied to older people was never examined by Cuddy and Fiske (2002), one might argue that incompetence in this case does not refer to a loss of one's abilities, but to the stereotypical view that older people become marginally more confused and forgetful as a consequence of the ageing process.

As this stereotype is widely applied to older people, one might argue that mild disorientation or memory loss could be deemed 'normal' in this patient group. Although dependency may be encouraged in these patients, they are able to co-operate with nursing staff and follow the general rules of the ward environment.

In a hospital setting, one might assume that those who are not described as 'mentally intact' find it harder to co-operate with medical procedures or to follow ward protocol as a consequence of illness such as dementia. Although these patients may be dependent in many respects, increased levels of confusion may result in challenging behaviour or the refusal to co-operate with aspects of their care (Moniz-Cook, *et al.,* 2000).

According to Stockwell (1972), such differences between patients can also influence the manner in which they are treated. For example, Stockwell observed that more popular patients were 'rewarded' with increased levels of interaction from staff and a more flexible approach towards their care, whilst those considered less popular were often ignored or forgotten and the rules of the ward were more strictly enforced upon them.

The observational nature of this study clearly makes it subject to bias, as the researcher was solely responsible for recording and interpreting the behaviour of nursing staff. It is nevertheless important to consider what this means for older patients and those with dementia; particularly in acute hospital settings where such patients are often viewed as 'not belonging' due to the belief that they ought to be cared for in a more specialist geriatric or psychiatric setting (Marshall, 1999).

Contrary to the findings of Koder and Helmes (2008), knowledge may also influence patient popularity. For example, a patient with loud, aggressive patient who is unable to independently motivate themselves may be deemed as inherently rude or lazy, whereas with more training, it may become clear that the patient in question could have executive functioning difficulties or is anxious or depressed (Basnett, 2001).

One might argue that this change in perspective can also impact on the way in which older patients are treated, as having the skills to support patients with dementia to co-operate can reduce the likelihood that they will be viewed negatively (and treated accordingly).

1.6.1 Nursing staff attitudes to older people

Several studies have suggested that ageist attitudes are commonplace in the nursing profession (Kearney *et* al, 2000; Meyer *et* al, 1999; Stevens & Crouch, 1995), whilst

others have reported that nurses hold neutral to positive attitudes towards this patient group (Hope, 1994; Tierney *et al*, 1998).

In a study by Stevens and Crouch (1995), nursing students were asked to rank their interest in working with older people on a series of Likert scales, as well as their opinion of older adult nursing and its impact on their self-esteem. Of the 610 respondents in their first year of training, 65 per cent had a negative view of older people and the nature of the work carried out in these settings whilst 24 per cent of those surveyed felt that working in these settings had a negative impact on their self-esteem. Upon being asked to elaborate on their responses, participants described older people as 'depressing', 'obsessed by dying' and 'frightening', whilst describing work as an older adult nurse as 'futile', 'dirty' and 'hopeless'. This reflects the views of wider society, as illustrated in Section 1.4.

By the end of their 3-year training course, 49 per cent of the remaining 283 respondents continued to harbour a negative view of older people and the type of work carried out in these settings, whilst 30 per cent felt that older adult nursing had a negative impact on their self-esteem. By this stage in their training, respondents felt that work in older adult settings damaged their career prospects, as it was considered to be 'a slave's job...which is not technical enough' (Stevens & Crouch, 1995, p.238). There was also a sense of hopelessness about recovery rates in older patients. This finding is consistent with that of Nay and Garratt (2004), who found that nurses in general medical settings preferred to care for younger patients with curable illnesses than older patients, as they gained a greater sense of satisfaction in their work.

According to Stevens and Crouch (1995), a number of respondents admitted that fears about their own ageing made it difficult for them to work with older people, as they felt 'scared of growing old and [did not] need to be reminded of it every day [they went] to work' (p.237). This supports Hochchild's theory regarding the potential impact of objectification and dissociation on behaviour (Hochschild, 1983).

It may therefore have been of interest to expand on the qualitative element of the study by examining participants views about ageing and mortality, in order to assess the influence of these factors in informing attitudes. Furthermore, it would have been interesting to question respondents about whether these views had an impact on the time they spent with this patient group.

On the other hand, the views of those with positive attitudes towards older people and their reasons for being drawn to this area of work were not explored by Stevens and Crouch (1995), which may have served to bias the data that was presented. Furthermore, one might argue that there was some positive impact of training as the percentage of respondents harbouring negative attitudes dropped by the second year of training. As the number of participants also dropped, however, it is difficult to assess whether this change relates to a loss of respondents who held negative attitudes towards older people, or if it actually relates to the impact of training.

As the majority of respondents had negative views about working with older patients in this instance, it is perhaps not surprising that the vast majority of Stevens and Crouch's

(1995) respondents rated working with older patients as their least popular specialism. A trend that was repeated as their training progressed. One could therefore argue that professionals who wish to work in specialist settings with older people are more likely to have positive attitudes towards them than those who choose to pursue careers in other specialties.

It is therefore interesting to consider the attitudes nursing staff in acute medical settings hold towards older people; particularly those in wards specialising in orthopaedics, cardiac rehabilitation and stroke who are likely to care for a high number of patients in this age bracket but may not have chosen a career working with older people. Perhaps the influence of contact on ageist attitudes is actually related to one's chosen profession, as in *choosing* to have contact with a particular group, one might argue that more positive attitudes are held towards them as a result.

The current study aimed to explore this concept by assessing the attitudes staff hold towards older people, older people with dementia and the illness of dementia across psychiatric and general medical settings. Many factors suggest that the attitudes of psychiatric nurses towards these patient groups are likely to differ from their general medical colleagues. For example, the theory of planned behaviour would suggest that dealing with people with dementia is a 'subjective norm' in psychiatric nursing, whilst general medical nurses may not feel that patients with dementia belong on their ward, as they do not consider the management of these patients to be an integral part of their role (Azjen, 1989; Marshall, 1999). As highlighted previously, this can have an adverse

influence by increasing the likelihood that negative attitudes are translated into discriminatory behaviour.

Differing attitudes between these groups could also arise as a consequence of varying degrees of knowledge and contact (Allport, 1954; Cummings & Galambos, 2002; Deforges *et al.*, 1991; Levy & Banaji, 2002). The structure of the nursing curriculum is such that those who choose to further their careers in general medical settings are provided with less basic training in issues pertaining to gerontology and geriatric mental health than those who opt for mental health nursing (Royal College of Nursing, 27 February 2010). It follows that nurses in psychiatric settings are likely to have a greater level of knowledge about gerontological issues and dementia. Given that many psychiatric wards for older people specialise in dementia care, one might also expect that nurses in these settings have more contact with older people with dementia than general medical nurses.

Due to the purported increase in older people with dementia being admitted to hospital with physical illnesses, the gulf in terms of contact may not be as wide as initially suspected. The current study therefore aimed to gather descriptive data, such as the level of contact nurses have with older people and older people with dementia and the frequency they are required to deal with issues relating to this patient group, in order to further explore the potential influence of contact in this case.

Previous studies have compared the attitudes of nursing staff across different settings (Hope, 1994; Tierney *et al*, 1998), however, these studies focused on attitudes towards older people and did not explore a potential relationship between these views and attitudes to older people with dementia. The current study will therefore attempt to address this gap.

In the study by Hope (1994), the attitudes of 86 nurses towards older people across two health authorities and based in two different types of wards (General Medical versus Geriatric) were explored. Attitudes were assessed using Kogan's Attitude to Older People (KOP) questionnaire, whilst knowledge about ageing was assessed using the Palmore Facts about Ageing Quiz (PFAQ).

The results indicated a significant difference ($p = 0.03$) between the attitudes of nursing staff in general medical settings and those in geriatric settings, with those in geriatric settings scoring more favourably. Unlike previous studies, both groups displayed neutral to positive attitudes towards older people in this case.

A correlation between post-basic gerontological education and attitude score indicated that medical care staff with additional gerontological education had a more positive attitude towards older people than those who did not. This reflects the view of Allport (1954) who hypothesised that knowledge and contact have a vital role to play, both in the promotion of positive attitudes and in the reduction of prejudice, whilst disputing the findings of Koder and Helmes (2008).

The method adopted by Hope (1994) was replicated by Tierney *et al* (1998), however, in this case, the emphasis was not on attitudinal difference between settings, but on potential differences in knowledge and education and their relationship to attitudes across one particular setting. A total of 161 nurses from four acute orthopaedic wards took part in the study (n= 45; 26; 37; 53), of which only two wards had access to input from geriatricians. In addition to using the KOAP and the PFAQ to measure attitudes and knowledge about ageing, Tierney *et al* (1998) also considered access to geriatricians as an important factor in promoting knowledge about the specific needs of older people.

On this occasion, there was no correlation between attitudes and knowledge; however, overall knowledge scores were noted to be considerably higher in the setting with the greatest geriatrician involvement.

Interestingly, the role of contact was not considered in addition to knowledge in this study, as the number of older people utilising each of the settings was not investigated. It is therefore difficult to establish whether the outcome of this study relates to increased knowledge via support from geriatricians, or if it simply relates to an increased level of contact and experience with this patient group in some cases. As highlighted previously, the current study aims to address this.

It is interesting to note that few studies have aimed to investigate nursing staff attitudes towards older people, in conjunction with their attitudes to older people with dementia. There is little evidence to suggest that studies have explored nursing staff attitudes

towards the illness of dementia, in order to assess whether aspects of this condition can influence the views that are held towards those with the illness.

1.7 NURSING STAFF ATTITUDES TO DEMENTIA

1.7.1 Attitudes to the illness of dementia

Research has suggested that the illness of dementia can often be viewed with great anxiety, given the nature of its symptoms, the sense that it cannot be treated and its perceived consequences (e.g. the potential of losing one's identity or losing control of one's life due to the requirement to be looked after either by one's family or formal caregivers) (Medical News Today, 5 July 2007; Roberts & Connell, 2000). As it is often considered to be a natural part of the ageing process, the perceived inevitability of this illness can result in both dementia and the ageing process itself being viewed as threatening.

In spite of this, few studies have explored how patients diagnosed with dementia perceive their illness or how other people, such as relatives or health professionals perceive an illness such as dementia. Such perceptions are also known as illness representations (Clare *et al.*, 2006; Roberts & Connell, 2000). According to Clare *et al* (2006), people with a diagnosis of dementia tended to refer to their difficulties in terms of memory problems or forgetfulness. Ageing was most commonly perceived to be the cause of their dementia, followed by stress or head injury. For some respondents, this reflected wider societal views of ageing, as they did not perceive their dementia to be an illness, but as a

consequence of 'old age creeping up' (p.763). Regarding the trajectory of the illness, some respondents took the view that death was approaching as a consequence of dementia, whilst others viewed their condition as stable. Whilst some respondents felt out of control and that nothing could be done, some felt that practical strategies, such as writing lists helped them to manage. The consequences of their illness were considered to be the negative impact it had on their emotions, daily life and their families. Roberts and Connell (2000) also explored illness representations in relatives of those who have a diagnosis of dementia, in which respondents considered genetic factors to be the most important cause of dementia.

Although illness representations have often been explored and utilised in health psychology, these have primarily been from the viewpoint of a person with a particular illness and have only recently been explored in healthy subjects (Figuerias & Alves, 2007). More importantly, there is a lack of research on illness representations held by health professionals towards the diseases they treat and support, in spite of suggestions that these might be influential on practice (Ogden, 1996). The current study seeks to redress this gap in the literature by incorporating a measure of illness representations (in relation to dementia) when examining attitudes of health professionals towards older people and older people with dementia.

According to Ogden (1996), the nature of illness representations held by health professionals may not only impact on their way of dealing with that illness on a personal level, it may also influence the way they act towards people with that illness in their care.

For example, if their emotional response towards an illness such as dementia is fear, they may be more likely to restrict the time they spend with those patients or to distance themselves from them, which can have a negative impact on rehabilitation (Hochschild, 1983).

The following section aims to expand on these issues by exploring the attitudes nursing staff hold towards older people with dementia across a variety of settings, whilst exploring some of the factors which can influence these views.

1.7.2 Attitudes to older people with dementia in acute hospital settings

Although older people can be stigmatised in many aspects of life, reports have suggested that those with dementia can be doubly stigmatised; as 'dementia continues to objectify common stereotypes of old age as a period of decline, ill-health and dependency' (Age Concern, 2000; Alzheimer's Society, 2007; Norman, 2003, p.52). As patients with dementia have the potential to be perceived as incurable, requiring a great deal of care within the standard paradigm of care, or requiring longer than average hospital stays, it is perhaps not surprising that such attitudes are in existence.

Surprisingly, few studies have actually examined the attitudes health professionals hold towards older people with dementia in acute hospital settings, as the emphasis has been placed on the views of professionals in nursing homes (e.g. Brodaty *et* al, 2003; MacDonald & Woods, 2005; Moniz-Cook *et al,* 2000). Furthermore, of those studies

carried out, none have examined any difference in views between caring for older people and older people with dementia, in order to explore whether the latter are actually subject to double stigmatisation.

Borbasi (2006) conducted a qualitative study to assess the views of medical professionals on dementia patients who are admitted to acute settings with a non-dementia related illness. A total of 25 medical professionals across 3 acute hospital settings participated in open ended interviews and a number of themes emerged. One the whole, respondents described patients with dementia as 'complex and challenging' and the general consensus was that acute hospital settings were not suitable for patients with dementia. Such settings were considered to reduce the functional independence of dementia patients, which was reported to influence whether or not people are able to return to their own homes.

This is consistent with the findings of Baltes and Wahl (1992), which suggest that nurses consider this patient as dependent and find it quicker to 'do' for them, as opposed to supporting them to maintain their independence. In line with their findings, one might argue that nursing staff feel more positively predisposed to this patient group, as a consequence of their increased levels of dependence (Baltes & Wahl, 1992).

On the other hand, if negative ageing stereotypes are applied to older people with dementia, the illness may be viewed as a natural part of the ageing process. If this is the case, nurses may not feel that patients with dementia require specialist support – only basic personal care. They may feel powerless to act, as they are unable to cure them. As

discussed previously, this can lead to the objectification of and the dissociation from this patient group, which may have a negative impact on quality of care. Furthermore, those with a cognitive impairment may be treated as 'difficult' as they do not fit with the 'dependent' patient role (Baltes & Wahl, 1992). Perhaps this difference results in the double stigmatisation of older patients with dementia, in comparison to older patients in general, which would fit with Stockwell's reflections on the profile of the popular patient (Stockwell, 1972).

Barriers to providing adequate care for this patient group were also highlighted by Borbasi (2006), such as political differences and environmental design. Many of the participants felt that the will to provide a good service was hampered by a lack of training in how to support people with dementia effectively. It was felt that 'specialists' such as those in psychiatric settings were better equipped to deal with this patient group. These views were also reflected in a keynote lecture by Marshall (1999), who considered there to be a lack of knowledge and understanding about dementia in acute settings, as well as a lack of training for nursing staff who work in these settings.

Observational studies using Dementia Care Mapping (DCM), a tool which assesses the quality of care that is provided to dementia patients, also highlighted 'sub-optimal' care for this patient group (Norman, 2007; Tolson *et al*, 1999). Such methods can be problematic; however, as they can account for behaviour in a vacuum without considering factors which may be driving the behaviour, or preventing more positive interactions from taking place. Surprisingly, there was no investigation as to whether the

observations correlated with staff attitudes towards this patient group, as this may have provided some useful findings in this field.

It is important to put these views into context by considering the factors which may serve to influence and maintain these views, such as the challenges nursing staff face in caring for patients with dementia, as well as the challenges those patients face in the hospital environment.

1.7.2.1 Challenges of supporting people with dementia in acute settings

Admission to hospital can be a stressful experience for people of all ages. As a patient, one is required to become accustomed to different routines and a new, unpredictable environment with unfamiliar sights and sounds during a period of ill-health and separation from friends and family:

'In addition to the frenetic activity, the patient's senses are continuously assailed by sounds, smells and sights that are unfamiliar, bewildering, and at times, extremely frightening...although unavoidable and integral to the running of a hospital, [this experience can] nonetheless be stressful for patients' (Laungani, 2005, p.22).

Anxiety about the condition of their health, impending medical procedures, and the length of their hospital stay can also arise, as well as a sense of powerlessness, as decisions about many aspects of their daily lives can be taken over by others (e.g.

frequency of personal care, when and where they can meet with family and friends, and what time they are required to get out of bed in the morning) (Laungani, 2005).

Ward environments can be particularly challenging for patients with dementia their ability to recognise that they are in hospital, to distinguish between groups of medical staff, or to recall why they are receiving treatment can often be impaired (Department of Health, 2003). As a consequence of this, they may become aggressive towards those who are caring for them, in order to protect themselves from what they perceive to be threatening situations. (Day *et al.*, 2000; Teresi *et al.*, 2000).

This can place mounting pressure on nursing staff and can lead to frustration and resentment towards patients with dementia, as staff may feel that caring for this patient group is outwith the remit of their role, or that they are not trained properly to provide them with the appropriate standard of care. According to Marshall (1999), the perception that patients with dementia 'are someone else's problem' or that they do not belong on a particular ward can influence the manner in which they are treated.

With this in mind, patients with dementia may be increasingly likely to be classed as 'unpopular' in these settings, which previous research has suggested can influence the level of staff attention and the way in which patients are treated (Schell, 2001; Stockwell, 1972).

1.7.2.1.1 Impact on staff

Whilst admission to hospital can be understandably distressing for a person with dementia, it can also present particular challenges to the staff involved in their care, which can serve to influence their attitudes towards them. As well as caring for a number of patients who are likely to have complex health problems and a high level of need, nursing staff may also have to manage behavioural and psychological symptoms of dementia, whilst often having little training or experience in this area (Marshall, 1999). Given the increased levels of disorientation and distress that can arise for patients with dementia in acute hospital settings, they can often present with a number of challenging behaviours. Nursing staff are often required to manage wandering, sexual disinhibition during personal care, agitation, and aggression in patients with dementia. Some of these behaviours can also compromise their treatment and recovery, as well as the treatment of others, including pulling out drips and catheters, or refusing food (Marshall, 1999).

Unsurprisingly, the high level of demand and sense of helplessness can have a significant impact on staff and can contribute to staff burnout (Gerdner and Buckwater, 1994). This can be facilitated, not only by the unsuitable nature of the ward environment, but also by a lack of knowledge and understanding of dementia (Norman *et al,* 2007), as well as by a lack of training in how to deal with challenging behaviour in these settings (Tolson *et al*, 1999). Research has noted that staff burnout is correlated with a reduction in both empathy and positive attitudes towards patients with dementia, which can subsequently impact on quality of life and quality of care (Astrom *et al*, 1991).

1.8 RESEARCH AIMS AND HYPOTHESES

1.8.1 Aims

The following study aimed to address gaps in the literature by exploring the attitudes nursing staff hold towards older people, older people with dementia and the illness of dementia. Given the proposed impact of knowledge and contact on the maintenance and development of attitudes, the attitudes of nurses across psychiatric and general medical settings will be compared. Unlike previous studies, demographic information will also be gathered in order to assess the level of difference between these groups in terms of age, patient contact, training and experience (which includes access to support of liaison nursing staff). Factors which potentially influence nursing staff attitudes and behaviour, such as subjective norms in relation to the time devoted to supporting dementia patients (Azjen, 1989), level of confidence and the suitability of the ward environment for this patient group will also be explored.

1.8.2 Hypotheses

1.8.2.1 Hypothesis 1:

Nursing staff working in psychiatric wards will hold more positive attitudes to older people than those working in general medical wards.

In a similar vein to previous studies which examined the difference in nursing staff attitudes towards older people (Hope, 1994; Tierney *et al.*, 1998), this study hypothesises that attitudes to older people are likely to differ across settings. Very little research has been conducted to explore the attitudes nursing staff in psychiatric settings hold towards older people, as the majority of the research base has focused on those working in care homes or general medical settings (Hope, 1994; Kearney *et* al, 2000; Meyer *et* al, 1999; Tierney *et al.*, 1998).

Given the proposed importance of knowledge, contact and the potential impact of subjective norms on attitudinal development (Azjen, 1989; Allport, 1954; Baltes & Wahl, 1992; Cuddy & Fiske, 2002; Cummings & Galambos, 2002; Vaughan & Hogg, 2005,), as well as the notion that general medical settings can be cure driven (Higgins *et al.*, 2007), it is hypothesised that those in psychiatric settings will have more positive attitudes towards caring for older people than those in general medical settings.

1.8.2.2 Hypothesis 2:

Nursing staff in psychiatric settings will hold more positive attitudes towards caring for older people with dementia than those working in general medical wards

Research has stressed the importance of knowledge and contact in attitudinal development, as well the relationship between attitudes to older people and those choosing to careers with this age group (Allport, 1954; Baltes & Wahl, 1992; Cuddy &

Fiske, 2002; Cummings & Galambos, 2002; Hope, 1994; Tierney *et al.*, 1998; Vaughan & Hogg, 2005). In accordance with the theory of planned behaviour, one might also assume that the subjective norm for a particular ward might serve to influence the attitudes that are held towards particular patient groups (Azjen, 1989; Taijfel & Turner, 1979). It is therefore hypothesised that nursing staff in psychiatric settings are likely to have a more positive attitude towards caring for older people with dementia than those working in general medical wards.

1.8.2.3 Hypothesis 3:

There will be a correlation between the attitudes nursing staff hold towards older people and the attitudes they hold towards older people with dementia.

Given that research has indicated the tendency for older people with dementia to be doubly stigmatised (Age Concern, 2000; Alzheimer's Society, 2007), it is hypothesised that the attitudes nursing staff hold towards older people will correlate with the attitudes they hold towards older people with dementia.

1.8.2.4 Hypothesis 4:

Nursing staff attitudes to the illness of dementia will differ between those working in general medical wards and those working in psychiatric wards.

As very little research has explored the illness representations of healthcare professionals to date, nursing staff views on the illness of dementia will be explored. Given that those in psychiatric settings are proposed to receive more in depth training in caring for people with dementia as part of their role, it is hypothesised that psychiatric nursing staff will have a more positive view of the illness of dementia than those in general medical settings.

2. METHODOLOGY

2.1 Design

The study used quantitative methods and a cross-sectional between groups design was employed to compare nursing staff attitudes in psychiatric settings with those working in general medical settings. Demographic information was requested (e.g. gender, age range, number of years in training) and standardised psychometric measures to assess attitudes to older people, caring for older people with dementia and the illness of dementia were employed. Relationships between participants' attitudes, age range and training were also considered.

2.2 Ethical approval

Ethical approval was sought and attained from the local Research and Ethics Committee, as well as from the NHS Research and Development team (Appendix 1).

2.3 Insurance and indemnity

Upon attaining ethical approval, the University of Edinburgh agreed to act as a sponsor for the research under the requirements of the Scottish Executive Health Department's Research Governance Framework for Health and Community Care (Appendix 2).

2.4 Inclusion and exclusion criteria

2.4.1 Inclusion criteria

Both trained and untrained nursing staff in both general medical and psychiatric wards across NHS Fife were invited to take part. Of the general medical wards, those specialising in conditions that were more likely to affect older people were chosen to take part in the study. These included orthopaedic, stroke, cardiac rehabilitation and urology wards, alongside general medical wards specialising in the care of the elderly. Although the majority of wards catered for mixed age groups, the structure of services meant that stroke wards, care of the elderly wards and several of the longer-stay psychiatric wards exclusively cared for patients aged 65 and over.

2.4.2 Exclusion criteria

As nursing staff provide the bulk of care and have the most contact with patients in comparison to other staff groups, nursing staff remained the focus of the study and other professions were excluded. Within the nursing profession, nursing students were excluded, as they have very short rotations, therefore, less experience on any particular ward.

To avoid the results reflecting the opinions of nursing staff who do not work with older people, wards which do not admit older people were excluded from the study. As length of admission to short stay or emergency admission wards are likely to be

fairly short and time-limited, it was felt that the nurses would be unlikely to be exposed to similar management difficulties as those working in wards where patients with dementia are likely to stay for longer. Staff working in accident and emergency, psychiatric assessment and short-stay admission wards were therefore excluded from the study, alongside intensive care settings where patients might be considered too physically ill or immobile to pose management difficulties for staff, as this was felt to be an unfair comparison with wards where patients were likely to be more active.

2.4.3 Confidentiality and consent

Demographic information that would compromise the identity of respondents, such as the specific ward or hospital in which they worked was not requested. At the request of the Research and Ethics Committee, the specific age of participants was not requested and was replaced with age ranges on the demographic front sheet to prevent the possible identification of individual staff members. As ratified by the Research and Ethics Committee, participants were made aware on the information sheet that consent to take part was implied by returning the questionnaire.

2.5 Measures

The questionnaire packs distributed to participants comprised of a participant information sheet (Appendix 3), front sheet (in which respondents provided demographic information, as well as general information about their experience of

working with patients with dementia) and three validated questionnaires. These explored nursing staff attitudes towards: older people (Kogan's Attitudes to Older People Scale; Kogan, 1961), caring for people with dementia (Approaches to Dementia Questionnaire; Lintern, 2000), and the illness of dementia (Illness Perception Questionnaire: Revised for Healthy Subjects; Figuerias & Alves, 2007).

2.5.1 Front sheet and demographic information

Demographic information was sought from participants on age, gender, type of ward (general medical or psychiatric), length of time in current post and length of time qualified (where applicable). Participants who noted the length of time qualified were classed as trained nursing staff, whereas those who did not were classed as untrained nursing staff. Participants were also asked to comment upon the nature of patients on their ward, including the range of patients aged 65 and over on the ward at any one time (about a quarter, about half, about three quarters, about all), how often participants encountered patients whom they suspected had dementia, and how often participants were required to manage behavioural difficulties that arose as a consequence of dementia (never, rarely, monthly, weekly, or daily) (please refer to Appendix 3a).

Further questions were included to establish whether or not participants cared for patients of a mixed age group, whether or not their ward had access to a liaison nurse, whether they had attending additional training regarding dementia care, and whether

they felt that a disproportionate amount of their time was taken up with difficulties that arose as a consequence of dementia. On a 5-point Likert scale where 1 = not at all and 5 = extremely, participants were also requested to rate the suitability of their ward environment to patients with dementia, as well as how confident they felt about managing any difficulties that arose on their ward as a consequence of patients with dementia.

Anecdotal information was also gathered regarding the main difficulties participants encountered when working with patients with dementia, factors that could improve their confidence in working with patients with dementia and what factors might make their current ward environment unsuitable for dementia patients to set the context. Participants were also encouraged to provide any further comments at the end of the front sheet.

2.5.2 Validated questionnaires

The three validated questionnaires included in the questionnaire pack are described in greater detail below:

2.5.2.1 Kogan's Attitudes to Old People Questionnaire (KAOP): (Kogan, 1961)

The KAOP is a 34 item self-report measure that is designed to assess attitudes towards older people (Appendix 3b). According to a 6-point Likert scale (where A =

strongly disagree and F = strongly agree) respondents are required to state how much they agree or disagree with each statement in accordance with their opinion of older people.

The KAOP consists of 17 positively rated statements and 17 negatively rated statements about older people, with point descriptors ranging from 1 to 6. In terms of scoring, a score of 6 denotes the most positive response and a score of 1 the most negative response. The sum of the value participants ascribe to negative statements is reverse coded. This is added to the value ascribed to the positive statements to provide a total score. The total KAOP score can range from 34 to 204. The lower the KAOP score, the more negative the attitude that is held towards older people, whilst the higher the score, the more positive it is considered to be. A score under 102 is considered to be indicative of a negative attitude, whilst a score higher than 102 is considered to be indicative of a positive attitude. According to Kogan (1961), the reliability co-efficient on the negative statements ranges between 0.73 and 0.83 across sample groups, with values ranging between 0.66 and 0.77 on positive statements across sample groups.

Although initially developed with college students, this questionnaire has been used in a number of studies to explore the attitudes of nursing staff towards older people across a variety of settings (e.g. Hope, 1994; Kearney *et al*, 2000). According to Courtney *et al,* (2000) this measure is most commonly used to assess staff attitudes due to the lack of alternative measures that are available to assess generic views on

older people, as well as the dearth in instruments that have been developed specifically for healthcare professionals to assess attitudes to older *patients*.

2.5.2.2 Approaches to Dementia Questionnaire (ADQ-19): (Lintern, 2001)

The ADQ-19 is a 19 item self-report measure designed to assess staff views on caring for people with dementia (Appendix 3c). Respondents are required to rate the extent to which they agree or disagree with each of the statements according to a 5-point Likert scale (where 1 = strongly agree and 5 = strongly disagree). Positive attitudes score high and negative attitudes score low. Items 1, 2, 3, 4, 6, 8, 10 and 13 are scored with 'strongly agree' as 1 and 'strongly disagree' as 5, whilst the remaining items are scored with 'strongly disagree' as 1 and 'strongly agree' as 5.

The measure consists of two sub-scales; one which measures the respondent's degree of hopefulness about people with dementia (eight items) and the other which measures the extent to which respondents utilise a person-centred approach when working with people with dementia (11 items). The sum of the hope and person-centred sub-scales provide a total ADQ score, which can range between 19 and 95. The total score for the hope sub-scale can range between 8 and 40, whilst the total score for the person-centred scale can range between 11 and 55.

According to MacDonald and Woods (2005), who utilised the ADQ-19 in their study, the Crohnbach alpha values for the hope and person-centred sub-scales are 0.76 and

0.85 respectively, while the value for the total scale is 0.83. In terms of re-test reliability, the values for the hope and person-centred sub-scales are 0.70 and 0.69 respectively, while the value for the total scale is 0.76. The questionnaire was developed with a range of care staff across the UK and has been cross-validated with a sample of 123 care staff (MacDonald & Woods, 2005).

2.5.2.3 Illness Perception Questionnaire: Revised for Healthy Subjects (IPQ-RH): Figuerias & Alves, 2007).

The IPQ-RH is a 26 item self-report measure developed for use with healthy individuals (Appendix 3d), which was adapted from the 38-item Illness Perception Questionnaire: Revised (Moss-Morris *et al*, 2002). Although this measure is not specifically designed for use with health professionals, the IPQ-RH was used as it allowed the exploration of respondents' *personal* attitudes towards the illness of dementia, as opposed to the attitudes held towards the dementia in others.

The IPQ-RH consists of three different sections; identity, illness representations and causal factors:

2.5.2.3.1 Identity

The first section of the IPQ-RH is the identity sub-scale, in which participants are required to state whether or not they associate a list of symptoms with the illness in question (in this case the illness of dementia).

In their original study Figuerias & Alves (2007) integrated a disparate list of symptoms with those of their featured illnesses (AIDS, tuberculosis and skin cancer) into the identity sub-scale. In keeping with the original study, symptoms of dementia were used in this case. The symptoms included a disparate list of general symptoms, alongside some symptoms which can arise as a consequence of dementia, such as memory problems, hallucinations, speech and language difficulties and problems learning new information.

The frequency with which each item was endorsed as relating to dementia will be explored in the results section. As the exploration of illness representations was one of the main focal points of the featured study, the data in this sub-scale will be explored descriptively and will not be used in the between groups analysis.

2.5.2.3.2 Illness representations

In the second section of the IPQ-RH timeline acute/chronic, timeline cyclical, consequences, personal control, treatment control, illness coherence and emotional representation dimensions of the IPQ-RH are rated on a 5-point Likert scale where 1 = strongly disagree and 5 = strongly agree. According to Figuerias and Alves (2007), all of the sub-scales demonstrated good internal reliability ranging from 0.64 for the personal control dimension to 0.81 for the emotional representation dimension.

In the original study by Figuerias & Alves (2007), the word 'illness' in the illness representations sub-scale was substituted with the particular illness they chose to study (in this case 'AIDS', 'tuberculosis' and 'skin cancer'). In keeping with this, the featured study substituted the word 'illness' in the illness representations sub-scale with 'dementia'.

2.5.2.3.3 Causal attributions

This section consists of two factors, psychological attributions (including items such as family problems, emotional state, stress or worry) and risk factors (including items such as ageing, heredity, diet, immunity, pollution, being overweight and poor medical care). According to Figuerias and Alves (2007), the Crohnbach's alpha for psychological attributions was 0.90 and 0.78 for risk factors.

Within this section, participants are also requested to select three of the psychological attributions or risk factors provided and to state which they believe to be the cause of the illness in rank order.

Similarly to the identity section of the questionnaire, the data in the causal attribution sub-section will be explored descriptively and will not be used in the between groups analysis.

2.6 Procedure

As a scoping exercise, nursing managers were initially approached to discuss the nature of the proposed study. The numbers of trained and untrained staff available to take part was also attained in order to establish feasibility. Following the provisional agreement of nursing managers, ethical approval was sought and gained from the Research and Ethics Committee (REC) and the local Research and Development team (see Appendix 1) on the proviso that a strict procedure was adhered to before any questionnaire packs could be distributed to staff groups.

As a consequence of this, clinical service managers for each Community Health Partnership (CHP) were contacted and only following their agreement could the approval of nursing managers be sought. Approval was sought and gained from nursing managers within the medical, orthopaedic and surgical directorates, as well as those responsible for each individual psychiatric setting. At this point, Senior Charge Nurses for each ward could be contacted and individual meetings were arranged to discuss the study and gain approval, following which, information sheets and questionnaire packs could be distributed to the ward. This also provided staff with the opportunity to ask any questions about the study and its requirements. Potential participants were also reminded that taking part in the study was optional and it was requested that they also complete the questionnaires in their own time and not as a group when possible, in order to reduce the likelihood of others influencing their response.

Those who participated in the study were asked to return their questionnaire pack to the researcher in the stamped addressed envelope provided. In order to ensure that the questionnaires could be placed within their respective psychiatric and general medical groups upon their return, different coloured questionnaires were provided for each participant group.

A total of 18 wards (7 psychiatric and 11 general medical) were contacted over the phone and visited on several occasions in order to distribute the questionnaire packs. As a consequence of infectious illness outbreaks and consequent ward closures on several occasions, distribution was often delayed. As Senior Charge Nurses on two general medical wards could not be contacted, despite attempts to make contact over the phone and in person, these wards could not be included in the study.

2.7 Statistical power

In a similar study by Hope (1994), which investigated staff attitudes towards older people between specialist geriatric and general medical settings, a sample of 76 nurses was used across the two groups. In this study, a significant difference was found between the two groups ($p \leq 0.05$) with the use of non-parametric statistics.

A power analysis was undertaken based on Cohen's (1992) methodology, which recommended a sample size of 64 participants per group (for both a between subjects t-test, two tailed and an ANOVA between two groups), in order to attain a medium

effect size (d=0.5). In order to explore the relationship between two variables by means of a bi-variate correlation (in this case, nursing staff attitudes toward caring for people with dementia and their attitudes towards older people), a recommended a sample size of 85 participants was also recommended to attain a medium effect (d=0.5).

2.8 Approach to Analysis

The current study utilised a primarily quasi-experimental approach to the analysis of data. Analysis of the data was undertaken using parametric methods. Primarily analyses concentrated on independent design methods. ANOVA provides a way of comparing the ratio of systematic error variance to unsystematic variance in an experimental study (Field, 2005). Univariate and Multivariate analyses were used throughout the analysis of the data. The analysis of the data was guided by the original aims and research questions of this study.

3. RESULTS

3.1 Sample

A total of 499 questionnaire packs were distributed. Of those, 223 packs were distributed across seven psychiatric wards (which consisted of 140 trained and 83 untrained nursing staff). 45 packs were returned by 29 trained and 16 untrained nursing staff; a return rate of 20.1 per cent. A total of 276 questionnaires were distributed across nine general medical wards (which consisted of 167 trained and 109 untrained nursing staff). 28 packs were returned by 18 trained and 10 untrained nursing staff; a return rate of 10.1 per cent.

3.2 Overview of data analysis

Data was analysed using the Statistical Package for the Social Sciences (SPSS) Version 15. Minimum and maximum values, alongside means and standard deviations were examined in order to ensure accuracy of data entry, while missing data was assigned a numerical value in order that it could be distinguished from the remainder of the data set.

The use of parametric statistics in the analysis was considered on the proviso that appropriate criteria were met with respect to variable measurements, normality of distribution and homogeneity of variance (Field, 2009).

Levene's test was carried out in order to assess homogeneity of variance in the sample. Normality of distribution was examined with the aid of histograms and Q-Q plots, in addition to exploring the significance of skewness and kurtosis. In line with the recommendations of Tabachnick and Fidell (2001), a more conservative alpha level of 0.001 ought to be adopted when evaluating the significance of skewness and kurtosis in small to moderate samples. As this more stringent alpha level was applied, z-scores with a critical value of +/- 3.29 were considered to indicate a distribution that varied significantly from normality (Field, 2009). Any variables considered to deviate significantly from normality were considered for transformation, if deemed appropriate.

Where assumptions were met, parametric statistics including independent t-tests and analyses of variance (ANOVA) were used to test hypotheses where assumptions were met. Non-parametric statistics such as Pearson's Chi-Square were used when the appropriate criteria were met (Field, 2009).

A bi-variate correlation was also carried out by means of a Pearson's correlation co-efficient, in order to explore the relationship between the nursing staff attitudes to older people and their attitudes towards caring for people with dementia. According to Field (2009), in order to establish a correlation co-efficient as significant, one must not only use data considered as interval; data must also be normally distributed in both categories. It was ensured that these assumptions were met before this method was applied.

As recommended by Clark-Carter (2004), alpha was set at $p \leq 0.05$ for hypothesis-related comparisons and was adjusted to a more conservative level of $p \leq 0.001$ if and when further tests were carried out, in order to reduce the possibility of Type 1 error.

3.3 Demographic Data

Of the total sample, 65 participants were female (87.8 per cent) and seven were male (9.5 per cent), whilst one participant failed to comment. As illustrated overleaf in Table 3.1, over half of the total sample was between 36 and 50 years of age, whilst the smallest proportion of respondents was aged 24 and under. This trend was also reflected across the general medical and psychiatric groups. The greatest percentage of respondents across both groups were between the ages of 36 and 50 years of age. A larger proportion of respondents in the psychiatric group were over the age of 51 (24.4 per cent) than in the general medical group (14.3 per cent). Whilst the general medical group had a small percentage of respondents under the age of 24 (10.4 per cent), the psychiatric group had no respondents in this age range.

Age Range	**Psychiatric (n = 45)**		**General Medical (n = 28)**		**Total Sample (n = 73)**	
	N	% group	N	% group	N	%
16 – 24	0	0.0	3	10.7	3	4.1
25 – 35	9	20.0	7	25.0	16	21.9
36 – 50	25	55.6	13	46.4	38	52.0
51 – 65	11	24.4	4	14.3	15	20.5
Missing Data	*0*	*0.0*	*1*	*3.6*	*1*	*1.4*

Table 3.1: Age range of respondents

Time Qualified	Psychiatric (n = 45)		General Medical (n = 28)		Total Sample (n = 73)	
	N	% group	N	% group	N	%
Less than a year	1	2.2	2	7.1	3	4.1
1 – 2 years	1	2.2	4	14.3	5	6.8
3 – 5 years	4	8.9	2	7.1	6	8.2
6 – 10 years	2	4.4	2	7.1	4	5.5
10 years +	20	44.4	7	25.0	27	37.0
Not applicable (Untrained)	16	35.6	10	35.7	26	35.6
Missing Data	*1*	*2.2*	*1*	*3.6*	*2*	*2.7*

Table 3.2: Level of qualification and length of time qualified

As illustrated above in Table 3.2, the highest proportion of the total sample consisted both of nursing staff who were qualified for 10 years or more (36.9 per cent) and untrained nursing staff (35.1 per cent). The greatest proportion of respondents in the psychiatric group were qualified for 10 years or more (44.4 per cent), followed by untrained staff (35.6 per cent). In the general medical group, the greatest proportion of respondents were untrained nurses (35.7 per cent) followed by those who were qualified for 10 years or more (25 per cent).

Level of Training	Medical (n = 28)	Psychiatric (n = 45)	Total Sample (n = 73)
Trained	18 (64.3%)	29 (64.4%)	47 (64.4%)
Untrained	10 (35.7%)	16 (35.6%)	26 (35.6%)

Table 3.2.1: Proportion of trained and untrained participants

As illustrated above in Table 3.2.1, 64.4 per cent of the total sample was classed as trained whilst 35.6 per cent was classed as untrained. This mirrored the proportions of trained and untrained respondents both across the general medical and psychiatric

groups. A Chi-Square ($X^2(1) = 4.50$ $p = 0.034$) indicated a significant difference in the proportion of trained and untrained participants across the whole sample, with significantly more participants being trained. A Pearson's Chi-Square ($X^2(1) = 0.004$, $p = 0.950$) and a Fisher's Exact Test ($df = 1$, $p = 1.000$) indicated that there was no significant differentiation in the level of training between groups.

Access to liaison nursing staff	**Psychiatric (n = 45)**		**General Medical (n = 28)**		**Total Sample (n = 73)**	
	N	% group	N	% group	N	%
Yes	17	37.8	15	53.6	32	43.8
No	20	44.4	2	7.1	22	30.1
Not sure	8	17.8	10	35.7	18	24.7
Missing Data	0	0.0	1	3.6	1	1.4

Table 3.3: Access to liaison nursing staff

As illustrated above in Table 3.3, a higher percentage of respondents in the general medical group (53.6 per cent) had access to a liaison nurse than in the psychiatric group (44.4 per cent). A greater proportion of respondents in the general medical group (35.7 per cent) were unsure about whether or not they had access to a liaison nurse than in the psychiatric group (17.8 per cent).

Additional training in dementia care	**Psychiatric (n = 45)**		**General Medical (n = 28)**		**Total Sample (n = 73)**	
	N	% group	N	% group	N	%
Yes	29	64.4	9	32.1	38	53.0
No	16	35.6	18	64.3	34	46.6
Missing Data	0	0.0	1	3.6	1	1.4

Table 3.4: Training in dementia care

As illustrated above in Table 3.4, the majority of the psychiatric group had received additional training in dementia care (64.4 per cent), whilst the majority of the general medical group had not (64.3 per cent). A Chi Square ($X^2(1) = 0.222$, $p = 0.637$) indicated that there was no significant difference in the level of training across the whole sample. A Pearson's Chi-Square ($X^2(1) = 6.55$, $p = 0.010$) and Fisher's Exact Test ($df = 1$, $p = 0.015$) revealed a significant differentiation in the level of additional dementia care training between groups.

Caring for mixed age group (over and under age of 65)	**Psychiatric (n = 45)**		**General Medical (n = 28)**		**Total Sample (n = 73)**	
	N	% group	N	% group	N	%
Yes	23	51.1	9	32.1	31	42.5
No	22	48.9	18	64.3	41	56.2
Missing Data	0	0.0	1	3.6	1	1.4

Table 3.5: The proportion of respondents caring for patients of a mixed age group (both over and under the age of 65 years of age).

As illustrated above in Table 3.5, a greater proportion of the total sample did not care for a mixed age group. In terms of each group, a greater proportion of the general medical group cared for patients over the age of 65 alone than those who cared for a mixed age group. On the other hand, a more equal proportion of participants in the psychiatric group cared for a mixed age group as those who cared for patients over the age of 65 alone. A Chi-Square ($X^2(1) = 10.89$, $p = 0.001$) indicated that there was a significant difference in the proportion of staff caring for a mixed age group of patients across groups, with significantly more respondents in the psychiatric group caring for patients over the age of 65 alone. A Pearson's Chi-Square ($X^2(1) = 19.88$, $p = 0.00$) and

Fisher's Exact Test (df = 1, p = 0.000) also indicated that there was a significant differentiation in the proportion of respondents caring for a mixed age group between the psychiatric and general medical groups.

Proportion of patients aged 65 and over	**Psychiatric (n = 45)**		**General Medical (n = 28)**		**Total Sample (n = 73)**	
	N	% group	N	% group	N	%
Less than a quarter	0	0.0	0	0.0	0	0.0
About a quarter	0	0.0	0	0.0	0	0.0
About half	0	0.0	8	28.6	8	11.0
About three quarters	2	4.4	15	53.6	17	23.3
About all	43	95.6	4	14.3	47	64.4
Missing Data	*0*	*0.0*	*1*	*3.6*	*1*	*1.4*

Table 3.6: The proportion of patients aged 65 and over at any one time

As illustrated above in Table 3.6, between three quarters and all of the patients in the psychiatric group are aged 65 and over at any one time, with 95.6 per cent of those surveyed working in settings where almost all of their patients aged 65 and over. In the general medical group between half and all of the patients are aged 65 and over at any one time, with the majority of those surveyed (53.6 per cent) working in settings where about half of the patients are aged 65 and over at any one time.

A Fisher's Exact Test (df = 1, p = 0.000) indicated that there was a significant differentiation in the proportion of respondents who reported almost three quarters of their ward consisting of patients aged 65 and over and those who reported almost all of their ward to consist of patients in this age range differed significantly between the psychiatric and general medical groups.

Frequency	Psychiatric (n = 45)		General Medical (n = 28)		Total Sample (n = 73)	
	N	% group	N	% group	N	%
Never	0	0.0	0	0.0	0	0.0
Rarely	0	0.0	1	3.6	1	1.4
Monthly	1	2.2	4	14.3	5	6.8
Weekly	3	6.7	8	28.6	11	15.1
Daily	41	91.1	14	50.0	55	75.3
Missing Data	*0*	*0.0*	*1*	*3.6*	*1*	*1.4*

Table 3.7: The frequency with which participants deal with patients who have a diagnosis of dementia.

As illustrated above in Table 3.7, the majority of respondents in the psychiatric group have contact with dementia patients on a daily basis (91.1 per cent). Of those in the general medical group, half of the participants have contact with dementia patients on a daily basis, whilst 28.6 per cent have contact with dementia patients on a weekly basis and 14.3 per cent on a monthly basis. A Fisher's Exact Test (df = 1, p = 0.000) also indicated that there was a significant differentiation in the proportion of respondents dealing with dementia on a weekly basis and those dealing with dementia on a daily basis between the psychiatric and general medical groups.

Frequency	Psychiatric (n = 45)		General Medical (n = 28)		Total Sample (n = 73)	
	N	% group	N	% group	N	%
Never	2	4.4	1	3.6	3	4.1
Rarely	15	33.3	2	7.1	17	23.3
Monthly	5	11.1	15	53.6	20	27.4
Weekly	3	6.7	5	17.9	8	11.0
Daily	16	35.6	4	14.3	20	27.5
Missing Data	*4*	*8.9*	*1*	*3.6*	*5*	*6.8*

Table 3.8: The frequency with which participants deal with cases of suspected dementia

As illustrated above in Table 3.8, around a third of the psychiatric group had contact with patients with suspected dementia on a daily basis (35.6 per cent), whilst a similar proportion rarely had contact with patients who did not already have a diagnosis of dementia (33.3 per cent). On the other hand, around half of respondents in general medical settings had contact with patients with suspected dementia on a monthly basis (53.6 per cent), whilst 17.9 per cent of respondents had contact with patients with suspected dementia on a weekly basis and 14.3 per cent on a daily basis.

Frequency	**Psychiatric (n = 45)**		**General Medical (n = 28)**		**Total Sample (n = 73)**	
	N	% group	N	% group	N	%
Never	0	0.0	0	0.0	0	0.0
Rarely	1	2.2	3	10.7	4	5.5
Monthly	2	4.4	6	21.4	8	11.0
Weekly	4	8.9	11	39.3	15	20.5
Daily	36	80.0	7	25.0	43	58.9
Missing Data	*2*	*4.4*	*1*	*3.6*	*3*	*4.1*

Table 3.9: The frequency with which participants are required to manage behavioural difficulties that arise as a consequence of dementia

As illustrated above in Table 3.9, over half of the total sample is required to deal with behavioural difficulties associated with dementia on a daily basis (58.9 per cent), whilst 20.5 per cent deal with these difficulties on a weekly basis and a further 11 per cent do so on a monthly basis.

In terms of the individual groups, 80 per cent of participants in psychiatric settings deal with behavioural difficulties associated with dementia on a daily basis, whereas a quarter of those in general medical settings do so. Furthermore, 39.3 per cent of

participants in general medical settings deal with these difficulties on a weekly basis, whilst around 21.4 per cent do so on a monthly basis.

Participants also provided anecdotal information about the type of difficulties (if any) that they tended to encounter when dealing with dementia patients. This information is summarised below and provided in full in Appendices 4a and 4b.

Whilst 15.6 per cent of respondents in the psychiatric sample failed to comment, 53.3 per cent reported that they encountered aggressive behaviour, be it physical or verbal from this patient group. Low staffing levels, dealing with wandering or absconding patients and non-compliance (e.g. resisting nursing interventions) were also raised as being problematic, as well as ward security and the nature of the environment.

Whilst 25 per cent of respondents in the general medical sample failed to comment, 32.1 per cent reported that they encountered verbal and physical aggression and a further 25 per cent found the patients' level of confusion as problematic. The patients' inability to carry out activities of daily living, such as eating, drinking were also considered to be problematic, in addition to the negative impact that challenging behaviour can have on the quality of their post-operative care. Wandering, tampering with medical equipment and non-compliance to medical procedures were also raised as being problematic, as well as the increased risk of falls in this patient group.

The proportion of time respondents spent in managing such difficulties was also explored and is discussed overleaf.

Disproportionate time dealing with dementia related CB	Psychiatric (n = 45)		General Medical (n = 28)		Total Sample (n = 73)	
	N	% group	N	% group	N	%
Yes	28	62.2	24	85.7	52	71.2
No	12	26.7	3	10.7	15	20.5
Missing Data	*5*	*11.1*	*1*	*3.6*	*6*	*8.4*

Table 3.10: The proportion of respondents spending a disproportionate amount of their time managing behavioural difficulties that arise as a consequence of dementia.

As illustrated above in Table 3.10, the majority of respondents in the total sample felt that they spend a disproportionate amount of time managing behavioural difficulties that arise as a consequence of dementia (71.2 per cent). A larger proportion of participants in the general medical group felt that they spent a disproportionate of their time dealing with these difficulties (85.7 per cent) than those in the psychiatric group (62.2 per cent).

A Chi-Square ($X^2(1) = 20.43$, $p = 0.000$) indicated that there was a significant difference in the proportion of staff from medical versus psychiatric care settings who felt that they spent a disproportionate amount of time dealing with behaviours that arise as a consequence of dementia across the whole sample, with significantly more respondents viewing this as a problem.

Upon further examination a Pearson's Chi-Square ($X^2(1) = 3.31$, $p = 0.069$) and Fisher's Exact Test ($df = 1$, $p = 0.061$) indicated that the proportion of respondents spending a disproportionate amount of their time on managing behavioural difficulties did not differentiate significantly between groups.

As illustrated below in Table 3.11, the majority of respondents either felt quite or very confident about managing difficulties that can arise as a consequence of dementia. A third of respondents in the psychiatric group (33.3 per cent) and 21.4 per cent of those in the general medical group felt 'very confident' about managing these difficulties and almost half of each group stated that they felt 'quite confident'. Whilst none of the respondents in the general medical group felt that they were 'extremely confident' about dealing with such difficulties, a small percentage of the psychiatric group stated that they were (8.9 per cent).

Level of confidence	**Psychiatric (n = 45)**		**General Medical (n = 28)**		**Total Sample (n = 73)**	
	N	% group	N	% group	N	%
Not at all confident	0	0.0	2	7.1	2	2.7
A little confident	4	8.9	5	17.9	9	12.3
Quite confident	22	48.9	14	50.0	36	49.3
Very confident	15	33.3	6	21.4	21	28.8
Extremely confident	4	8.9	0	0.0	4	5.5
Missing Data	*0*	*0.0*	*1*	*3.6*	*1*	*1.4*

Table 3.11: Participants' level of confidence in dealing with difficulties that arise as a consequence of dementia.

Participants also provided anecdotal evidence regarding what might improve their confidence in dealing with dementia patients. This information is summarised below and provided in full in Appendices 4a and 4b.

Of those in the psychiatric group, 24.5 per cent failed to comment, 42.2 per cent felt that further training would be helpful (either in dementia care or in control and restraint), whilst 28.9 per cent of respondents stated that an increase in staffing levels would serve to increase their confidence. Improvements in the general ward environment, such as introduction of 'Wanderguard' systems to alert staff of wandering patients were also suggested.

Of those in the general medical group, 57.1 per cent failed to comment, whilst 21.5 per cent felt that further training would be useful in improving their confidence. Further to this, respondents also felt that access to support from liaison nursing staff, more time to spend with patients and increased staffing levels would serve to increase their confidence in dealing with this patient group.

Suitability of ward environment	**Psychiatric (n = 45)**		**General Medical (n = 28)**		**Total Sample (n = 73)**	
	N	% group	N	% group	N	%
Not at all suitable	15	33.3	9	32.1	24	32.9
A little suitable	16	35.6	13	46.4	29	39.7
Quite suitable	10	22.2	5	17.9	15	20.5
Very suitable	4	8.9	0	0.0	4	5.5
Extremely suitable	0	0.0	0	0.0	0	0.0
Missing Data	0	0.0	1	3.6	1	1.4

Table 3.12: The suitability of the ward environment for patients with dementia

As illustrated both above in Table 3.12, the majority of respondents felt that their ward environment was either a little suitable (39.7 per cent), not at all suitable (32.9 per cent), or quite suitable for patients with dementia (20.5 per cent), whilst no respondents

in either group felt that their ward environment was extremely suitable for this patient group. In the psychiatric group, over a third of participants felt that their environment was a little suitable for patients with dementia (35.6 per cent); a third felt that it was not at all suitable (33.3 per cent) and around a fifth felt that it was quite suitable (22.2 per cent). The minority of respondents felt their ward environment to be very suitable (8.9 per cent).

Participants also provided anecdotal evidence regarding what makes their current ward environment unsuitable. This information is summarised below and provided in full in Appendices 4a and 4b.

In the psychiatric group 13.3 per cent of respondents failed to comment, whilst 31.1 per cent felt that the ward size and layout was problematic (e.g. décor, signage, lack of natural light):

'*The ward was built 23 years ago (and was) designed for clients who were FAR less dependent and much more physically active. Ward is on the 1st floor. Limited bathroom space. Dark inside corridor. No separate dining area. Lack of storage of personal items*' (Psychiatric Participant 30).

Furthermore, mixed patient groups, the inability of patients to go outside, and inadequate activities for patients were considered to be problematic, alongside reduced

ward security and lack of staffing. It was also pointed out that many adaptations are made by staff in spite of such challenges:

'*Despite the failings in the material design of the buildings, we aim to provide the very best of care to our clients and their families and over the years have adapted many features of the ward to meet our needs*' (Psychiatric Participant 30).

Of the general medical group, 38.5 per cent of respondents failed to comment, whilst 39.2 per cent reported that the specialised or busy nature of their ward meant that it was *'not geared for people with dementia'* (General Medical Participant 17):

'Busy surgical ward with many pre and post op. patients who require regular monitoring or lots of rest... can be more difficult with dementia patients. These patients require lots of reassurance or closer observation' (General Medical Participant 26).

The lacked of locked units was also considered to be problematic for wandering patients, as well as the lack of staff.

3.3.1 Additional information

As illustrated in Appendix 5a, all respondents who completed the identity sub-scale of the IPQ-RH associated changes in mood, confusion and memory problems with dementia. Over 95 per cent respondents associated dementia with repetitive behaviour,

hallucinations, weight loss, fatigue, incontinence, sleep difficulties, speech and language problems and problems in learning new information. Over half of the respondents (64.4 per cent) associated dementia with a loss of strength, whilst just under half (49.3 per cent) associated this illness with pain and 41.1 per cent with headaches. Between 25 and 40 per cent of respondents associated dementia with dizziness (39.7 per cent), breathlessness (28.8 per cent) and stiff joints (27.4 per cent).

As illustrated in Appendix 5b, a large proportion of respondents neither agreed nor disagreed with that the situations stated caused dementia. Over half of the respondents agreed that dementia was caused by ageing (56.8 per cent) or heredity (51.4 per cent). Between 20 and 33 per cent of respondents felt that dementia could be caused by emotional state (31.1 per cent), stress or worry (27 per cent), diet (23 per cent) or family problems (20.3 per cent).

In terms of ranking, both ageing and heredity were most frequently ranked first as causing dementia (ageing 44.6 per cent; heredity, 23 per cent), as well as being most frequently ranked as the second most common cause (ageing 17.6 per cent, heredity, 29.7 per cent). The third most frequently ranked cause of dementia was emotional state (17.6 per cent) followed by miscellaneous statements (9.5 per cent). Those in the miscellaneous category included alcohol use, stroke and chemical poisoning (aluminium).

3.4 Exploration of data

3.4.1 Missing data

Of the questionnaire packs returned, one participant failed to provide any information on the demographic front sheet. Three participants failed to return the Approaches to Dementia Questionnaire (AQQ-19); one from the psychiatric group and two from the general medical group. Three participants also failed to return the Kogan's Approaches to Older People questionnaire (KOAP); one from the psychiatric group and two from the general medical group (of whom one had also failed to return the ADQ-19). As the participants in question returned the remaining questionnaires in the packs provided, these were still included in the analysis. All participants completed the Illness Perception Questionnaire: Revised for Healthy Subjects (IPQ-RH).

Of the few items of demographic data omitted, participants most frequently failed to state whether or not they spent a disproportionate proportion of their time managing behavioural difficulties that can arise as a consequence of dementia, which equated to 8per cent of the total sample.

In terms of hypothesis-related data, almost all variables had some missing values, but no more than 10 per cent of the data in each questionnaire was omitted. Interestingly, around 97 per cent of omissions were items in the KOAP, which may reflect particular difficulties with this measure, such as poor wording, the use of double negatives, or the fact that participants are unable to provide a neutral response. Upon reviewing the frequency distribution both across the total sample and each group (see Appendix 6c), it

was also noted that a high proportion of participants provided neutral responses on the IPQ-RH ('neither agree nor disagree'). These issues and their potential influence on the outcome of this study will be discussed in greater depth in the forthcoming chapter.

Missing values were replaced with mean variable scores where appropriate. Mean variable scores were obtained from within the participants' respective groups, rather than being drawn from the entire sample, in order to avoid the mean value of the total sample influencing the value of the individual groups.

3.4.2 Normality of distribution

Homogeneity of variance was assessed using Levene's test and was not deemed to be significant in any of the items. Of the scale distributions examined, both across the total sample and within each group, the majority of items were considered to be normally distributed and did not exhibit a significant level of either skewness or kurtosis (see Appendix 7a).

A few significant deviations from normality were observed across the 'Timeline Cyclical' and 'Consequences' sub-scales of the IPQ-RH. Significant levels of both skewness and kurtosis were also observed in the IPQ-RH 'Consequences' sub-scale. This sub-scale related to participant's views on the financial and personal consequences of dementia and as to whether or not they considered this illness to be serious. As illustrated in Appendix 6b, a negatively skewed, platykurtic distribution is evident across whole sample and in both the psychiatric and general medical groups. This

suggests a trend in participants viewing the illness of dementia as serious and as having serious personal and financial consequences. As one might propose that this level of skewness and kurtosis is expected given the nature of the question, this was also taken into account.

Clark-Carter (2004) states that parametric tests continue to be robust, even when some assumptions are not met and recommends either variable transformation or the use of non-parametric tests only if more than one assumption is violated within each variable. With this in mind, only one variable in the dataset needed to be considered for transformation before parametric tests could be administered (IPQ-RH 'Consequences' sub-scale).

3.4.3 Data transformation

Although data can often be skewed in attitudinal research, efforts were made to report the data pre and post transformation, in order that this could be taken into account. In accordance with Field (2009), given the negative skew of the distribution, a reverse score transformation was carried out on the IPQ-RH 'Consequence's sub-scale. As the level of skewness and kurtosis may have been expected, both transformed and untransformed data will be reported, in order to provide a conservative approach.

3.4.4 Outliers

The presence of significant outliers was determined by examining box-whisker diagrams for each group. As only a few non-significant outliers were present, the data was not adjusted further.

3.5 HYPOTHESIS-RELATED DATA

3.5.1 Hypothesis 1: *Nursing staff working in psychiatric wards will hold more positive attitudes to older people than those working in general medical wards.*

The mean values on the KOAP, a measure of participants' attitudes towards older people, were similar across both the psychiatric and general medical group. The mean score on the KAOP scale for the psychiatric group was 139.43 (SD 14.04), whilst the mean score for the general medical group was 141.38 (SD 13.10). As the total KOAP score ranges from 34 to 204 (with scores above 102 being indicative of a positive attitude), these results suggests that on average, both groups had moderately positive attitudes towards older people.

In the psychiatric group, total scores on the KOAP ranged from slightly above neutral (107) to moderately positive (167), whereas in the general medical group, the range was slightly higher (between 122.43 and 176). The frequency distribution of responses to KOAP items both in each group and in the total sample are also provided (Appendix 6a) alongside histograms which provide an illustration of score distribution and range between each respective group (Appendix 7b).

A between subjects ANOVA revealed no significant inter-group differences on the Kogan's Attitudes to Old People Questionnaire; $F(1, 67) = 0.33$, $p = 0.73$). This result does not support Hypothesis 1 that nursing staff working in psychiatric wards will hold more positive attitudes toward older people than nursing staff working in general medical settings.

3.5.2 Hypothesis 2: *Nursing staff in psychiatric settings will hold more positive attitudes towards caring for older people with dementia than those working in general medical wards*

The mean score on the ADQ-19 Hope sub-scale for the psychiatric group was 28.57 (SD 3.66), whilst the mean score for the general medical group was 28.08 (SD 5.72). Given that the minimum score that can be achieved on this sub-scale is 8 and the maximum is 40, the results suggest that, on average, both groups had a moderately high degree of hopefulness about people with dementia. In terms of range, total scores on this sub-scale ranged between 20 and 35 in the psychiatric group, whilst in the general medical group the range was slightly wider (between 15 and 39).

The frequency distribution of responses to ADQ-19 items both in each group and in the total sample are also provided (Appendix 6b) alongside histograms which provide an illustration of score distribution and range between each respective group (Appendix 7b).

A between subjects ANOVA revealed no significant inter-group differences on the ADQ-19 Hope sub-scale; $F(1,68) = 0.19$, $p = 0.66$. These results suggest that there is no significant difference in the degree of hopefulness held about people with dementia between the psychiatric and general medical groups.

The mean score on the ADQ-19 Person Centred sub-scale for the psychiatric group was 46.77 (SD 4.34), whilst the mean score for the general medical group was 46.77 (SD 4.42). Given that the scores on this sub-scale can vary between 11 and 55, the results suggest that, on average, both groups aim to utilise a person-centred approach when working with people with dementia. In terms of range, total scores on this sub-scale were similar across each group (psychiatric = 38 to 56; general medical = 37 to 54).

A between subjects ANOVA revealed no significant inter-group differences on the ADQ-19 Person Centred sub-scale; $F(1,68) = 0.00$, $p = 0.99$. These results suggest that there is no significant difference in the intention of nursing staff to utilise a person-centred approach with dementia patients between the psychiatric and general medical group.

The mean score on the ADQ-19 Total score for the psychiatric group was 75.39 (SD 5.84), whilst the mean score for the general medical group was 74.85 (SD 7.21). Given that the scores on this sub-scale can vary between 19 and 95, the results suggest that, on average, both groups have moderately positive attitudes towards caring for people with dementia. In terms of range, total scores on this sub-scale were similar across each group (psychiatric = 62 to 88; general medical = 61 to 86).

A between subjects ANOVA revealed no significant inter-group differences on the ADQ-19 Total Score; $F(1,68) = 0.12$, $p = 0.73$.

These results do not support Hypothesis 2 that nursing staff in psychiatric settings will hold more positive attitudes towards caring for older people with dementia than those working in general medical wards.

3.5.3 Hypothesis 3: *There will be a correlation between the attitudes nursing staff hold towards older people and the attitudes they hold towards older people with dementia.*

A bi-variate Pearson's correlation co-efficient was carried out in order to assess the relationship between nursing staff attitudes towards older people (KOAP total score) and the attitudes they hold towards older people with dementia (ADQ-19 total score).

As illustrated overleaf in Figure 3.1, there was a significantly positive correlation between these variables ($r = 0.344$; $p = \leq 0.004$), suggesting that the more positive nursing staff are about older people, the more positive they are about older people with dementia.

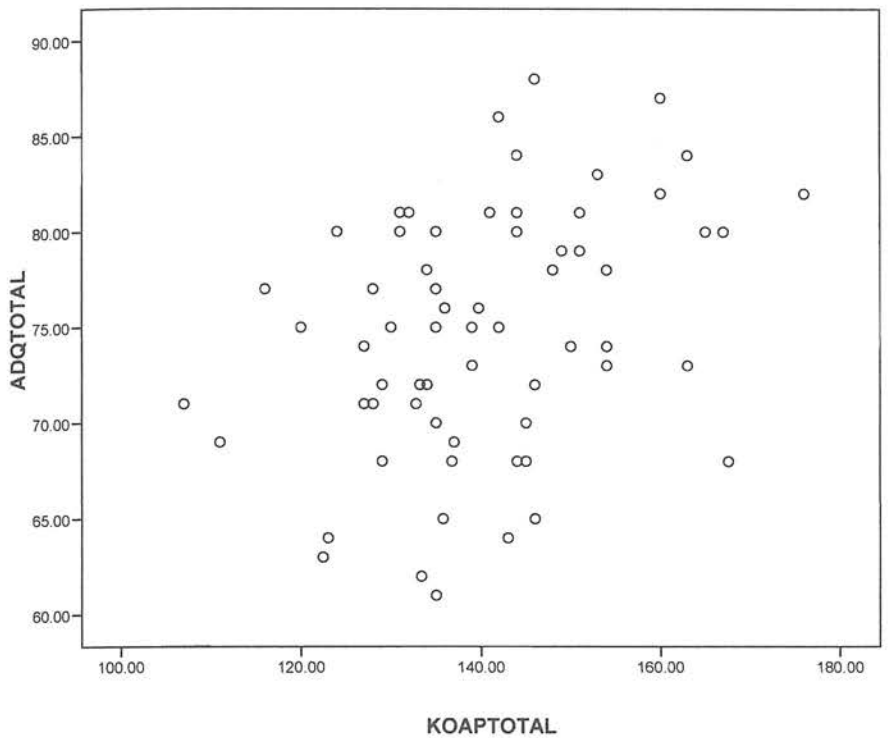


Figure 3.1: The relationship between nursing staff attitudes to older people and older people with dementia (n = 73)

3.5.4 Hypothesis 4: *Nursing staff attitudes to the illness of dementia will differ between those working in general medical wards and those working in psychiatric wards.*

The mean scores and standard deviations for each of the sub-scales within the illness representation section of the IPQ-RH are presented in the following sections alongside the outcome of between subjects ANOVA's, which were used to assess the significance of intergroup differences across each of the sub-scales. The frequency distribution of responses to individual items on the IPQ-RH (both in the total sample and across each group) can be reviewed in Appendix 6c.

3.5.4.1 Timeline Acute/Chronic

The mean score on this sub-scale for the psychiatric group was 21.11 (SD 2.99), whilst the mean score for the general medical group was 21.07 (SD 2.57). The results suggest that on average, both groups consider dementia to be an illness that is chronic in nature. A between subjects ANOVA revealed no significant inter-group differences on this sub-scale; $F_{(1,71)} = 0.003$, $p = 0.96$.

3.5.4.2 Timeline Cyclical

The mean score for the psychiatric group on this sub-scale was 11.11 (SD 2.29), whilst the mean score for the general medical group was 11.39 (SD 2.27). The results suggest that on average, respondents in both groups consider dementia to be an unpredictable, cyclical illness; as opposed to an illness with a well-defined trajectory. A between subjects ANOVA revealed no significant inter-group differences on this sub-scale; $F_{(1,71)} = 0.26$, $p = 0.61$.

3.5.4.3 Consequences

In terms of the transformed data, the mean score for the psychiatric group on this sub-scale was 1.18 SD (0.10), whilst in the general medical group the mean score was 1.17 (SD 0.13). A between subjects ANOVA revealed no significant inter-group differences on this subscale of the IPQ-RH; $F_{(1,71)} = 0.34$, $p = 0.17$.

In terms of the untransformed data, a between subjects ANOVA revealed no significant inter-group differences on this subscale of the IPQ-RH; $F_{(1,71)} = 0.27$, $p = 0.60$.

3.5.4.4 Personal Control

The mean score for the psychiatric group on this sub-scale was 7.16 (SD 2.25), whilst in the general medical group the mean score was 7.96 (SD 2.61). Upon observing the frequency distribution of responses for these items, the results suggest that on average, respondents in both groups were either unsure about the personal control that they had over the illness of dementia, or they felt that they had very little personal control over the illness. A between subjects ANOVA revealed no significant inter-group differences on this sub-scale of the IPQ-RH; $F_{(1,71)} = 1.93$, $p = 0.17$.

3.5.4.5 Treatment Control

The mean score for the psychiatric group on this sub-scale was 8.16 (SD 2.10), whilst in the general medical group the mean was 8.42 (SD 1.77). Upon observing the frequency distribution of responses for these items, the results suggest that on average, respondents in both groups felt that dementia could not be controlled by means of treatment. A between subjects ANOVA revealed no significant inter-group differences on this sub-scale of the IPQ-RH; $F_{(1,71)} = 0.30$, $p = 0.59$

3.5.4.6 Illness Coherence

The mean score for the psychiatric group on this sub-scale was 6.87 (SD 2.43), whilst in the general medical group the mean score was 7.15 (SD 3.00). As scores on this sub-scale can range between 5 and 15, the results suggest that on average, respondents in both groups considered dementia to be an illness that they could make sense of. A

between subjects ANOVA revealed no significant inter-group differences on this sub-scale of the IPQ-RH; $F(1,71) = 0.19$, $p = 0.58$.

3.5.4.7 Emotional Representations

The mean score for the psychiatric group on this sub-scale was 14.31 (SD 4.33), whilst in the general medical group the mean score was 13.69 (SD 4.73). As scores on this sub-scale can range between 5 and 25, the results suggest that on average, respondents had a moderately emotional reaction towards the illness of dementia. A between subjects ANOVA revealed no significant inter-group differences on this sub-scale of the IPQ-RH; $F(1,71) = 0.32$, $p = 0.56$.

On the whole, these results do not support Hypothesis 4 that nursing staff attitudes to the illness of dementia will differ between those working in general medical wards and those working in psychiatric ward.

4. DISCUSSION

4.1 Summary of findings

The current study employed a quantitative methodology to compare nursing staff attitudes towards older people, older people with dementia and the illness of dementia across general medical and psychiatric settings. Demographic and anecdotal information was also gathered in order to place the attitudinal data within an appropriate context where possible.

Contrary to previous findings, analyses indicated that the majority of nursing staff in both groups held positive attitudes towards both older people and older people with dementia, while no significant difference in nursing staff attitudes between the psychiatric and general medical groups was reported on these variables. Similarly, no significant difference in nursing staff attitudes was reported between groups towards the presence of dementia. There was a significant and positive correlation between the attitudes nursing staff held towards older people and older people with dementia across the whole sample. This indicated that those who had positive attitudes towards older people were more likely to hold positive attitudes towards older people with dementia as well.

Factors which may have influenced the outcome of this study, such as the age of respondents, level of staff training and experience (both in general terms and in caring for patients with dementia) and access to liaison nursing services were

considered, as well as the potential influence of methodological drawbacks and limitations. These issues will be considered in greater depth in the remainder of this chapter.

4.1.1 Hypothesis 1

Contrary to the hypothesis that nursing staff in psychiatric settings will hold more positive attitudes towards older people than those in general medical settings, there was no statistical difference in attitudes between the two groups.

Overall both groups of nursing respondents held positive attitudes towards older people in their care. The findings of the current study are consistent with those of Hope (1994), who reported that participants in geriatric and general medical settings had neutral to positive attitudes towards older people, and these views did not differ significantly between groups. However, this is contrary to evidence presented in previous research studies in which nursing staff were reported as having neutral to negative attitudes towards this patient group; particularly those in acute medical settings (Courtney *et al*, 2000; Higgins *et al,* 2007; Kearney *et al*, 2000; Meyer *et al*, 1999; Stevens & Crouch, 1995).

The apparent inconsistency with results obtained in the current study and that of other published studies, may be explained in the following ways; Perhaps general attitudes towards this patient group are improving due to an increasing awareness of older

people's issues and improvements in staff training via the introduction of governmental policies and guidelines (Commission for Healthcare Audit and Inspection, 2006; Scottish Executive, 2007) and the advent of media campaigns aimed at tackling ageist attitudes (e.g. The 'See the Person Not the Age' campaign launched by the Scottish Government (Scottish Executive, 2007)). This is somewhat speculative, however, as research to explore the outcome of these campaigns is lacking.

On the other hand, one might argue that additional factors served to influence the results in this case. For example, as the response rate for this study was particularly low (20.1 per cent for the psychiatric group and 10.1 per cent for the general medical group), those who elected to take part may have had a specific interest in older people's issues, or may be more positive in their experiences with older people resulting in a biased sample.

As around 75 per cent of the participants in each group were between 36 and 65 years of age, one might argue that the age of respondents had an impact on the direction of the results. This fits with the premise of previous research, which suggests that people are more likely to have positive views about ageing and older people as they themselves become older (Levy, 2003). The potential correlation between age and attitudinal scores could not be explored in the current study, however, as requesting the exact age of respondents was forbidden by the Research and Ethics Committee in order to protect the confidentiality of respondents. Age ranges were consequently

employed as an alternative method; however, this served to limit the specific evaluation of age as a variable.

Given the proposed role of knowledge and contact on attitudinal development, one could also argue that a bias in the level of training and experience across the sample served to influence the results (Allport, 1954; Cummings & Galambos, 2002; Deforges *et al,* 1991; Levy & Banaji, 2002). For example, a significantly greater proportion of the total sample was trained (registered) in comparison to those who were untrained (auxiliary). Of the trained respondents, the majority had a high level of experience, with the greatest proportion in both groups being registered for a period of 10 years or more. Interestingly, a significantly greater proportion of respondents in the psychiatric group were qualified for this length of time in comparison to those in the general medical group, who had a wider range of experience. Although these differences did not appear to influence attitudes, it is clear that a larger sample would be required in order to investigate the potential impact of training and experience on attitudes in greater depth.

It could be argued that the untrained nurses were too busily engaged in direct care tasks to participate in the current study, yet the attitudes of those most frequently involved in the direct care of this patient group may well be the most important. Perhaps the frequency and type of contact untrained nurses have both with older people and those with dementia varies greatly to that of their trained colleagues, which is something the current study did not take account of. For example, trained

nurses may have a different experience of working with this patient group, as they may be required to do more administrative and managerial work in addition to the provision of nursing care. As a consequence of this, junior or untrained members of staff may be required to manage a greater proportion of the basic care on the ward. This could arguably result in a variation of attitudes within a ward setting, with untrained nurses potentially holding more negative attitudes towards older people and those with dementia in their care, as a consequence of more prolonged and negative contact with this patient group.

With this in mind, it would have been useful not only to examine the percentage of older people and people with dementia on a particular ward, but also to explore the bulk of time that each staff participant spent providing direct care. Unfortunately the sample size did not allow for further exploration of any difference in attitudes between trained and untrained staff in this instance, however, this would provide an interesting avenue for future research.

This potential recruitment bias refers to *general* levels of training, however, as the level of *geriatric* training was not requested. Upon reflection, it may have been more beneficial to explore the level of gerontological training in each group, in order to assess differences in knowledge and training specific to the older people in their care. Very few studies have explored the specific impact of geriatric training on the attitudes of healthcare professionals. According to Hope (1994), the level of gerontological training had a significant impact on the attitudes of healthcare

professionals towards older people; however, in this aspect of the study the number of participants was insufficient to provide a strong evidence base.

As this study aimed to investigate nursing staff attitudes towards both dementia *and* older people, participants in the general medical group were selected from settings where older people were more likely to be admitted, such as orthopaedic and cardiac rehabilitation wards. Thus staff would have higher contact levels with older people. Given the increased level of contact these particular nurses are likely to have with older patients, one might argue that the general medical sample was biased in favour of having positive attitudes towards older people (Bowling, 2001).

This potential bias in recruitment was clearly reflected in the demographic data in which 64 per cent of the general medical sample cared exclusively for patients aged 65 and over, whilst between half and all of the patients in the general medical wards surveyed were in this age bracket at any one time. With this in mind, one might suppose that the general medical sample in the current study had more in common with Hope's specialist care of the elderly sample (Hope, 1994). Given the proposed importance of contact in attitudinal development, one might argue that a similar level of contact in each group accounted for the attitudinal similarities in this instance.

Upon further examination, however, this may not be the case. Although respondents in general medical settings worked with a less diverse patient group than those in psychiatric settings, the results indicated that a significantly greater proportion of

respondents in the psychiatric group (96 per cent) had contact with older patients almost all of the time in comparison to 14 per cent of those in the general medical group.

In spite of a difference in the level of contact between the two groups, there was no difference in the attitudes they held towards older people. This outcome is at odds with previous research, which suggests that the level of contact is likely to have a positive impact on attitudinal development (Allport, 1954; Cummings, Galambos & DeCoster, 2003; Desforges *et al*, 1991). The outcome also contradicts evidence which suggests that increased levels of contact may have a detrimental effect on the attitudes that are held towards a particular patient group (Hochschild, 1983; Koder & Helmes, 2008), as respondents in the current study held equally positive attitudes towards older people in spite of differences in contact. One could therefore argue that the role of contact may not be as influential in attitudinal development as previous research suggests.

It is important to note, however, that the complexities of contact were not fully explored in the current study, such as the proposed role of the *type* of contact in attitudinal development (Cummings, Galambos & DeCoster, 2003). With this in mind, perhaps an assessment of 'frequency of contact' alone is not enough to contradict its role in influencing attitudes, as it may be the case that the nursing staff surveyed had positive contact with older people on the whole. It would therefore have been interesting to consider whether respondents viewed contact with this patient

group as challenging, positive or even both and to assess any attitudinal differences that arose.

One could also argue that contact was not assessed accurately in the current study, as the distinction between older *people* and older *patients* was not explored and may have influenced the direction of the findings. In investigating the attitudes of healthcare professionals, research has frequently employed measures which assess their views of older *people*, as opposed to measures which assess their views of older *patients*. This distinction is particularly important, as according to Penner *et al.* (1984), the attitudes held by nursing staff towards older patients were significantly more negative than the views they held about older people. Investigating issues that relate to older patients would be far more revealing, as the views staff hold about older people in general may be less relevant to the older people in their care.

As the KAOP (Kogan, 1961) utilised in the current study measures attitudes towards older *people*, one might propose that the results highlight nursing staff attitudes towards older people in general and that they are not representative of the views they hold towards the older *patients* in their care. While nursing staff might perceive older *people* in generic terms, as healthy, active members of the community, healthcare professionals may arguably develop a universally skewed perception of older *patients*, as they can become accustomed to associating people in this age group with serious illness and death (Basnett, 2001).

As a consequence of this potential discrepancy, further research is required in order to examine these issues. Perhaps the development of measures which examine the attitudes of healthcare professionals to patients in their care is required, or more qualitative research may be necessary in order to explore the wider issues highlighted by such measures (see Section 4.2.1).

4.1.2 Hypothesis 2

The results do not support the hypothesis that psychiatric nursing staff will hold more positive attitudes towards caring for older people with dementia than those working in general medical settings, as there was no significant difference in attitudes between the two groups.

Contrary to existing research, which suggests that healthcare professionals hold negative views of this patient group (Borbasi, 2006; Courtney *et al*, 2000; Marshall, 1999; Norman, 2003; Schell, 2001), participants across both groups reported positive attitudes towards caring for older people with dementia. This finding challenges the notion that patients with dementia are likely to be unpopular with nursing staff, as a consequence of their potential communication difficulties, reduced mental ability or the challenging behaviour (CB) that might result from their condition (Stockwell, 1972).

The current findings may simply reflect the fact that participants across both groups had positive attitudes towards caring for older people with dementia. In accordance with the 'dependency support' literature, for example, healthcare professionals are more likely to hold positive attitudes towards dependent patient groups (Baltes & Wahl, 1992). It is therefore possible that respondents had positive views of this patient group as a consequence of their perceived dependence, which could actually have negative implications for their care. For example, Baltes and Wahl (1992) suggested that the benefits of finding it quicker to 'do' for this patient group can be outweighed by compromising the promotion of their independence. This can result in lengthier periods in hospital and a decreased likelihood of them returning to their own home (Baltes & Wahl, 1992).

This highlights a further limitation of the current study, as the perceived dependency level of this patient group was not explored and no information was gathered to examine whether this had an impact on nursing staff attitudes towards them. If the patient groups in the current study were considered as compliant by respondents, they may have been viewed more positively, as they would adhere to the 'warm but incompetent' stereotype of older people highlighted previously (Cuddy & Fiske, 2002).

Interestingly, when asked to note what particular aspects of behaviour they found most challenging in patients with dementia, only those in general medical settings noted non-compliance with treatment as being problematic. Perhaps the level of

compliance to treatment is more important in general medical settings where the primary aim is the recovery of physical health and discharge from hospital as soon as possible. With a greater number of subjects, it would have been interesting to explore the 'warm but incompetent' stereotype (Cuddy & Fiske, 2002) by asking subjects about how compliant they felt patients with dementia are in comparison to those with other forms of illness. This would also allow a comparison of views on compliance to be made across settings, as well as noting any correlation between levels of compliance and the attitudes that are held towards this patient group.

Given the higher proportion of trained respondents across the sample, the current findings may represent the views of staff with a particular experience and may not represent the views of untrained nurses, who may have a different experience of working with this patient group. Further research in this area is required in order to gain a wider understanding of these issues. Perhaps a comparison of care workers in nursing homes with those working in medical settings would provide an interesting contrast, given the different nature of their roles.

Strikingly, the attitudinal disposition of the psychiatric group was *not* positively influenced by a significantly greater proportion of its respondents having additional training in dementia care. This further challenges the view that the advancement of gerontological knowledge via training and further education serves to promote positive attitudes towards older people with dementia (Ballard, 2002; Hope, 1994; Tierney *et al*, 1998).

This fits with research which suggests that knowledge may play a less significant role in influencing staff attitudes than was first thought. In investigating the relationship between staff training and the recognition of dementia in nursing home residents, for example, MacDonald and Woods (2005) found that training was not 'significantly independently related to [the recognition] of dementia' in care staff (p.389). Furthermore, Zimmerman *et al.* (2005) reported that training alone did not have a direct influence on practice, unless it was embedded within a positive culture that promoted staff well-being. Some potential barriers to putting knowledge into practice were examined in the current study and will be explored at a later stage in this chapter.

In terms of contact, the frequency with which participants dealt with patients with a diagnosis of dementia was noted to vary significantly between groups. Whilst 91 per cent of those surveyed in psychiatric settings reported having contact with dementia patients on a daily basis, 50 per cent of those in general medical settings reported a similar level of contact. The frequency with which respondents were required to manage behavioural difficulties that arise as a consequence of dementia also varied significantly. 80 per cent of those surveyed in psychiatric settings were required to manage such difficulties on a daily basis in comparison to 25 per cent of those surveyed in general medical settings.

Once again, such differences in contact did not appear to have an impact on nursing staff attitudes towards this patient group, which contradicts the findings of previous

research and further contradicts the role of contact in attitudinal development (Allport, 1954; Cummings & Galambos, 2002; Deforges *et al*, 1991; Levy & Banaji, 2002). It is, however, worth considering whether contact is actually important in a busy ward environment, where the potential to gain a prolonged, enriched level of contact may not be sufficient to alter any existing ingrained prejudices. Most of the research carried out in relation to contact has involved professions who tend to see individuals for a prolonged period of time and this may not reflect the transient nature of some acute hospital settings.

Strikingly, in spite of having greater levels of additional training in dementia care and significantly more contact with older people with dementia, only 8.9 per cent of respondents in the psychiatric sample reported feeling extremely confident about managing Challenging Behaviour (CB) that can arise as a consequence of dementia.

This raises the question of whether training actually has an impact on confidence levels, or if other factors prevent additional training being put into practice with confidence. According to Higgins *et al.* (2007), experienced staff can be less receptive to training programs, as they may be more confident about using outdated approaches than applying new ones. The current findings do not reflect those of Higgins *et al.* (2007), however, as respondents in the psychiatric group reported feeling less confident than one might expect.

Nevertheless, participants in psychiatric settings were more confident in dealing with CBs that arise as a consequence of dementia than their colleagues in general medical settings. Only 8.9 per cent of respondents in the psychiatric group were 'a little confident' in dealing with CB, however, 7.1 per cent of participants in the general medical group were 'not at all confident' about managing these difficulties, whilst 17.9 per cent were only 'a little confident'.

It is difficult to determine whether such differences in confidence levels actually translate into a difference in the quality of practice. For example, nursing staff may feel very confident that they are providing a high standard of care to patients with dementia, but in reality, their level of confidence may not equate to their level of *competence* in caring for this patient group. It would therefore have been useful to explore the techniques participants used to manage such behaviours, in order to establish whether this was carried out with competence as well as confidence. This would be an interesting avenue for future research.

It was interesting to note that a significant proportion of respondents in both groups felt that they spent a disproportionate amount of their time managing CB that arose as a consequence of dementia (62 per cent of the psychiatric sample and 86 per cent of the general medical sample). In some respects, these results are not surprising, as evidence has suggested that patients with dementia are often viewed as 'not belonging' in general medical settings (Higgins *et al*, 2007; Marshall, 1999). This outcome does jar somewhat with the positive views which were aired by general

medical respondents in relation to caring for this patient group. It also contradicts the 'unpopular patient' literature (Stockwell, 1972) as one might propose that those exhibiting CB might be viewed in a more negative light.

With this in mind, one could argue that certain aspects of caring for people with dementia may not have been examined effectively by the ADQ-19 (Lintern, 2001). In fact none of the items in the ADQ-19 (Lintern, 2001) actually explored staff views on managing CB in this patient group. This highlights a potential flaw in measurement scales and thus there is a limited coverage of wider issues that manifests itself, as only positive attitudes that are reported in this study and these do not refer to dementia patients who present with these difficulties. Given that a large percentage of respondents admitted to managing these difficulties on a daily basis, it is particularly important to address this distinction in future research.

The measurement of CB in hospital settings is challenging in itself, however, as tools are often unsuitable for use in these environments. The Challenging Behaviour Scale (CBS) (Moniz-Cook *et al*, 2001) is a 25-item scale used to assess the incidence, frequency and 'management difficulty' of people with dementia, which would have been useful to implement in this instance. The measure is noted to be robust and quick to complete with good internal reliability and validity.

The CBS (Moniz-Cook *et al*, 2001) was not considered for use in the current study, however, as it was exclusively developed with care staff in nursing homes. One might

argue that issues that are considered challenging in settings which are often adapted to meet the needs of older people with dementia vary greatly from incidences which are considered challenging in a general medical ward. The measure did not transfer well to the fluid nature of the hospital environment, as it recommended that respondents were familiar with the particular individual who was exhibiting challenging behaviour.

Furthermore, part of the measure requires participants to note whether or not particular behaviours have occurred within a period of 8-weeks. They are subsequently required to note the frequency with which these incidents occur on a scale ranging from one (occasionally present/less than once a month) to four (present on a daily basis). Noting the frequency of challenging behaviours in this way does not transfer particularly well to the transient nature of a hospital environment, in which patients are often moved to and from various wards and where a number of different healthcare professionals are likely to deal with a individual patient's needs at any one time. They may even be discharged within a month, which makes elements of this scale redundant for use with hospital patients.

Instead of a measure such as the CBS (Moniz-Cook *et al*, 2001), which assesses the challenge that a particular individuals' behaviour can pose to care staff, perhaps a more general measure which explores behaviours considered challenging in general hospital settings might prove more useful. It may therefore be interesting to adapt elements of the CBS (Moniz-Cook *et al*, 2001), such as the section which measures

the total level of challenge posed by a particular behaviour, in order to explore similarities and differences in what nursing staff in these settings find difficult to manage. As the CBS (Moniz-Cook *et al*, 2001) was too narrow in focus for use in the current study, a broader more comprehensive measure was required. Although such a scale does not exist at present, the outcome of the current study highlights the need to develop such a scale in the future.

Perhaps managing patients with dementia who present with CB is viewed more negatively than managing patients with dementia who do not present with these difficulties. This would fit with the 'unpopular patient' (Stockwell, 1972) and 'dependency support' literature (Baltes & Wahl, 1992), as those with CB may be viewed as failing to either accept support or comply with the rules and regulations of the ward, as lacking in warmth, being aggressive or as putting other patients at risk (Higgins *et* al, 2007; Marshall, 1999; Stockwell, 1972).

Given that the ADQ-19 (Lintern, 2001) did not afford specific examination of nursing staff views on patients with dementia who also exhibit CB, one might argue that the current study examined a narrower dimension of caring for this patient group than may be the experience of practitioners working with this group. This limitation of the Scale was not apparent prior to the use in this study and the originators of the scale appear to be unaware of this lack of coverage. The results may therefore reflect the 'warm but incompetent' stereotype of older people, which proposes that respondents are more likely to have a positive view of older people if they present with memory

problems or have difficulties looking after themselves; if they also have a warm demeanour and accept support (Cuddy & Fiske, 2002).

One could therefore propose that the current study did not cover staff views on those who present with CB effectively, leading respondents to provide a skewed positive view of working with people with dementia. Given that respondents in both groups highlighted difficulties with wandering, as well as verbal and physical aggression to be the most common difficulties they experienced with this patient group, one might argue that the positive views towards caring for older people with dementia recorded by the ADQ-19 (Lintern, 2001) may not accurately reflect views on all dimensions of dementia care. It is clear that further research is required in order to examine these issues in greater depth.

It was surprising to note that 62 per cent of respondents in the psychiatric group felt that they spent a disproportionate amount of their time managing CB, as one might consider this to be a 'subjective norm' in psychiatric nursing (Azjen, 1989), particularly as 91 per cent of those surveyed had contact with this patient group on a daily basis. It is, however, difficult to interpret what this might mean for the psychiatric nursing staff surveyed. For example, does this mean that they did not consider the management of CB to be part of their role as a nurse? Perhaps the result simply reflects the sheer amount of time that nursing staff spent managing CB in comparison to what they consider to be the more pressing key aspects of their role, such as the administration of medication or the provision of basic care.

With this in mind, one could also argue that the term 'disproportionate' is rather subjective and that it may be interpreted in a variety of ways by respondents, which may indicate a methodological flaw in the study. Regardless of how this has been interpreted, however, the outcome of the current study suggests that those in general medical settings find this aspect of care more troubling than their colleagues in psychiatric wards. Further qualitative research is required, however, in order to examine these issues in greater depth.

Interestingly, nursing staff in general medical settings were also least confident about managing CBs, whilst more respondents in this group felt that they spent a disproportionate amount of their time managing these difficulties. These findings jar somewhat with the positive views that were provided about caring for this patient group, as one might expect nurses in this situation to have more negative attitudes, or to be more stressed than their psychiatric colleagues (Zimmerman *et al*, 2005). It would have been interesting to use a measure the levels of stress and burnout in the sample, in order to gain a broader understanding of these issues.

This may once again highlight issues with the ADQ-19 (Lintern, 2001) as a measure of this aspect of dementia care. Alternatively, one might argue that the positive attitudes towards caring for patients with dementia reported by nursing staff represent a theoretical ideal, whilst in practice; they can face a host of barriers which prevent them from carrying out the service they would most like to provide. For example, nursing staff may consider the application of a person-centred approach as the gold

standard when working with people with dementia; however in reality, issues such as low staffing levels may prevent this approach from being carried out at all times.

This can lead to a 'Catch-22' situation, whereby the application of a person-centred approach, which is likely to reduce levels of aggression and agitation in dementia patients and result in a reduction in staff stress levels can be hampered by a lack of staff to carry it out (Kitwood, 1997; Zimmerman *et al*, 2007). These issues were also highlighted by Higgins *et al.* (2007), who reported that nursing staff often felt that lack of time, as a consequence of low staffing levels was responsible for a reduction in the quality of care they were able to provide.

Such barriers were hinted at in the current study, with some respondents in both groups highlighting difficulties with staffing levels and management, which they felt made it difficult to manage patients with dementia effectively. Further qualitative exploration would have been required, however, in order to provide more substantive evidence of their frequency and impact, which was outwith the remit of the current study.

In terms of the ward environment, no respondents in either group considered their ward environment to be extremely suitable for patients with dementia. On the one hand, one might argue that endorsing any environment as being *extremely* suitable is rather unlikely. This may highlight a methodological flaw in the study, as it may have been sufficient to request whether participants found the ward environment to be

suitable or unsuitable for patients with dementia. On the other hand, however, one might argue that investigating levels of suitability also allows participants to

The majority of respondents in *both* groups felt that their wards with either 'not at all suitable' for this patient group, or only 'a little suitable'. This was particularly surprising given the high level of contact those in psychiatric settings had with people with dementia. One might expect that psychiatric settings, which are frequently required to support people with dementia, as well as people with other conditions which may result in challenging behaviours, would be designed in a suitable manner for these patient groups.

The nature of the current study did not allow these relationships to be explored in greater detail. One might propose that nature of staff attitudes are far less influential when additional barriers, such as a poorly designed environment, may prevent them from putting them into action. So even if respondents viewed patients with dementia in a positive light, they may be unable to act upon these views in practice, as external factors outwith their control, such as ineffective ward design and staff shortages, may require them to work with these patients in a manner that is incongruent with their beliefs. This fits both with theories of cognitive dissonance (Festinger, 1957) and professional socialisation (Basnett, 2001; Norman, 2006) and serves to highlight the major difficulties with attitudinal research; namely the ability of the human mind to actively choose to act upon or to suppress certain thoughts and feelings and to adapt their behaviour to suit a variety of situations. These issues merit further exploration,

as in doing so, staff views of what is getting in the way of service delivery can be examined, in conjunction to their view of an ideal service. Any differences in these would be telling and serve to highlight service improvements.

4.1.3 Hypothesis 3

The result supported the hypothesis that there would be a significant correlation between the attitudes nursing staff held towards dementia and the attitudes they held towards older people across the sample.

This indicated that nurses with a positive attitude towards older people were more likely to hold a positive attitude towards those with dementia as well. This outcome opposes the 'double stigmatisation' hypothesis, which suggests that older people are likely to be viewed in a negative light; those with dementia even more so (Age Concern, 2000; Alzheimer's Society, 2007). Although significant, the correlation is not particularly strong, however, which may reflect the tendency for people to hold opposing views simultaneously (Hazan, 1994; Quinn *et al,* 2009).

If positive attitudes towards older people can serve to influence the attitudinal disposition of nursing staff towards older people with dementia and vice versa, this may have implications for the way in which current training is applied (see Section 4.3).

4.1.4 Hypothesis 4

Contrary to the hypothesis that nursing staff in psychiatric settings will hold more positive attitudes towards the illness of dementia than their colleagues in general medical settings, no statistical difference in staff attitudes was found between groups on any of the IPQ-RH sub-scales examined (Figuerias & Alves, 2007). It is important to re-iterate that no research has been done in this area to date; therefore, the results of the current study cannot be compared against previous studies.

In general terms, respondents perceived dementia as an illness that is chronic and unpredictable in nature, as opposed to being an illness with a well-defined trajectory. They also considered dementia to result in high personal and financial consequences. Respondents were either unsure about the level of personal control that they had over the illness, or felt that they had very little control over it. Respondents had a moderately emotional reaction towards the illness of dementia, as they reported feelings of fear and sadness in relation to the illness.

As a large proportion of the items on the illness representation section of this measure were marked 'neither agree nor disagree', this could represent a degree of uncertainty or ambiguity about the illness. It is, however, difficult to determine if these views are reflective of the uncertain trajectory of the illness itself. One might also argue that this indicated a tendency for response bias in this measure, which may have served to influence the variation in results to some degree (Bowling, 2001). Although this may suggest difficulties with the questionnaire itself, this may also reflect the busy

environment within which nursing staff are working and suggest that measures were consequently filled in as quickly as possible. Steps were taken to reduce this possibility, as potential participants were encouraged to complete the questionnaires in their own time.

Although participants were asked to complete this measure from a personal as opposed to a professional viewpoint, it was clear that some of the sub-scales could be perceived as rather ambiguous and that the nature of response required may have been misinterpreted as a result. Items on the personal control sub-scale in particular, such as the statement 'the course of this illness depends on me', may have been viewed in a number of ways. On the one hand, the response may have reflected their personal views on how they could influence the illness of dementia as a sufferer (e.g. changing diet, improving exercise). On the other hand, however, they may have considered this statement from a professional perspective in terms of whether or not dementia could be treated, or if the course of the illness was dependent on their actions as a nurse. For a further exploration of the limitations of this tool, please refer to Section 4.2.2.3.

It is also possible that respondents were influenced by social desirability bias (Bowling, 2001) by reporting what they believed to be the accepted norms for professionals, as reporting otherwise may have indicated that they held negative views about older people and they may have feared the consequences of this. For example, being reprimanded or removed from their post.

Upon reflection, it would have been interesting to explore the extent to which a nurse's personal representation of dementia impacted on their practice. For example, if a nurse feels depressed or sad when they think about dementia, are they more likely to objectify a patient with dementia in their care or to dissociate from them (Hochschild, 1983).

Furthermore, it may have been more revealing to explore a model of 'patient representation', as opposed to a model of illness representation, whereby healthcare professionals' perceptions of older patients are explored in terms of aspects such as illness trajectory, likelihood of recovery, age, time spent in hospital, influence of illness on their ability to perform their role as a nurse etc.

4.2 Study limitations

The following section aims to explore the methodological inadequacies of the current study in greater depth. Limitations in the employment of a quantitative methodology will be discussed, alongside the drawbacks of using attitudinal measures (both in general terms and with respect to some of the particular instruments that were used in this study).

4.2.1 The limitations of attitudinal measures

As illustrated in previous chapters, a wide range of factors can influence the development and applications of attitudes, including knowledge and understanding and the context within which this is applied, cultural influences and beliefs, and a person's view of their role within a particular group (Allport, 1954; Hazan, 1994). One could therefore argue that the use of attitudinal measures in isolation serves to provide a somewhat static and one-dimensional snapshot of nursing staff views, as they fail either to encapsulate the fluid nature of an individual's attitudes, or to account for the potential fluctuation in staff views that can arise in response to a number of variables (e.g. staffing levels or the suitability of the ward environment; Higgins *et al*, 2007).

According to Hazan (1994), several opposing views can be held on a particular topic at any one time, which can either be acted upon or ignored depending on the circumstances. Such issues are evident in the attitudinal shifts that can arise as a consequence of professional socialisation, as in order to 'fit in and muck in', nursing staff may have to adopt attitudes or behaviours that apply to their role or particular ward environment, in spite of the fact that these views may not reflect their own personal stance (Norman, 2006, p.11). This issue was also highlighted in a study by Quinn *et al*, (2009), in which participants were noted to simultaneously hold conflicting positive and negative attitudes towards ageing and mental health.

Bearing in mind the propensity for attitudinal change and the limitations of quantitative measures in exploring more than one viewpoint at any one time, one might argue that it is difficult to determine exactly *which* stance is being measured by these instruments. On the one hand, attitudinal measures may assess the *personal* views nursing staff hold about older people and those with dementia, whilst on the other, they may simply represent the views they feel *obliged* to hold in order to be politically correct or to 'get the job done'. For example, those working on a ward with a high number of older people may not wish to voice any negative views towards this patient group, given the likelihood of action by management. This may serve to influence reporting regardless of the validity and reliability of the measures used. It was hoped that the quantitative nature of the study would allow nursing staff to express their views more freely than in an interview format, however the possibility of this bias remains.

This was highlighted by Bowling (2001), who reported that the view shared by participants in attitudinal research can often be subject to social desirability bias, whereby respondents are more likely to share the views they consider to be socially or politically acceptable than those which reflect their true opinions for fear of reprisal.

Although Davison and Philp (2003) highlighted the importance of tackling ageist attitudes in the healthcare profession, it is clear that one must carefully consider the manner in which one goes about making these changes, as well as the method used to

measure attitudinal change. Otherwise there is a danger that healthcare professionals will simply pay lip service to what they have been taught to think about certain patient groups, as opposed to what they continue to think, in order to avoid conflict. This can prevent further discussion about deeper issues that need to be resolved, such as the removal of barriers that provide additional challenges to working with this patient group.

On reflection, it is also interesting to consider the impact of these issues on the outcome of the current study, as it is unclear as to whether or not the same attitudinal stance is presented throughout the whole sample. For example, some participants may feel more comfortable than others about sharing their personal views with a researcher. As a consequence of this, a mixed bag of viewpoints can merge within one dataset; some of which represent the personal views of respondents and others which represent a political ideal.

One might also propose that the use of attitudinal measures in the absence of further qualitative exploration serves to divorce participants' views from the context in which they have developed. This may consequently lead to the conclusion that the views provided by respondents on a particular questionnaire are applicable across all situations, when in reality this process is likely to be far more complex.

The importance of context was particularly evident during the data collection process upon visiting one of the general medical wards. On this occasion a large proportion of

patients were recovering from an outbreak of an infectious illness and as several nursing staff had also fallen ill, the ward was understaffed. The remaining nurses described the challenges they faced in caring for patients with dementia under these circumstances, such as keeping wandering patients safe in an unsecure ward, whilst attempting to change bedding and move high dependency patients in the process. Implications for patient care and infection control were also discussed, as nursing staff explained that patients with dementia often removed intravenous lines that were provided to rehydrate them. These patients were also considered to pose a risk to others in terms of spreading infection, as they tended to wander when attempts were being made to isolate infected patients or to disinfect areas of the ward. If those wandering also contracted the illness, this was even more problematic.

Bearing this in mind, one could argue that a staff member completing a questionnaire about caring for people with dementia might have a very different viewpoint on this occasion, in comparison to the views that they might share at a more manageable time. Certain situations may therefore result in cognitive dissonance, whereby the desire to adhere to the 'gold standard' approach may be outweighed by the importance of meeting other needs, such as preventing the spread of a potentially lethal infection.

This observation highlights the importance of context in attitudinal research, as it is often these issues that need to be addressed in order to improve patient care, as opposed to the views of an individual nurse. For example, if more nursing staff are

available, they may feel less stressed and have more time to spend with individual patients, which could have a direct impact on the way they feel about working with this patient group.

By gathering anecdotal information, some context was provided in this study; however, this may have been somewhat richer had a mixed methodology been adopted and the information described above gathered via interview as opposed to observation. This will be discussed in greater depth, with reference to the limitations of the design, in the following section.

One might also argue that the use of attitudinal measures alone fails to explore potential links between attitudes and practice. This may be considered as a limitation in this case, which merits further investigation in the future. As discussed previously, this was outwith the remit of the current study given the length and nature of the observation required. Perhaps future research might explore the use of questionnaires or interviews to encourage staff to discuss their management techniques with this patient group as a suitable alternative to lengthy observations.

4.2.2 Methodological limitations

As a number of methodological limitations have already been highlighted throughout this chapter, this section aims to focus specifically on the use of a quantitative methodology in the current study.

In some respects, the employment of a quantitative methodology in the absence of further qualitative exploration could be called into question, as one might argue that the use of attitudinal measures alone provides less scope to explore the wider context within which these attitudes have developed (Bowling, 2001; Field, 2009).

Although some context was provided in terms of demographic and anecdotal information in this study, perhaps a mixed methodology would have allowed for a richer exploration of these issues and for broader themes to be considered. In some respects, this approach may have proven problematic with this particular participant group, as it was challenging to arrange brief meetings with nursing staff to discuss the current study. As a mixed methodology would also have involved participation in interviews, it may have been difficult to encourage staff to take part, as a consequence of the time pressures on their part.

One might also argue that a quantitative methodology provides participants with greater anonymity than a qualitative approach, as views can be aired in private. With this in mind, it was felt that a quantitative approach would encourage nursing staff to take part by allowing them to take part in their own time, whilst the anonymity of this approach was hoped to reduce social desirability bias. It was hoped that this approach would also prevent individuals taking on the view of the group, which can often occur in focus group settings (Bowling, 2001).

Although there are clearly some methodological limitations in the current study, it is important to reiterate that very little research which simultaneously examines nursing staff attitudes towards older people, older people with dementia and the illness of dementia has been carried out to date.

Of the research conducted on nursing staff views in relation to older people and older people with dementia, it was clear that the vast majority of research has been carried out by practicing nurses or researchers in the field of nursing (Courtney *et al*, 2000; Higgins *et al,* 2007; Hope, 1994; Kearney *et al,* 2000; Norman, 2006; Tierney *et al,* 1998; Stevens & Crouch, 1995; Stockwell, 1972) whilst fewer studies were carried out by those in non-nursing professions (Cummings, Galambos & DeCoster, 2003; Hinrichsen & McMeniman, 2002). As a researcher in the nursing profession analysing the behaviour of fellow nurses towards patients with dementia, Norman (2006) noted that her relationship with her colleagues changed to one of an outsider, as she was no longer viewed as an in-group member, but as someone evaluating their work. It is therefore likely that undertaking attitudinal research with nursing staff as an outsider to the profession and to the wards invited to take part in the study had an impact on the return rates, as well as on the responses that were provided.

On the other hand, perhaps it could be argued that researchers and non-ward members will always be viewed as 'outsiders' regardless of professional status and as a result of this it may be easier for respondents to provide an honest opinion to an outsider, as the nature of their responses may have been less likely to have repercussions than if

the research was carried out by a nursing manager. Either way, it is clear that the relationship the researcher has with the respondents may serve to influence the responses that they provide in many respects.

Furthermore, research on illness representations of dementia is currently limited to people with dementia and their first degree relatives (Clare *et al*, 2006; Roberts & Connell, 2000); despite the fact that the illness representations held by healthcare professionals may have a part to play in the way they react to patients with particular illnesses (Ogden, 1996). With this in mind, it was felt that aspects of this study could add new information to this area, as well as highlighting themes for future qualitative research, in spite of its limitations.

4.2.2.1 Limitations of the Kogan's Attitudes to Older People Scale

Although the KAOP scale is one of the most widely used measures in assessing the attitudes of nursing staff towards older people, the validity of its use with healthcare professionals has been widely debated (Courtney, *et al,* 2000; Higgins *et al,* 2007; Ingham & Fielding, 1985).

As the highest percentage of missing data in this study is from the KAOP scale, this may indicate specific weaknesses in this measure, such as poor wording, the use of double negatives, or the fact that participants were unable to provide a neutral response (Bowling, 2001).

In general terms, as the scale was developed in the early 1960's, one might consider it to be somewhat outdated. Bearing in mind the influence of social and cultural norms on the definition of old age, for example, one might argue that society's perception of when one becomes 'old' or of what it means to be an 'older person' may have changed a great deal over the past forty to fifty years (Schenk & Achenbaum, 1994).

As the KAOP scale was not designed for use in acute hospital settings, this may also have an impact on its validity and the way it ought to be interpreted (Ingham & Fielding, 1985). For example, upon considering the statement 'it would probably be better if most old people lived in residential units with people their own age', participants in a healthcare population may consider this to apply to a hospital setting, whilst the college students in Kogan's original sample may have applied this statement to a more generic setting, such as sheltered housing.

With this in mind, whether one's response to a particular item on the KAOP scale is considered to denote a positive or negative attitude might depend on the value a respondent has attributed to that statement. For example, a healthcare professional's view that an older person would be better placed on a ward with people of a similar age range might be deemed as positive, as this may result in that person receiving a more specialist service. If viewed in a more generic context, agreeing with that statement could be viewed as negative, as in this context, there is a sense that older people ought not to be part of the community and that it would be better if they were segregated. It is important that these subtleties are fully considered, as participants

from healthcare populations could otherwise be labelled as having negative attitudes; purely as a consequence of poor wording and questionnaire design (Bowling, 2001).

In a similar vein, it would have been clear to the students in Kogan's original group that they were being asked to ascribe a value to statements about older people in a generic sense. Whilst using this measure with healthcare professionals, however, this distinction may be somewhat blurred, as on the one hand, they may be making generic statements about older people, whilst on the other, they may be making statements about the older people in their care. This is particularly important as values ascribed to older *people* and older *patients* may be very different, which brings the validity of this measure with healthcare professionals into question.

As a consequence of these difficulties, alternative measures were considered; however, many of these were felt to be unsuitable for the purpose of this study. For example, sub-scales of the Attitudes to Ageing Questionnaire (AAQ) could not be used as an alternative, as it measured participants' attitudes to their *own* ageing, as opposed to the ageing of others (Laidlaw *et al,* 2007). These researchers deliberately chose to develop a scale that would be primarily used to ask older people about their attitudes towards ageing as it was considered the only sensible approach to understand ageing; that is by asking the group with the greatest level of knowledge about the subject – older people themselves. The stance adopted was as much as political stance as a research one as the AAQ scale was explicitly developed to be useful for policy makers as well as a research tool.

Given the dearth of validated questionnaires that have developed to measure attitudes towards older people, alongside the frequent use of this measure with nursing professionals, it was felt that the KAOP questionnaire ought to be included in the current study in spite of its apparent limitations. This also allowed the outcome to be compared with the existing evidence base more easily.

4.2.2.2 Limitations of the ADQ-19

Although the ADQ-19 (Lintern, 2000) was considered to be a well-validated tool in many respects, it has mainly been used in residential settings, such as nursing homes. Aspects of this measure may consequently be interpreted differently by nurses in acute hospital settings. In comparison to nursing home settings, for example, many of the older people with dementia in hospital settings are in fact 'sick and need to be looked after', as they are likely to be receiving treatment for complex physical health conditions. In this context, agreeing with this item may not be indicative of the infantalisation of this patient group, as it might in other settings. With this in mind, perhaps some elements of this questionnaire ought to be interpreted with caution.

Furthermore, upon considering the item 'there are lots of things that people with dementia can do', it would be interesting to explore what nursing staff consider those to be and whether or not those serve to contribute to their status as a 'popular' patient (Stockwell, 1972). For example, do staff perceive patients with dementia as being

able to support themselves and to co-operate with nursing interventions and if not, how does it influence their overall view of this patient group (Baltes & Wahl, 1992).

As a consequence of this, it may have been beneficial to explore aspects of this questionnaire, in order to gain a wider understanding of contextual factors. For example, although the ADQ-19 refers to people with dementia, it does not include any items that explore the potential difficulties of caring for people with dementia in conjunction with additional health problems or the issues that this can pose in providing effective treatment.

As discussed previously, this measure also failed to examine views on managing CB with this patient group, which may have inadvertently led to the examination of dementia patients who fit the 'warm but incompetent' stereotype (Cuddy & Fiske, 2002), as opposed to those who present more of a challenge to nursing staff. This may have led to a positive bias in the results.

Given the particular challenges for nursing staff in caring for patients with dementia on general medical wards (Norman, 2006; Pritchard & Dewing, 2001; Schell, 2001), it might be richer to examine the relationship between the attitudes that are held on the ADQ-19 and the personal experiences of staff in caring for this patient group. As discussed previously, their may be a gulf between the 'gold standard' of care that staff wish to provide and the reality of everyday practice. This can result in the

marginalisation of this patient group, in spite of the positive intentions of nursing staff.

It would perhaps be more satisfactory if tools existed to assess the 'dependency support' concepts (Baltes & Wahl, 1992), or to assess challenging behaviour in general medical settings, however such measures were either missing from the literature or deemed inadequate for use in the current study, as previously discussed.

4.2.2.3 Limitations of the IPQ-RH

The IPQ-RH (Figuerias & Alves, 2007) was chosen in this study as unlike its predecessors, it allows the views healthy subjects hold about a particular illness to be explored, instead of its use being restricted only to those who suffer from that illness. This allowed nursing staff views on the illness of dementia to be explored in isolation from the *person* with dementia, in order to find out if the attitudes held towards that illness might stem from fears about the illness itself, difficulties in managing the presentation of the illness in patients, or perhaps even both.

However, the IPQ-RH (Figuerias & Alves, 2007) may not be the most optimal comparative measure for the purpose utilised here. Similarly to the IPQ-R (Moss-Morris *et al,* 2002), the IPQ-RH has been used primarily as an exploratory tool to gain knowledge about the illness representations of individuals. As the questionnaire was only recently developed, there was also a lack of evidence available to explore its

use with additional groups of healthy subjects, outwith those who were recruited to aid in its development (Figuerias & Alves, 2007). With this in mind, the IPQ-RH may be better used as an exploratory tool to gain knowledge about the illness representations held by nursing staff in relation to particular illnesses.

Given the nature of their training, one might argue that nursing staff are likely to have similar views on the severity and trajectory of an illness, even though they do not have as much experience in dealing with the particular illness firsthand. This could arguably account for the similar scores in the psychiatric and general medical groups.

It would be interesting to explore the illness representations section of the questionnaire further by means of a qualitative study, in which nurses could be invited to discuss the impact their views have on caring for this patient group. For example, does feeling angry or sad about dementia have an impact on the way in which nursing staff care for patients with dementia, or does professional socialisation take over?

As stated previously, the IPQ-RH (Figuerias & Alves, 2007), was designed to explore the views of a lay person about an illness, as opposed to examining the views of a person suffering that illness. Upon using this measure with health professionals, it is clear that it may require further adaptation. As stated previously, perhaps the personal views a nurse holds about contracting an illness such as dementia differ greatly from their views about working with or managing the behaviour of a patient with dementia.

This outcome of the current study therefore highlights a gap in the literature and a need either for the further adaptation of this measure, or for the development of new measures, in order to examine these issues in greater depth.

4.2.3 Sample size

Despite continued attempts to increase the level of respondents via telephone, e-mail and arranging personal meetings with staff members, the response rate was low (psychiatric sample, 45 participants (which equates to 20 per cent of the potential pool); general medical sample, 28 participants (which equates to 10 per cent of the potential pool)). Unfortunately frequent viral outbreaks on the ward also limited access, as well as the ability of nurses to respond due to the consequent high levels of staff sickness and low staffing levels at these times.

As a consequence of the low response rate the study was underpowered, as according to Cohen (1992), at least 64 participants were required in each group in order to attain a medium effect size ($d = 0.5$).

This is not comparable to previous studies, which had much higher return rates (e.g. Hope (1994) who reported a return rate of 58 per cent whilst Kearney *et al.* (2000) also reported a return rate of 58 per cent). As both of these studies were conducted by fellow nursing staff and not an outsider to the profession and the wards in question, one might argue that this supported a higher rate of return.

Ideally, more participants were required; however, as none of the comparisons were close to being significant upon observation of the means, a greater number of participants may have served to strengthen the existing results, as opposed to increasing the possibility of inter-group difference.

As ethical approval was only granted for one healthcare region it was difficult to gain a greater number of participants who met the criteria for this study. Furthermore, recruitment was restricted due to a number of ward-based infections, which resulted in ward closures and a high rate of staff sickness. This made it challenging to arrange staff meetings and distribute questionnaires, whilst the resulting strain on the service may have impacted on return rates.

4.3 Clinical implications

Given that the difference in the attitudes nursing staff held towards older people with dementia was not significant between groups, in spite of significantly more participants in the psychiatric group having additional training in dementia care, this raises some questions about the role of training in clinical practice.

The extreme stance might be that additional training fails to have a considerable impact on the nature of staff attitudes towards older people and older people with dementia. Interestingly, however, a number of respondents in both groups indicated

that training would help them to improve their confidence in better managing patients with dementia. Although links between confidence and level of training were not widely explored, it is clear that training is considered useful by nursing staff – even though the relationship between training, attitudinal development and quality of care continues to require further exploration.

Interestingly, other comments provided evidence to the contrary, with some participants noting that training in control and restraint would improve their confidence in dealing with this patient group, as opposed to training in psychological approaches to dementia care. Perhaps this illustrates time pressures in the ward environment, as the priority for these respondents was the provision of a fast solution to contain a patient, as opposed to an approach which allows a deeper understanding of the patient but takes more time and resources to implement.

Perhaps the presence of barriers in the nursing environment can prevent the application of existing positive attitudes, or the administration of new approaches. The current study revealed potential barriers in relation to the ward environment, as well as some indications of difficulties with staff shortages and aspects of management. In fact, several respondents in both groups felt that an improvement in staff numbers alone would serve to improve their confidence in managing patients with dementia who present with challenging behaviour. Any potential links between practice, confidence and staffing levels could not be examined in this instance.

With this in mind, one could also argue that any benefits of training cannot be successfully administered if such barriers are in existence and remain unaddressed. This reflects the view of Zimmerman *et al.* (2005) who reported that training alone did not have a direct influence on practice, unless it was embedded within a positive culture that promoted staff well-being. Perhaps ward based training would be more beneficial than rolling out a blanket program which may not suit the needs of individual settings and therefore dishearten those who attend and wish to improve the quality of care for this patient group.

4.4 Implications for further research

A number of potential areas for future research have been discussed in detail throughout this chapter, some of which include the wider examination of aspects of knowledge, contact, differences in training, compliance with treatment and the exploration of dependency levels. In order to avoid repetition, any further avenues for research which have not yet been discussed are presented in this section.

Although there is some evidence that attitudes can have an impact on one's behaviour, this link should not be overstated, as a confluence of additional factors can interfere with whether or not one follows through with a particular behaviour, such as cognitive dissonance, cultural beliefs, moral issues, professional boundaries, social desirability or external pressures (e.g. time limitations, stress) to name but a few (Allport, 1954; Barker, 2003; Hazan, 1994, Zimmerman *et al*, 2005).

With this in mind, it would be interesting to explore the ways in which the attitudes held by nursing staff might impact on real life practice. For example, do the positive attitudes held by the nursing staff in this study actually translate into a high standard of care for older patients in their care?

Although attempts have been made to investigate these issues via Dementia Care Mapping (DCM) and observation (Norman, 2006) this can be time consuming and difficult to achieve as part of one's professional practice. It might be more beneficial to employ a mixed methodology which explores staff attitudes via quantitative measures and explores this in greater depth with the employment of a qualitative approach, such as semi-structured interviews, focus groups or vignettes. As potential barriers to carrying out practice have been highlighted in the current study, it may also be useful to explore the 'ideal' service that nurses would like to provide for older patients and for older patients with dementia and to explore the factors that can prevent this.

In a similar vein to Morris *et al.* (2007), it may also be beneficial to conduct a triangulation of user and staff experience, in order to explore the factors influencing staff and patient morale, as well as the views of nurses and older patients regarding care provision. This could provide a more balanced view, as the views of those receiving treatment can be married with the views of those providing it and any inconsistencies examined.

It may also be useful to explore whether there is a relationship between the level of stress and burnout, level of training and experience and the level of confidence in nursing staff who work with older people with dementia, as well as the factors which serve to reduce stress and improve confidence levels. Given the potential influence of high stress levels on the quality of care patients receive (Zimmerman *et al*, 2005), this would be an interesting avenue to pursue.

Given the dearth of validated measures, which specifically assess the attitudes healthcare professionals hold towards older patients, this issue could not be fully addressed in this study and more generic views of older people were employed instead. The development of a measure to assess the attitudes of healthcare professionals towards older patients (or towards the patients in their care in general to allow comparisons to be made between age groups), is a necessary element in order to provide a step forward in achieving a more rounded view allowing staff views to be better placed into context.

Finally, in terms of nursing staff views on dementia, it would also be interesting to assess whether ageism can have an impact on the care that is provided to older patients with dementia in comparison to their younger counterparts. Further exploration of the illness representations healthcare professionals hold about dementia might be beneficial in doing this, as ageing was considered to be the major causal factor in the development of dementia in this study. It is of course difficult to

determine whether this was an indication of the increased likelihood of dementia developing, or whether it may have signified a more global view that dementia is a consequence of ageing, as opposed to something that becomes more prevalent with age.

4.5 Conclusion

Overall the findings highlight the complex nature of attitudinal research, as the attitudes of healthcare professionals can be shaped by a plethora of factors. Contrary to previous findings, analysis indicated that the majority of nursing staff in both groups held positive attitudes towards both older people and older people with dementia, whilst no significant difference in nursing staff attitudes between the psychiatric and general medical groups was reported. Similarly, no significant difference in nursing staff attitudes was reported between groups towards the illness of dementia. There was a significantly positive correlation between the attitudes nursing staff held towards older people and older people with dementia across the whole sample.

Upon further examination, factors such as the age of respondents and the level of staff training and experience may have influenced the outcome in this instance and were considered as areas of future investigation. A disparity between the level of confidence nursing staff had in dealing with dementia and the level of training they had received was also identified, however, further research would be required in

order to discover if confidence is improved by training and if this results in a greater level of competence in managing the care of those with dementia. Difficulties in translating the impact of the results on practice were also noted, as very few studies have attempted to examine these issues fully.

Methodological issues were also raised. For example, it was noted that available attitudinal measures do not distinguish between older people and older patients effectively, which may have had an impact on the outcome of this study. Perhaps these tools do not measure attitudes towards older patients in these settings as effectively as was hoped? One might therefore argue that attitudinal measures fail to capture the real views of staff, or that the nature of attitudinal scales fail to provide enough scope to explore the complex nature of attitudes.

With this in mind, the current study may not truly address the more complex brands of ageism that older people are purported to face. It does, however, provide a foundation for future study, as these issues have been raised as a consequence of the research process. Furthermore, no previous studies have set out to examine any potential differences in staff attitudes between psychiatric and general medical settings. As a number of views were shared by respondents in these groups, one might argue that this also has implications for future research and the manner in which training in dementia care is applied.

5. REFERENCES

Age Concern. (2000). *How Ageist is Britain?* London: Age Concern England.

Age Concern. (2007). *Improving Services and Support for Older People with Mental Health Problems*. London: Age Concern England.

Allport, G. (1954). *The nature of prejudice*. Reading MA: Addison-Wesley Publishers.

Alzheimer's Society. (2007). *Dementia UK: The full report.* London: Alzheimer's Society.

Alzheimer's Scotland. (2008). *Statistics: Number of people with dementia in Scotland*. Retrieved on 22 May 2008 from alzscot.org/pages/statistics.htm.

Astrom, S., Nilsson, M., Norberg, A. & Sandman, P.O. *et al.* (1991). Staff burnout in dementia care: Relations to empathy and attitudes. *International Journal of Nursing Studies, 28(1)*, 65-75.

Azjen, I. (1989). Attitudes structure and behaviour. In A.R. Pratkanis, S.J. Breckler & A.G. Greenwald (Eds.) *Attitude structure and function* (pp.241-252). London: LEA Publications

Ballard, C.G., Powell, I., James, I., Reichnell, K., Myint, P. & Potkins, D. *et al.* (2002). Can psychiatric liaison reduce neuroleptic use and reduce health service utilization for dementia patients residing in care facilities? *International Journal of Geriatric Psychiatry, 17*, 140-145.

Baltes, M.M & Wahl, H. (1992). The dependency-support script in institutions: generalization to community settings. *Psychology and Ageing*, 7(3*), 409-418.*

Barker, P. (2003). *Cognitive dissonance*. Retrieved on 27 August 2008 from beyondintractibility.org/essay/cognitive_dissonance.

Basnett, I. (2001). Health care professionals and their attitudes toward and decisions affecting disabled people. In G.L. Albrecht, K.D. Seelman & M. Bury (Eds.) *Handbook of disability studies* (pp. 450-467). London: Sage Publications.

Beck, A.T. (1976). *Cognitive therapy and emotional disorders*. New York: International Universities Press.

Blanchard, M. (1992). The elderly. *International Review of Psychiatry, 4 (3-4),* 251-256.

Blythe, R. (2005). *The view in winter: reflections on old age*. Norwich: Canterbury Press.

Borbasi, S., Jones, J., Lockwood, C. & Emden, C. (2006). Health professionals' perspectives of providing care to people with dementia in the acute setting: toward better practice. *Geriatric Nursing*, 27 (5), 300-308.

Bowling, A. (2001). *Measuring disease: A review of disease specific quality of life measurement scales*. Buckingham: Open University Press.

Brodaty, H., Draper, B. & Low, L.F. (2003). Nursing home staff attitudes towards residents with dementia: strain and satisfaction with work. *Journal of Advanced Nursing, 44(6)*, 583-590.

Burns, N. (1992). Measuring cancer attitudes. In M. Frank-Stromborg (Ed): *Instruments for clinical nursing* (pp. 297-309). San Francisco, CA: Jones and Bartlett.

Butler, R.N. (1975). *Why survive? Being old in America.* New York: Harper & Row.

Bytheway, B. (1995). *Ageism.* Maidenhead: Open University Press.

Cheston, R. & Bender, M. (2002). *Understanding dementia: the man with the worried eyes.* London: Jessica Kingsley Publishers.

Clare, L., Goater, T. and Woods, B. (2006). Illness representations in early-stage dementia: a preliminary investigation. *International Journal of Geriatric Psychiatry*, 21, 761-767.

Clark-Carter, D. (2004). *Quantitative psychological research: a student's handbook.* Hove: Psychology Press.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112 (1)*, 155-159.

Coleman, P.G. (1996). Identity management in later life. In R.T. Woods (Ed.) *Handbook on the clinical psychology of ageing* (pp.93-114). Chichester: John Wiley and Sons.

Commission for Healthcare Audit and Inspection. (2006). *Living Well in Later Life: A Review of the Progress Against the National Service Framework for Older People.* London: Author.

Courtney, M., Tong, S. & Walsh, A. (2000). Acute care nurses' attitudes toward older patients: a literature review. *International Journal of Nursing Practice*, *6*, 62-69.

Cuddy, A.J.C. and Fiske, S.T. (2002). Doddering but dear: process, context and function in stereotyping of older persons. In T.D. Nelson (Ed.) *Ageism: stereotyping and prejudice against older persons* (pp 3-26). Massachusetts: MIT Press.

Cuddy, A.J.C., Norton, M.I., Fiske, S.T. (2005). This old stereotype: the pervasiveness and persistence of the elderly stereotype. *Journal of Social Issues*, 61(2), 267-285.

Cummings S. & Galambos, C. (2002). Social work student attitudes toward and interest in working with the elderly: Impact of an educational intervention. *Journal of Gerontological Social Work, 39 (3),* 77-94.

Cummings, S., Galambos, C., & DeCoster, V. (2003). Predictors of MSW employment in gerontological practice. *Educational Gerontology, 29 (4)*, 295-312.

Davison, S. and Philp, I. (2003). Time to deliver with dignity. *British Medical Journal*, 326, 1300.

Day, K., Carreon, D. and Stump, C. (2000). The therapeutic design of environments for people with dementia: a review of the empirical research. *The Gerontologist, 40 (4)*, 397-416.

Department of Health. (2003). *Discharge from hospital: getting it right for people with dementia: a supplementary checklist to help with planning the discharge from acute general hospital settings of people with dementia.* London: Health & Social Care Change Agent Team/Department of Health.

Desforges, D.M., Lord, C.G., Ramsey, S.L., Mason, J.A., Van Leeuwen, M.S., West, S.C. *et al.* (1991). Effects of structured cooperative contact on changing negative attitudes toward stigmatised social groups. *Journal of Personality and Social Psychology, 60 (4),* 531-544.

Dugan, M.A. (2004). *Prejudice.* Retrieved on 8 September 2008 from beyondintractability.org/essay/prejudice.

Erikson, E. (1997). *The life cycle completed: a review*. WW Norton & Co: London, New York.

Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.

Field, A. (2009). *Discovering statistics using SPSS (3rd edn)*. London: Sage Publications.

Figuerias, M.J. & Alves, N.C. (2007). Lay perceptions of serious illnesses: an adapted version of the Revised Illness Perception Questionnaire for healthy people. *Psychology and Health, 22 (2)*, 143-158.

Fiske, S.T., Cuddy, A.J.C. & Glick, P. (2002). A model of (often mixed) stereotype content: competence and warmth respectively followed from perceived status and competition. *Journal of Personality and Social Psychology, 82(6),* 878-902.

Gerdner, L.A. & Buckwater, K.C. (1994). A nursing challenge: assessment and management of agitation in Alzheimer's patients. Journal of Orthopaedic Nursing, 20(4), 20. In E. Pritchard & J. Dewing (2001). Older people with dementia in acute settings. *Nursing Older People, 12 (10),* 21-25.

Gilleard, C. & Groom, F. (1994). A study of two dementia quizzes. *British Journal of Clinical Psychology*, 33, 529-534.

Health Advisory Service 2000. (1998). *'Not Because They Are Old': An Independent Inquiry into the Care of Older People in Acute Wards in General Hospitals'*. London: Health Advisory Service.

Hazan, H. (1994). *Old age: constructions and deconstructions*. Cambridge: Cambridge University Press.

Helmuth, A.M., Lookinland, S., Anson, K. & McCabe, B.W. (1995). Nurses' attitudes toward older persons on their use of physical restraints. *Orthopaedic Nursing, 14*, 43-51.

Higgins, I., Van der Riet, P., Slater, L. & Peck, C. (2007). The negative attitudes of nurses towards older patients in the acute hospital setting: a qualitative descriptive study. *Contemporary Nurse: a Journal for the Australian Nursing Profession*, 26 (2), 225-237.

Hinrichsen, G.A. & McMeniman, M. (2002). The impact of geropsychology training. *Professional Psychology: Research and Practice, 33*, 337-340.

Hochschild, A. (1983). *The managed heart: Commercialization of human feeling.* Berkeley: University of California Press.

Hogg, M. & Vaughan, G. (2005). *Social Psychology (4th edn).* London: Prentice Hall.

Hope, K.W. (1994). Nurses' attitudes towards older people: a comparison between nurses working in medical and acute care of elderly patients' settings. *Journal of Advanced Nursing, 20*, 605-612.

ISD Scotland. (2009).*Acute Hospital Activity (annual and quarterly data to 31 March 2009).* Retrieved on 26 July 2009 from isdscotland.org.

JIT Scotland (2009). *Delayed discharge: Improving outcomes round table event. Focus on older people*. Event report 18th September 2009.

Katz, D. and F.H. Allport (1931). *Student attitudes*. Syracuse, N.Y.: Craftsman.

Kearney, N., Miller, M., Paul, J. & Smith, K. (2000). Oncology healthcare professionals' attitudes toward elderly people. *Annals of Oncology, 11*, 599-601.

Kirby, L. (1998). Dementia is people aged 65 and older: a growing problem? *Population Trends*, *92*, 23-28.

Koder, D. A. & Helmes, E. (2008). Predictors of interest in working with older adults: A survey of post-graduate trainee psychologists. *Gerontology and Geriatrics Education, 29*, 158-171.

Kogan, N. (1961). Attitudes toward old people: the development of a scale and an examination of correlates. *Journal of Abnormal and Social Psychology*, 62, 44-54.

LaPiere, R.T. (1934). Attitudes vs. actions. *Social Forces*, *13(2),* 230-237.

Laidlaw, K. & Pachana, N. (2009) Aging, mental health and demographic change: Challenges for psychotherapists. *Professional Psychology: Research and Practice, 40 (6),* 601-608.

Laidlaw, K., Thompson, L.W., Dick-Siskin, L. & Gallagher-Thompson, D. (2003) *Cognitive behaviour therapy with older people*. Chichester: John Wiley and Sons.
Laidlaw, K., Power, M.J., Schmidt, S. & the WHOQOL-OLD Group (2007) The attitudes to ageing questionnaire (AAQ): development and psychometric properties. *International Journal of Geriatric Psychiatry, 22,* 367-379.

Laungani, P. (2005) Stress in a life threatening illness. In C.D. Spielberger & I.G. Sarason (Eds.). *Stress and emotion: anger, anxiety and curiosity* (pp.3-26). CRC Press.

Levy, B.R. (1996). Improving memory in old age by implicit self-stereotyping. *Journal of Personality and Social Psychology, 71 (6),* 1092-1107.

Levy, B.R. (2003). Mind matters: Cognitive and physical effects of aging self-stereotypes. *Journal of Gerontology. Series B: Psychological Sciences and Social Sciences, 58B (4)*, 203-211.

Levy, B.R. & Banaji, M. R. (2002). Implicit ageism. In T. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 49-75). Cambridge, MA: MIT Press.

Lintern, T., Woods, B. and Phair, L. (2000). Before and after training: a case study of intervention. *Journal of Dementia Care, 8,* 15–17.

Lothian, K. & Philp, K. (2001). Care of older people: maintaining the dignity and autonomy of older people in the healthcare setting. *British Medical Journal, 322,* 688-670.

MacDonald, A.J.D. & Woods, R.T. (2005). Attitudes to dementia and dementia care held by nursing staff in U.K. "non-EMI" care homes: what difference do they make? *International Psychogeriatrics, 17(3)*, 383–39.

Marshall, M. (1999). 'They should not really be here' – people with dementia in the acute sector. *Age and Ageing, 28*, 9-11.

Marshall, M. (2001). The challenge of looking after people with dementia. *British Medical Journal*, 323, 410-411.

McCloskey, R.M. (2004). Caring for patients with dementia in an acute care environment, *Geriatric Nursing, 25(3),* 139-144.

Moniz-Cook, E., Woods, R. & Gardiner (2000). Staff factors associated with perception of behaviour as 'challenging' in residential and nursing homes. *Ageing & Mental Health, 4(1)*, 48-55.

Morris, R., Payne, O. & Lambert, A. (2007). Patient, carer and staff experience of a hospital-based stroke service. *International Journal for Quality in Health Care, 19(2),* 105-112.

Moss-Morris, R., Weinman, J., Petrie, K.J., Horne, R., Cameron, L.D. & Buick, D. (2002). The revised illness perception questionnaire (IPQ-R). *Psychology and Health, 17(1),* 1-16.

National Audit Office. (2007). *Improving Services and Support for People with Dementia.* London: The Stationery Office.

Nay, R. & Garratt, S. (2004). *Nursing Older People: issues and innovation (2nd edn).* Sydney: Churchill Livingstone.

Norman. R, (2003). Acute nursing care for people with dementia. *What happens when a person with dementia is admitted to hospital for acute care?* Faculty of health and social care: University of the West of England, Bristol. Unpublished PhD thesis.

Norman, R. (2006) Observations of the experiences of people with dementia on general hospital wards. *Journal of Research in Nursing, 11 (5),* 453-465.

Ogden, J. (1996). *Health psychology: a textbook.* Buckingham: Open University Press.

The Oxford English Dictionary. (2008). Oxford: Oxford University Press.

Palmore, E. (1977). Facts on aging: A short quiz. *Gerontologist, 17,* 315-320.

Palmore, E. (1990). *Ageism: negative and positive.* New York: Springer.

Penner, L.A., Ludenia, K. & Mead, G. (1984). Staff attitudes: image or reality? *Journal of Gerontological Nursing, 10,* 110-117.

Pratkanis, A.R., Breckler, S.J. & Greenwald, A.J. (1989). *Attitude structure and function.* Hillsdale, NJ: LEA.

Prevost, S., Wilson, E. & Gerber, D. Acute care nurses' knowledge and attitudes related to aging. *Heart and Lung, 20,* 302.

Pritchard, E. and Dewing, J. (2001). Older people with dementia in acute settings. *Nursing Older People, 12(10),* 21-25.

Quinn, K.M., Laidlaw, K. & Murray, L.K. (2009). Older peoples' attitudes to mental illness. *Clinical Psychology and Psychotherapy, 16(1),* 33-45.

Roberts, J.S. & Connell, C.M. (2000). Illness representations among first-degree relatives of people with Alzheimer disease. *Alzheimer Disease and Associated Disorders, 14 (3),* 129-136.

Royal College of Nursing (2008). *An Ageing Population: Education and Practice Preparation for Nursing Students Learning to Work with Older People.* London: Author.

Schell, E.S. (2001). Nurses' perceptions of elderly patients. *Age and Ageing,* 30, 367-368.

Scottish Executive. (2002). *Adding Life to Years: Report of the Expert Group on Healthcare of Older People.* Edinburgh: Crown Copyright.

Scottish Executive. (2005). *Building a Health Service Fit for the Future.* Edinburgh: Crown Copyright.

Scuffham, P., Chaplin, S. & Legood, R. (2003). Incidence and costs of unintentional falls in older people in the United Kingdom. *Journal of Epidemiology and Community Health*, 57, 740-744.

Smith, E.R. & Mackie, D.M. (2007). *Social Psychology* (3rd edn.). Hove: Psychology Press.

Stevens, J. & Crouch, M. (1995). Who cares about care in nursing education? *International Journal of Nursing Studies, 32(3),* 233-242.

Stockwell, F. (1972). The unpopular patient: a study of interpersonal relationships in general wards. London: Royal College of Nursing. In A.M.Rafferty & M. Traynor (Eds.) Exemplary research for nursing and midwifery (pp. 23-41). New York: Routledge.

Tabachnik, B.G. & Fidell, L.S. (2001). *Using multivariate statistics (4th edn).* Needham Heights MA: Allyn & Bacon.

Tajfel, H. & Turner, J. C. (1979). An Integrative Theory of Intergroup Conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations.* Monterey, CA: Brooks-Cole.

Teresi, J.A., Holmes, D. and Ory, M.G. (2000). The therapeutic design for people with dementia: further reflections and recent findings from the national institute on ageing collaborative studies of dementia special care units. *The Gerontologist, 40 (4),* 417-421.

Tierney, A.J., Lewis, S.J. & Vallis, J. (1998). Nurses' knowledge and attitudes towards older patients admitted to acute orthopaedic wards. *Journal of Orthopaedic Nursing, 2,* 67-75.

Tolson, D., Smith, M. & Knight, P. (1999). An investigation of the components of best nursing practice in the care of acutely ill hospitalized older patients with coincidental dementia: a multi-method design. *Journal of Advanced Nursing, 30(5),* 1127-1136.

United Nations Population Division. (2009). *World Population Prospects: The 2009 Revision.* New York: United Nations.

Vaughan, G.M & Hogg, M.A. (2005). Introduction to social psychology. Frenchs Forest, N.S.W: Pearson Education.

Wannamethee, S.G. (2005). Cardiovascular diseases among older adults: incidence, prognosis and new avenues for prevention. In H.W. Wahl, H. Brenner, H. Mollenkopf, D. Rottenbacher & C. Rott (Eds.). *The many faces of health, competence and well-being in old age: integrating epidemiological, psychological and social perspectives.* Netherlands: Springer.

WHO (2002). *Active ageing: a policy framework.* Geneva: World Health Organisation.

Wicker, A.W. (1969). Attitude versus actions: The relationship of verbal and overt behavioral responses to attitude objects. *Idea: A Journal of Social Issues, 25,* 41 - 78.

Wilson, G. (2000). *Understanding old age: critical and global perspectives.* London: Sage Publishing.

Wilson, V. (2006) Diabetes and older people: issues of diagnosis and care. *Journal of Diabetes Nursing, 10,* 4-9.

Wolf, D.A. (2001). Population change: friend or foe of the chronic care system. Health Affairs, 20(6), 28-42. In WHO (2002). *Active ageing: a policy framework.* Geneva: World Health Organisation.

Zimmerman, S., Williams, C.S., Reed, P.S., Boustani, M., Preisser, J.S., Heck, E. & Sloane, P.D. (2005). Attitudes, stress and satisfaction of staff who care for residents with dementia. *The Gerontologist, 45(1)* 96-105.

Appendix 1

Research and Ethics Committee Approval

NHS Research and Development Team Approval

Fife and Forth Valley REC

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	08/S0501/79	**Issue number:**	1	**Date of issue:**	21 October 2008
Chief Investigator:	Miss Gillian Mackie				
Full title of study:	Do nursing staff attitudes towards ageing and dementia differ across settings?				

This study was given a favourable ethical opinion by Fife and Forth Valley REC on 07 October 2008. *The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.*

Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes [1]
Miss Gillian Mackie	Trainee Clinical Psychologist	NHS Fife	Fife and Forth Valley REC	21/10/2008	

Approved by the Chair on behalf of the REC:

L. Reilly ..... Assistant Administration Manager (Signature of Chair/~~Co-ordinator~~)

(delete as applicable)

MRS. LORRAINE RILEY ..... (Name)

The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.

Appendix 2

Confirmation of Sponsorship

Confirmation of Indemnity Insurance

NHS NHS NHS

Dear Miss

Full title of study: **Do nursing staff attitudes towards ageing and dementia differ across settings?**

REC reference number: **08/S0501/79**

The Research Ethics Committee reviewed the above application at the meeting held on 07 October 2008. Thank you for attending to discuss the study.

Ethical opinion

- You should note that the return of the questionnaire implies consent, therefore no consent form is required.
- In respect of the demographic information requested and that this may put some people off, you stated that the data would still be used even if some of the demographic information was not complete/omitted.
- Q A38 should have mentioned that the supervisor would also have access to data.
- In respect of the length of time that the records would be kept, the REC advised that 5 years was usual, rather than 1 year.
- You stated that in respect of Q36, the data was anonymised enough to be stored on computer and that was why no boxes were ticked.
- In respect of QA23, there was general training for staff, but the researcher agreed to highlight this issue and it was intended to support their working practice. The contact person could be someone outwith the department. It was acknowledged that you had tried to strike the right balance.
- You had looked at various questionnaires that were available, but the ones chosen were the most relevant.
- You confirmed that the reporting of results would not identify staff.

- Also, in the PIS, the standard thank you statement should be included at the end, ie, 'Thank you for taking the time to read this Information Sheet and for considering taking part.

- If the value of any cell was less than 5, the specific value should not be reported to prevent individuals potentially being identified (the value can be reported as '<5').

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Please submit a revised version of the Participant Information Sheet

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Copy of Application to R & D Office, Fife	1.1	16 September 2008
Letter of Professional Indemnity		20 August 2008
Participant Information Sheet: Nursing Staff Views on Dementia and Ageing	1	16 September 2008
Questionnaire: Front Sheet Version 1		16 September 2008
Questionnaire: Illness Perception Questionnaire		
Questionnaire: Kogan's Attitudes Toward Old People Scale		
Questionnaire: Approaches to Dementia Questionnaire		
Letter from Sponsor		12 September 2008
Covering Letter		16 September 2008
Protocol	1	11 September 2008
Investigator CV		15 September 2008
Application		16 September 2008
Investigator CV		

NHS
Fife

Miss Gillian Mackie
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Tel 01592 643355
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Date 4 December 2008
Our Ref 08/S0501/79
Enquiries to Aileen Yell
Tel No 01383 565110 Cheshire? interviews
Email aileen.yell@faht.scot.nhs.uk

Dear Gillian

Project Title: **Do nursing staff attitudes towards ageing and dementia differ across settings?**

Thank you for your application to carry out the above project. Your project documentation has been reviewed for resource and financial implications for NHS Fife Primary Care Division and I am happy to inform you that Management Approval has been granted.

Details of our participation in this study have in the past been included in returns to the National Research Register and will in the future be included in annual returns we are expected to complete as part of our agreement with the Chief Scientist Office. The enclosed Research Registration Form has been prepared and should be checked, signed and returned to the R&D Office, Lynebank Hospital, Halbeath Rd, Dunfermline KY11 4UW. If you have any questions or need further information contact Aileen Yell, Research Governance Officer on: 01383 565110 or at aileen.yell@faht.scot.nhs.uk

May I take this opportunity to remind you that all research undertaken in NHS Fife is managed strictly in accordance with the Research Governance Framework for Health & Community Care (http://www.sehd.scot.nhs.uk/cso/) and that all research should be carried out according to Good Clinical Practice (GCP). In order to comply with the RGF, the R&D Office are required to hold copies of all study protocols, ethical approvals and amendments for the duration of this study.

You will also be required to provide information in regard to monitoring and study outcomes, including a lay summary on completion of the research. I would like to wish you every success with your study and look forward to receiving a summary of the findings for dissemination once the project is complete.

Yours sincerely

Stella Clark

DR STELLA CLARK
Medical Director, Primary Care
NHS Fife

Cc : Aileen Yell, Research Governance Officer, NHS Fife, Lynebank Hospital, Dunfermline

POSITIVE ABOUT DISABLED PEOPLE

ECTU
Edinburgh Clinical Trials Unit

Edinburgh Clinical Trials Unit
The Queen's Medical Research Institute
47 Little France Crescent
Edinburgh, EH16 4TJ

Tel: 0131 242 9446
Email: ECTU@ed.ac.uk

12th September 2008

Miss Gillian Mackie
Psychology Department
Stratheden Hospital
Fife
KY15 5RR

Dear Miss Mackie

REC Number: 08/S0501/79
Study Title: Do nursing staff attitudes towards ageing and dementia differ across settings?

Under the requirements of the Scottish Executive Health Department's Research Governance Framework for Health and Community Care, the University of Edinburgh agrees in principle to act as Sponsor for this project. Sponsorship is subject to you obtaining a favourable ethical opinion and local NHS R&D management approval (if required).

As Chief Investigator, you must ensure that the study does not commence until all applicable approvals have been obtained. Following receipt of all relevant approvals, you should ensure that any amendments to the project are notified to the Sponsor, REC and relevant NHS R&D office(s).

Yours sincerely

Elspeth Currie
Research Governance Manager

AON

Commercial Insurance

10 Torpichen Street
Edinburgh
EH3 8JB
Tel 0131 456 3000
Fax 0131 456 3013 General
0131 456 3050 Claims

TO WHOM IT MAY CONCERN

20 August 2008

Dear Sir / Madam

The University of Edinburgh – Professional Indemnity Insurance

As Insurance Brokers to the above, we confirm details of their annual Professional Indemnity Insurances are as follows:-

Professional Indemnity

Insurer	QBE Insurance
Policy Number	To Be Advised
Renewal Date	1 August 2009
Limit of Indemnity	£10M any one claim and in all during the period

I trust that the above details are sufficient for your requirements, but please do not hesitate to contact us if you require further information.

Yours faithfully

A Parker

Alan Parker
Client Service Adviser – Commercial Insurance Division
For and on behalf of Aon Limited

Direct Dial : 0131 456 3074
E-Mail : alan.parker@aon.co.uk

Appendix 3

Participant Information Sheet

APPENDIX 3: Participant Information Sheet

The University of Edinburgh

Nursing Staff Views on Dementia and Ageing

Information for Prospective Participants

Thank you for reading this.

♦Introduction ♦

You are being invited to take part in a research study about nursing staff views on dementia and ageing. This study is being undertaken for educational purposes and is in part contribution towards a doctorate degree in clinical psychology in conjunction with the University of Edinburgh and NHS Fife. Before you decide if you would like to participate it is important that you know more about the study and what participation will involve. Please take time to read the following information carefully and raise any questions you may have with the study researcher (contact details are provided at the end of this sheet). Please ask if there is anything you are unclear about or if you would like more information.

♦What is the study about? ♦

Our attitudes can often influence how we view ourselves and other people, how we approach situations and how we react to events and experiences. Attitudes can also be influenced by our environment, our level of knowledge and understanding and levels of stress. The aim of this study is to explore nursing staff views of older people with the dementia, the illness of dementia, and older people in general, alongside examining factors that can make it difficult to work with this client group (e.g. current ward environment, confidence levels). It is hoped that the results will help to identify any gaps in training and look at ways of improving staff support.

♦Why have I been chosen? ♦

You have been chosen as you are a nurse who is likely to work with patients who are aged 65 or over. Two groups of nursing staff have been asked to participate in this study, those who work in acute medical settings and those who work in psychiatric settings.

♦Do I have to take part in the study?♦

Participation in this study is <u>entirely voluntary</u> – this information is provided to help you make that decision. The study does not require you to provide information that would make you personally identifiable. This means that if you choose to take part in the study and then change your mind, the information you provide will not be detailed enough for us to identify your particular responses and remove them from inclusion in the study.

<u>Due to this, your consent to take part cannot be withdrawn after you have returned the questionnaires.</u> Please consider this before returning the questionnaires in the envelope provided.

♦What will participation involve? ♦

If you agree to take part, you will be asked to provide some general demographic information both about you (e.g. age, gender and length of time in your current post), and the type of ward you work in (e.g. medical or psychiatric), alongside some more general questions (e.g. how often you encounter patients with dementia). You will also be asked to complete three short questionnaires about your views of older people with dementia, the illness of dementia, and older people in general in your own time. Your responses to all of these will be entirely confidential, and should take approximately 30-40 minutes to complete and can be returned in the stamped addressed envelope provided.

♦What are the possible benefits of taking part?♦

There is no direct benefit to you taking part, however, the information you provide will be extremely useful in helping us to find out about how staff feel, both about dementia and working with patients who have dementia. This can help to examine gaps in support and training for staff or highlight any particular concerns (e.g. suitability of the ward environment for people with dementia).

♦Will my participation in the study be kept confidential?♦

The information you provide will be kept **strictly confidential**. It is not possible for you to be personally identified from the information you provide. The only person with direct access to the information you provide will be the study researcher. All of the information held by the researcher will be held on a protected database.

♦What will happen to the results of the study?♦

The results will be included in a doctoral thesis submitted to the University of Edinburgh by the study researcher. You will not be identified in this, or in any other report resulting from the study. A brief summary of the results will be made available to all those who participated in the study, if requested.

♦Who else knows about the study? ♦

The study has been reviewed and approved by Fife and Forth Valley Research Ethics Committee, NHS Fife Research and Development team and the University of Edinburgh Doctorate in Clinical Psychology Course Organisation Committee.

♦What should I do now? ♦

If you wish to take part: please fill out the four questionnaires and front sheet and return them to the study researcher in the envelope provided. By returning the questionnaires you are consenting for the information you provide to be used in the study.

If you do not wish to take part: We would like to thank you for taking the time to read through this information sheet. You need do nothing more. Your decision not to take part is completely respected.

If you have any queries about any aspect of the study or require further information, please do not hesitate to contact us at the address given below:

Gillian Mackie
Study Researcher
Clinical Psychology Department
Stratheden Hospital
Cupar
Fife
KY15 5RR

Telephone: 01334 696336
Email: Gillian.Mackie@fife-pct.scot.nhs.uk

Dr. Ken Laidlaw
Research Supervisor
School of Health in Social Science
Medical School
University of Edinburgh
Teviot Place
Edinburgh
EH8 9AG

Telephone: 0131 651 3947
Email: klaidlaw@staffmail.ed.ac.uk

Thank you for taking the time to read this letter.

Appendix 3a

Demographic Front Sheet

16-24 25-35 36-50 51-65 65+

Male Female

of ward you work in Medical Psychiatric

h of time in current post Less than a year 1-2 years 3- 5 years 6-10 years 10 years or more

h of time qualified Less than a year 1-2 years 3- 5 years 6-10 years 10 years or more

u care for a mixed age group of patients on your ward (both over and under the age of 65)? Yes No

how many patients on your ward are **over the age of 65** at any one time? *(Please circle)*

a quarter are over 65 About half are over 65 About three quarters are over 65 About all are over 65

ften do you encounter patients **with a diagnosis of dementia**? (*Please circle*)

Rarely On a monthly basis On a weekly basis On a daily basis

ften do you encounter patients **whom you suspect have dementia but have not been diagnosed**? (*Please circle*)

Rarely On a monthly basis On a weekly basis On a daily basis

ften are you required to manage behavioural difficulties that arise as a consequence of dementia? *(Please circle)*

Rarely On a monthly basis On a weekly basis On a daily basis

what are the main difficulties that you tend to encounter with these patients?

scale of 1 to 5 (1 = 'not at all confident' and 5 = 'extremely confident') how confident do you feel about managing these difficulties?

1 all confident 2 A little confident 3 Quite confident 4 Very confident 5 Extremely confident

thing, what might help to improve your confidence?

scale of 1 to 5, (1 = 'not at all suitable' and 5 = 'extremely suitable', how suitable do you think your current ward environment is for nts with dementia? *(Please circle)*

1 all suitable 2 A little suitable 3 Quite suitable 4 Very suitable 5 Extremely suitable

Appendix 3b

Kogan's Attitudes to Older People Scale (KAOP)

APPENDIX 3b: Kogan's Attitudes to Older People Scale

KOGAN'S ATTITUDES TOWARD OLDER PEOPLE SCALE

Directions:

Circle the LETTER on the scale following each statement, according to the following key, that is closest to your opinion of older people.

Key:

Strongly Disagree	Slightly Disagree	Disagree	Agree	Slightly Agree	Strongly Agree
A	B	C	D	E	F

1. It would probably be better if most old people lived in residential units with people their own age.
   A B C D E F

2. It would probably be better if most old people lived in residential units with younger people.
   A B C D E F

3. There is something different about most old people; it's hard to find out what makes them tick.
   A B C D E F

4. Most old people are really no different from anybody else; they're as easy to understand as younger people.
   A B C D E F

5. Most old people get set in their ways and are unable to change.
   A B C D E F

6. Most old people are capable of new adjustments when the situation demands it.
   A B C D E F

7. Most old people would prefer to quit work as soon as pensions or their children can support them.
   A B C D E F

8. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.
   A B C D E F

9. Most old people tend to let their homes become shabby and unattractive.
   A B C D E F

10. Most old people can generally be counted on to maintain a clean, attractive home.
    A B C D E F

Key:

Strongly Disagree	Slightly Disagree	Disagree	Agree	Slightly Agree	Strongly Agree
A	B	C	D	E	F

11. It is foolish to claim that wisdom comes with age.
A B C D E F

12. People grown wiser with the coming of old age.
A B C D E F

13. Old people have too much power in business and politics.
A B C D E F

14. Old people should have power in business and politics.
A B C D E F

15. Most old people make one feel ill at ease.
A B C D E F

16. Most old people are very relaxing to be with.
A B C D E F

17. Most old people bore others by their insistence on talking "about the good old days".
A B C D E F

18. One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.
A B C D E F

19. Most old people spend too much time prying into the affairs of others and giving unsought advice.
A B C D E F

20. Most old people tend to keep to themselves and give advice only when asked.
A B C D E F

21. If old people expect to be liked, their first step is to try to get rid of their irritating faults
A B C D E F

22. When you think about it, old people have the same faults as anybody else.
A B C D E F

Key:

Strongly Disagree	Slightly Disagree	Disagree	Agree	Slightly Agree	Strongly Agree
A	B	C	D	E	F

23. In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.
A B C D E F

24. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.
A B C D E F

25. There are a few exceptions, but in general most old people are pretty much alike.
A B C D E F

26. It is evident that most old people are very different from one another.
A B C D E F

27. Most old people should be more concerned with their personal appearance; they're too untidy.
A B C D E F

28. Most old people seem quite clean and neat in their personal appearance.
A B C D E F

29. Most old people are irritable, grouchy, and unpleasant.
A B C D E F

30. Most old people are cheerful, agreeable, and good humored.
A B C D E F

31. Most old people are constantly complaining about the behavior of the younger generation.
A B C D E F

32. One seldom hears old people complaining about the behavior of the younger generation.
A B C D E F

33. Most old people make excessive demands for love and reassurance than anyone else.
A B C D E F

34. Most old people need no more love and reassurance than anyone else.
A B C D E F

Appendix 3c

Approaches to Dementia Questionnaire (ADQ-19)

APPENDIX 3c:
The Approaches to Dementia Questionnaire (ADQ-19)

Approaches to Dementia Questionnaire

University of Wales, Bangor

Please indicate to what extent you agree or disagree with each of the following statements:

1. It is important to have a very strict routine when working with dementia sufferers.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

2. People with dementia are very much like children.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

3. There is no hope for people with dementia.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

4. People with dementia are unable to make decisions for themselves.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

5. It is important for people with dementia to have stimulating and enjoyable activities to occupy their time.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

6. Dementia sufferers are sick and need to be looked after.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

7. It is important for people with dementia to be given as much choice as possible in their daily lives.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

8. Nothing can be done for people with dementia, except for keeping them clean and comfortable.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

9. People with dementia are more likely to be contented when treated with understanding and reassurance.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

10. Once dementia develops in a person, it is inevitable that they will go down hill.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

11. People with dementia need to feel respected, just like anybody else.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

12. Good dementia care involves caring for a person's psychological needs as well as their physical needs.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

13. It is important not to become too attached to residents.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

14. It doesn't matter what you say to people with dementia because they forget anyway.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

15. People with dementia often have good reasons for behaving as they do.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

16. Spending time with people with dementia can be very enjoyable.

Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree

17. It is important to respond to people with dementia with empathy and understanding.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

18. There are a lot of things that people with dementia can do.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

19. People with dementia are just ordinary people who need special understanding to fulfil their needs.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

Appendix 3d

Illness Perception Questionnaire: Revised for Healthy Subjects (IPQ-RH)

APPENDIX 3d: Illness Perception Questionnaire Revised for Healthy Subjects

Illness perception questionnaire (IPQ-RH)

Listed below are a number of symptoms that you may or may not associate with dementia. Please indicate by circling *Yes* or *No*, whether you think that any of these symptoms are related to this illness. There are no right or wrong answers, but simply an exploration of your views.

Pain	**Yes/No**
Changes in mood or behaviour	**Yes/No**
Confusion	**Yes/No**
Sore throat	**Yes/No**
Nausea	**Yes/No**
Breathlessness	**Yes/No**
Hallucinations	**Yes/No**
Weight loss	**Yes/No**
Fatigue	**Yes/No**
Repetitive behaviour	**Yes/No**
Stiff joints	**Yes/No**
Incontinence	**Yes/No**
Memory problems	**Yes/No**
Sore eyes	**Yes/No**
Wheeziness	**Yes/No**
Headaches	**Yes/No**
Upset stomach	**Yes/No**
Sleep difficulties	**Yes/No**
Speech and language difficulties	**Yes/No**
Dizziness	**Yes/No**
Loss of strength	**Yes/No**
Problems learning new information	**Yes/No**

Please indicate how much you agree or disagree with the following statements about dementia by ticking the appropriate box:

	Views about this illness	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	This illness will last a short time					
	This illness is likely to be permanent rather than temporary					
	This illness will last for a long time					
	This illness will pass quickly					
	I expect this illness to last for the rest of one's life					
	This illness is very unpredictable					
	The symptoms come and go in cycles					
	This illness goes through cycles in which it gets better or worse					
	This illness has serious financial consequences					
	This illness strongly affects the way the patient sees himself as a person					
	This illness causes difficulties to those close to the patient					
	This illness is very serious					
	The course of this illness depends on me					
	I have the power to influence this illness					
	What I do can determine whether this illness gets better or worse					
	The negative effects of this illness can be prevented or avoided by treatment					
	Treatment can control this illness					
	The treatment will be effective in curing this illness					
	This illness is a mystery to me					
	I don't understand this illness					
	The symptoms of this illness are puzzling to me					
	When I think about this illness I get upset					
	I get depressed when I think about this illness					
	This illness makes me feel afraid					
	Thinking about having this illness makes me feel anxious					
	This illness makes me feel angry					

	Possible causes	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	Stress or worry					
	Personal attitude					
	Personality					
	Emotional state					
	Family problems					
	Overwork					
	Diet or eating habits					
	Pollution					
	Overweight					
	Poor medical care					
	Immunity					
	Ageing					
	Heredity					

In the table below, please list in rank-order the three most important factors that you now believe cause this illness. You may use any of the items from the box above:

1. _____

2. _____

3. _____

Appendix 4a

Summary of Anecdotal Information:
Psychiatric Group

APPENDIX 4a:
SUMMARY OF ANECDOTAL INFORMATION (Psychiatric Group)

If any, what are the main difficulties that you tend to encounter with these patients?

Participant 1
- Encouraging patients to eat and drink
- Mobility problems
- Patients who wander
- Occasional violent/aggressive patients
- Communication problems

Participant 2
- Managing several patients within one area with variety of capabilities and behavioural problems, particularly male and female and different stages of dementia

Participant 3
- No comment

Participant 4
- Aggression
- Confusion
- Removal of clothes
- Agitation
- Hallucinations of all types

Participant 5
- No comment

Participant 6
- Resistance to nursing interventions
- Aggression

Participant 7
- Physical and verbal aggression
- Sexual disinhibition
- Non-compliance

Participant 8
- Aggressiveness
- Emotional
- Delusional

Participant 9

- Ward area not secure for mobile dementia patients. Can be difficult returning them to the ward area.

Participant 10

- No comment

Participant 11

- Wandering

Participant 12

- Wandering patients. We have open plan ward areas – fire exit doors alarmed but front door of hospital open. Some patients have been found in the car park!

Participant 13

- Aggressiveness when carrying out personal care

Participant 14

- Their misinterpretation of what you have asked them to do

Participant 15

- Violence and aggressive behaviour
- Verbal abuse
- Wandering outside ward setting

Participant 16

- Aggression
- Trying to abscond
- Increased falls

Participant 17

- Violence and aggressive behaviour

Participant 18

- Resistance
- Verbal aggression
- Physical aggression
- Manual handling challenges
- Communication problems (Comprehension, understanding and misinterpretation)

Participant 19

- Aggression, coping with the variability of each individual patient's diagnosis, understanding their own diagnosis, trying to identify if the patient is depressed, sad

or if it is a consequence of their illness that they appear unhappy, some difficulties with their medication

Participant 20

- Mix of patients on ward is not appropriate, rehab transitional and continuing care, palliative care
- Reduced staffing levels make it difficult for staff to give the time to provide the quality of care to dementia patients

Participant 21

- Severe lack of staffing

Participant 22

- Not enough staff to give one to one attendance

Participant 23

- Aggression both physical and verbal
- Non-compliance with medication
- Trying to reassure confused patients

Participant 24

- Not medicated properly so it can make our jobs harder
- Behaviour problems

Participant 25

- Confusion, disorientation, aggression, communication problems

Participant 26

- Health and safety – climbing on furniture, moving furniture, turning taps on, interfering in fellow clients medical equipment (e.g. catheters, zimmers), aggression from client whilst tending to personal care with often small areas to work in (e.g. bathrooms)

Participant 27

- Behavioural problems
- Unpredictable problems – sometimes too many difficulties and not enough staff to cope with it – constantly prioritising

Participant 28

- Behaviour problems
- Not medicated properly

Participant 29

- No comment

Participant 30

- Increase in agitation
- Increase in activity – increasingly restless
- Increasingly vocal response in some clients
- Poor sleep and reduced appetite
- Challenging behaviours (e.g. physical and verbal aggression)
- Anti-social behaviours (e.g. removing clothing)

Participant 31

- Communication
- Eating and drinking

Participant 32

- Confusion
- Wandering

Participant 33

- No comment

Participant 34

- Frustration
- Communication

Participant 35

- Aggression – verbal and physical
- Challenging behaviours

Participant 36

- Physical/verbal aggression
- Agitation

Participant 37

- No comment

Participant 38

- Physical and verbal aggression

Participant 39

- Verbal and physical aggression
- Communication difficulties

Participant 40

- Verbal and physical aggression
- Communication

Participant 41
- Aggression mainly on nursing interventions
- Non-compliance

Participant 42
- Aggression

Participant 43
- Patients' aggressive behaviour
- Patients' non-cooperation and resistance during interventions
- Non-compliance with medication
- Absconding attempts from wards

Participant 44
- No comment

Participant 45
- Patients tend to be aggressive at times and wander. They can become very demanding of the nurses time in a busy ward environment.

If anything, what might help to improve your confidence?

Participant 1
- More information about how to deal with problems – especially violent/aggressive behaviour
- How to stop/prevent patients wandering out of the ward/hospital

Participant 2
- More suitable environment

Participant 3
- No comment

Participant 4
- Increase in staffing levels
- More support from management

Participant 5
- No comment

Participant 6
- Knowing that everyone else that I work with is confident about managing these difficulties too

Participant 7
- Continual updates on dementia care

Participant 8
- More training
- Training updates

Participant 9
- No comment

Participant 10
- Doing training course on dementia

Participant 11
- Additional training

Participant 12
- More secure environment – wanderguard system
- More staff on duty if we have wandering/confused patients
- Better education re: handling behaviour problems

Participant 13
- No comment

Participant 14
- No comment

Participant 15
- More training on de-escalation
- More dementia training

Participant 16
- More training

Participant 17
- Appropriate training

Participant 18
- No comment

Participant 19
- My own mother has Alzheimer's which has helped my own understanding of other patients with the diagnosis – training and a better understanding of the illness and the areas of the brain the patient is affected

Participant 20
- No comment

Participant 21
- More dementia training
- More staff

Participant 22
- Further training in dealing with situations
- Again more staff to ensure safe environment for patients

Participant 23
- Additional staff on every shift
- Having more than one trained nurse on shift at all times for added support. All staff should be given more training

Participant 24
- More staff

Participant 25
- More staff

Participant 26
- More experience
- Continue to attend updates and courses

Participant 27
- More staff appropriate for needs of clients

Participant 28
- More staff

Participant 29
- No comment

Participant 30
- No comment

Participant 31
- More training

Participant 32
- No comment

Participant 33
- Improved training days

Participant 34
- No comment

Participant 35
- No comment

Participant 36
- No comment

Participant 37
- No comment

Participant 38
- Attending courses for management of violence and aggression, control and restraint

Participant 39
- More training

Participant 40
- More training

Participant 41
- Relatives having more knowledge about dementia. Perhaps having unrealistic expectations about how 'well' being in hospital can make their relative

Participant 42
- No comment

Participant 43
- No comment

Participant 44
- No comment

Participant 45
- Improving staffing levels so that the nurse has more time to spend with the patient. Support from my line manager when situations in the ward are stressful.

In your opinion, what factors (if any) make the current ward environment unsuitable?

Participant 1
- Open ward
- Mixture of other patients in the ward – can be variable

Participant 2
- Little area for patients to wander around
- Confined space – only one main area

Participant 3
- No comment

Participant 4
- Lack of being able to go out in the garden with the patients due to being on level 1 instead of the ground floor

Participant 5
- No comment

Participant 6
- Not enough stimulation

Participant 7
- Layout – not enough room to wander
- Sleep areas – 6 bedded group – better with single
- Should have rooms where they could go for quietness

Participant 8
- I work in a rehab ward patients recovering from shocks, falls, heart attacks etc

Participant 9
- Not secure

Participant 10
- Understaffed

Participant 11
- Unsecure

Participant 12
- As above

Participant 13
- No comment

Participant 14

- Upstairs and very limited space to wander, little fresh air
- Due to restrictions of staff patient ratio- very little reminiscence
- No quiet area for patients to sit

Participant 15

- Unsuitable for patients who wander
- Not enough staff to observe these patients
- Aggressive patients frighten other patients and are hard to assess at times

Participant 16

- Too many exits
- Not enough staff to observe all areas

Participant 17

- Too many exits and places that can be difficult for nurses to observe at times

Participant 18

- 6 beds in a bedroom area
- Straight corridor only for patients to walk in
- Toilets too small
- Only 1 sitting room and no separate dining area

Participant 19

- Lack of stimulation, door guards, mats on the floor for patients that wander, sometimes not enough staff

Participant 20

- Inappropriate mix of patients
- Geographical layout of the ward

Participant 21

- Patients can walk out of hospital (no patient tagging)
- No resources for stimulation

Participant 22

- Ward on one level – no door security – patients can walk out of hospital – no alarms on ward door and no patient tagging

Participant 23

- Lack of staff

Participant 24

- No comment

Participant 25

- Not enough space, inadequate signage, décor not suitable for patients with dementia i.e. too many patterns, not enough natural light, not enough bold contrasting colours

Participant 26

- Upstairs in hospital and limited access to outdoors
- Very small side-rooms/bathrooms whilst dealing with hoists and/or an aggressive client
- Ripped old wallpaper on day-room walls unhomely
- Out of 24 beds only 1 hydraulic bed with approx 8 clients bed-bound

Participant 27

- Locked wards and rooms
- Mixed sex ward
- Unable to get into the open as it's up two flights of stairs

Participant 28

- Locked bedroom doors on a second level floor so patients can't get out for fresh air and it's a mixed ward. I believe that patients with dementia should be in a ward that's the same sex. The patients only have the ward corridor to walk up and down.

Participant 29

- Lack of staff

Participant 30

- The ward was built 23 years ago and therefore this designed with clients who were FAR less dependent and much more physically active. Ward is on the 1st floor. Limited bathroom space. Dark inside corridor. No separate dining area. Lack of storage for personal items.

Participant 31

- Unsecure unit and mix of patients due to being a rehab ward.

Participant 32

- No comment

Participant 33

- No comment

Participant 34

- Depending on level of patients with mixture of psychotic diagnosis can make it unsuitable

Participant 35

- No comment

Participant 36
- Ward size and layout

Participant 37
- No comment

Participant 38
- Mixed sex ward.
- No quiet area for agitated patients.
- Not enough space for patients to wander
- Poor lighting
- Lack of comfortable chairs
- No outside area that is safe to wander in
- Lack of resources for reality orientation, reminiscing
- Lack of therapies for patients

Participant 39
- Outdated equipment
- General layout of the ward

Participant 40
- Can't get outside
- Not enough quiet areas
- Not enough side rooms

Participant 41
- Dormitory style rooms
- No access (suitable) for clients to go outside either escorted or otherwise
- Lack of space

Participant 42
- Locked doors giving patients a small area to wander in

Participant 43
- Lack of space
- Lack of privacy
- Poor décor
- Poor light

Participant 44
- None

Participant 45

- Low staffing levels
- Mixed group of patients in ward
- Too many patients in bay
- Not enough single rooms
- Not enough stimulation and activities for the patients

Further comments (across all questionnaires returned)

- Otherwise ward environment homely and therapeutic as far as safety allows (26)
- Despite the failings in the material design of the buildings, we aim to provide the very best of care to our clients and their families and over the years have adapted many features of the ward to meet our needs (30)
- Ward being re-located soon to purpose built unit (43)

Appendix 4b

Summary of Anecdotal Information:
Medical Group

APPENDIX 4b:
SUMMARY OF ANECDOTAL INFORMATION (Medical Group)

If any, what are the main difficulties that you tend to encounter with these patients?

Participant 1
- Wandering around ward
- Agitated

Participant 2
- No comment

Participant 3
- Aggression
- Compliance
- High risk of falls

Participant 4
- No comment

Participant 5
- Unpredictable behaviour
- Wanting to go home

Participant 6
- Increase in dementia confusion due to change of environment post-anaesthesia
- Assessment of pain
- Risk assessment of falls
- Nutrition

Participant 7
- Communication
- Being able to wash, dressing and eating/drinking
- The patient not understanding where they are

Participant 8
- No comment

Participant 9
- Wanting out
- Disorientated in time and place

Participant 10

- Confusion
- Aggression
- Unsafe to mobilise on their own
- A lot of time spend with these patients – only takes one patient within a busy surgical ward to upset other patients and nurses

Participant 11

- No comment

Participant 12

- Aggression
- Confusion

Participant 13

- Aggression both verbally, physically
- Pulling out lines i.e. IVI's, catheters, oxygen

Participant 14

- People wanting to leave ward and having to be constantly reminded of where they are

Participant 15

- Lack of understanding
- Non-communication

Participant 16

- No comment

Participant 17

- Poorly managed on ward

Participant 18

- High risk of falls while wandering
- Aggression

Participant 19

- Poorly managed

Participant 20

- Disruptive

Participant 21

- Post-operative care is difficult due to non-compliance from patient due to patients' lack of understanding of the situation

Participant 22

- Unable to understand instructions

Participant 23

- Compliancy post-surgery
- Comprehension regarding these issues

Participant 24

- No comment

Participant 25

- Verbal and physical aggression

Participant 26

- No comment

Participant 27

- Getting support to help manage difficult behaviours

Participant 28

- Confusion, aggression, incontinence

If anything, what might help to improve your confidence?

Participant 1

- No comment

Participant 2

- No comment

Participant 3

- More training

Participant 4

- No comment

Participant 5

- Update on de-escalation skills and breakaway

Participant 6

- No comment

Participant 7

- At the moment I am doing a course on dementia but also my own mother suffers from this so I have more of an understanding

Participant 8

- No comment

Participant 9

- No comment

Participant 10

- No comment

Participant 11

- No comment

Participant 12

- Training

Participant 13

- No comment

Participant 14

- Experience

Participant 15

- Further training
- More time available to spend with patients with dementia to obtain a better understanding

Participant 16

- No comment

Participant 17

- Better access to help and support and encourage staff to attend training days

Participant 18

- No comment

Participant 19

- Better access to support staff to manage and provide holistic care for these patients

Participant 20

- No comment

Participant 21

- No comment

Participant 22

- More training

Participant 23

- Management ensuring enough staff are available to nurse these patients

Participant 24

- No comment

Participant 25

- No comment

Participant 26

- Training about dementia

Participant 27

- Further training

Participant 28

- No comment

In your opinion, what factors (if any) make the current ward environment unsuitable?

Participant 1

- No comment

Participant 2

- No comment

Participant 3

- Busy ward therefore unable to monitor appropriately

Participant 4

- No comment

Participant 5

- Very busy orthopaedic ward

Participant 6

- No comment

Participant 7

- A lot of dementia patients tend to wander and being a urology ward we don't have a locked unit

Participant 8

- Lack of staff and sometimes unable to give the patients the time they need

Participant 9

- Busy high turnover of patients

Participant 10

- It's a busy surgical ward

Participant 11

- No comment

Participant 12

- The patient has no freedom to walk on the ward as the ward is not secured

Participant 13

- No comment

Participant 14

- Busy trauma ward nurses always on the go

Participant 15

- Open bays
- Restricted staffing numbers
- Mix of ages – provision ability
- Lack of understanding patients with staff – staff/other patients

Participant 16

- No comment

Participant 17

- It's an orthopaedic trauma ward – not geared for people with dementia

Participant 18

- Nursed beside patients without dementia – unsettling for other visitors, sleeplessness for other patients

Participant 19

- Orthopaedic trauma ward

Participant 20

- Specialised ward

Participant 21

- No comment

Participant 22

- Position of beds (unable to see all patients)

Participant 23

- Not enough staff
- Danger unto themselves
- Mobility issues
- Pain issues – comprehension

Participant 24

- No comment

Participant 25

- No comment

Participant 26

- Busy surgical ward with many pre and post op. patients who require regular monitoring or lots of rest, which can be difficult with dementia patients. These patients require lots of reassurance or closer observation.

Participant 27

- Low staff levels
- Lack of training

Participant 28

- Short-staffed

Appendix 5a

Frequency Distribution:
IPQ-RH Identity Sub-Scale

APPENDIX 5a: Frequency distribution of IPQ-RH identity data

Symptoms	Psychiatric (n = 45)		General Medical (n = 28)		Total Sample (n = 73)	
	N	%	N	%	N	%
Pain	25	55.6	11	39.3	36	49.3
Changes in mood	45	100.0	28	100.0	73	100.0
Confusion	45	100.0	28	100.0	73	100.0
Sore throat	4	8.9	3	10.7	7	9.6
Nausea	8	17.8	4	14.3	12	16.4
Breathlessness	13	28.9	6	21.4	21	28.8
Hallucinations	42	93.3	27	96.4	69	94.5
Weight loss	43	95.6	27	96.4	70	95.9
Fatigue	39	86.7	27	96.4	66	90.4
Repetitive behaviour	44	97.7	27	96.4	72	98.6
Stiff joints	13	28.9	7	15.6	20	27.4
Incontinence	43	95.6	24	85.7	67	91.8
Memory problems	45	100.0	28	100.0	73	100.0
Sore eyes	4	8.9	4	14.3	8	10.9
Wheeziness	5	11.1	2	7.1	7	9.6
Headaches	18	40.0	12	42.9	30	41.1
Upset stomach	6	13.3	2	4.0	8	10.9
Sleep difficulties	43	95.6	27	96.4	70	95.9
Speech and language difficulties	43	95.6	25	89.3	70	95.9
Dizziness	17	37.8	12	42.9	29	39.7
Loss of strength	24	53.3	23	82.1	47	64.4
Problems in learning new information	45	100.0	26	92.9	71	97.3

Appendix 5b

Frequency Distribution:
IPQ-RH Causation Sub-Scale

APPENDIX 5b: Frequency distribution of IPQ-RH causation data (Total Sample n = 73)

	Causation	RESPONSE											
		Strongly Agree		Agree		Neither agree nor disagree		Disagree		Strongly Disagree		Missing Values	
		N	%	N	%	N	%	N	%	N	%	N	%
1	Stress/Worry	0	0.0	20	27.0	32	43.2	15	20.3	6	8.1	0	0.0
2	Personal attitude	1	1.4	4	5.4	30	40.5	31	41.9	7	9.5	0	0.0
3	Personality	1	1.4	8	10.8	31	41.9	26	35.1	7	9.5	0	0.0
4	Emotional state	3	4.1	23	31.1	27	36.5	15	20.3	5	6.8	0	0.0
5	Family problems	2	2.7	15	20.3	27	36.5	22	29.7	7	9.5	0	0.0
6	Overwork	1	1.4	10	13.5	31	41.9	25	33.8	6	8.1	0	0.0
7	Diet	3	4.1	17	23.0	31	41.9	19	25.7	3	4.1	0	0.0
8	Pollution	1	1.4	8	10.8	38	51.4	23	31.1	3	4.1	0	0.0
9	Overweight	1	1.4	5	6.8	35	47.3	25	33.8	7	9.5	0	0.0
10	Poor medical care	1	1.4	9	12.2	32	43.2	25	33.8	6	8.1	0	0.0
11	Immunity	1	1.4	6	8.1	40	54.1	21	28.4	5	6.8	0	0.0
12	Ageing	9	12.2	42	56.8	20	27.0	1	1.4	1	1.4	0	0.0
13	Heredity	7	9.5	38	51.4	26	35.1	2	2.7	0	0.0	0	0.0

Appendix 6a

Frequency Distribution: KAOP

Appendix 6a: Frequency Distribution of Responses to KOAP Items: General Medical Group (n = 28)

	ITEM	RESPONSE													
		Strongly Disagree		Disagree		Slightly Disagree		Slightly Agree		Agree		Strongly Agree		Missing Values	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
1	It would probably be better if most old people lived in residential units with people their own age.	14	50.0	7	25.0	1	3.6	2	7.1	1	3.6	1	3.6	2	7.1
2	It would probably be better if most old people lived in residential units with younger people.	6	21.4	10	35.7	3	10.7	2	7.1	3	10.7	1	3.6	2	7.1
3	There is something different about most old people, it's hard to find out what makes them tick.	10	35.7	6	21.4	1	3.6	2	7.1	6	21.4	1	3.6	2	7.1
4	Most old people are really no different from anybody else; they're as easy to understand as younger people	0	0.0	3	10.7	2	7.1	4	14.3	9	32.1	8	28.6	2	7.1
5	Most old people get set in their ways and are unable to change.	0	0.0	6	21.4	3	10.7	5	17.9	9	32.1	3	10.7	2	7.1
6	Most old people are capable of new adjustments when the situation demands it.	1	3.6	7	25.0	0	0.0	8	28.6	6	21.4	4	14.3	2	7.1
7	Most old people would prefer to quit work as soon as pensions or their children can support them.	6	21.4	11	39.3	3	10.7	3	10.7	3	10.7	0	0.0	2	7.1
8	Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.	2	7.1	3	10.7	0	0.0	5	22.7	8	28.6	4	18.2	2	9.1
9	Most old people tend to let their homes become shabby and unattractive.	9	32.1	11	39.3	5	17.9	0	0.0	0	0.0	1	3.6	2	7.1
10	Most old people can generally be counted on to maintain a clean, attractive home.	3	10.7	3	10.7	0	0.0	5	17.9	11	39.3	4	14.3	2	7.1
11	It is foolish to claim that wisdom comes with age	1	3.6	8	28.6	1	3.6	4	14.3	9	32.1	3	10.7	2	7.1
12	People grow wiser with the coming of age	1	3.6	9	32.1	1	3.6	2	7.1	10	35.7	3	10.7	2	7.1
13	Old people have too much power in business and politics.	7	25.0	16	57.1	1	3.6	1	3.6	0	0.0	0	0.0	3	10.7
14	Old people should have power in business and politics.	2	7.1	9	32.1	2	7.1	10	35.7	3	10.7	0	0.0	2	7.1
15	Most old people make one feel ill at ease.	12	42.9	11	39.3	1	3.6	2	7.1	0	0.0	0	0.0	2	7.1
16	Most old people are very relaxing to be with.	0	0.0	7	25.0	1	3.6	4	14.3	12	42.9	2	7.1	2	7.1
17	Most old people bore others by their insistence on talking about 'the good old days'.	5	17.9	13	46.4	5	17.9	1	3.6	1	3.6	1	3.6	2	7.1
18	One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.	0	0.0	1	3.6	0	0.0	5	17.9	13	46.4	7	25.0	2	7.1

	ITEM	RESPONSE													
		Strongly Disagree		Disagree		Slightly Disagree		Slightly Agree		Agree		Strongly Agree		Missing Values	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
19	Most old people spend too much time prying into the affairs of others and giving unsought advice.	5	17.9	16	57.1	2	7.1	3	10.7	0	0.0	0	0.0	2	7.1
20	Most old people tend to keep to themselves and give advice only when asked.	2	7.1	9	32.1	0	0.0	8	28.6	7	25.0	0	0.0	2	7.1
21	If old people expect to be liked, their first step is to try to get rid of their irritating faults.	11	39.3	11	39.3	3	10.7	1	3.6	0	0.0	0	0.0	2	7.1
22	When you think about it, old people have the same faults as anybody else.	0	0.0	0	0.0	0	0.0	2	7.1	13	46.4	13	46.4	2	7.1
23	In order to maintain a nice residential neighbourhood, it would be best if too many old people did not live in it.	13	46.4	10	35.7	2	7.1	0	0.0	1	3.6	0	0.0	2	7.1
24	You can count on finding a nice residential neighbourhood when there is a sizeable number of old people living in it.	3	10.7	7	25.0	0	0.0	4	14.3	8	28.6	4	14.3	2	7.1
25	There are a few exceptions, but in general most old people are pretty much alike.	5	17.9	13	46.4	4	14.3	2	7.1	1	3.6	1	3.6	2	7.1
26	It is evident that most old people are very different from one another.	0	0.0	2	7.1	0	0.0	4	14.3	11	39.3	9	32.1	2	7.1
27	Most old people should be more concerned with their personal appearance; they're too untidy.	11	39.3	9	32.1	3	10.7	1	3.6	2	7.1	0	0.0	2	7.1
28	Most old people seem quite clean and neat in their personal appearance.	1	3.6	2	7.1	1	3.6	5	17.9	13	46.4	4	14.3	2	7.1
29	Most old people are grouchy and unpleasant.	14	50.0	8	28.6	2	7.1	2	7.1	0	0.0	0	0.0	2	7.1
30	Most old people are cheerful, agreeable and good humoured.	0	0.0	1	3.6	4	14.3	5	17.9	12	42.9	4	14.3	2	7.1
31	Most old people are constantly complaining about the behaviour of the younger generation.	1	3.6	10	35.7	1	3.6	7	25.0	6	21.4	1	3.6	2	7.1
32	One seldom hears old people complaining about the behaviour of the younger generation.	2	7.1	10	35.7	7	25.0	3	10.7	4	14.3	0	0.0	2	7.1
33	Most old people make excessive demands for love and reassurance than anyone else.	6	21.4	11	39.3	7	25.0	1	3.6	1	3.6	0	0.0	2	7.1
34	Most old people need no more love and reassurance than anyone else.	4	14.3	2	7.1	3	10.7	1	3.6	13	46.4	2	7.1	3	10.7

Note that of these missing values x were substituted with the average of the group (be it medical, psychiatric or the total sample) whilst x were completely missing.

Appendix 6b

Frequency Distribution: ADQ-19

Appendix 6b: Frequency Distribution of Responses to ADQ Items: Medical Group (n = 28)

	ITEM	RESPONSE											
		Strongly Agree		Agree		Neither agree nor disagree		Disagree		Strongly Disagree		Missing Values	
		N	%	N	%	N	%	N	%	N	%	N	%
1	It is important to have a very strict routine when working with dementia sufferers.	1	3.6	11	39.3	8	28.6	6	21.4	0	0.0	2	7.1
2	People with dementia are very much like children.	0	0.0	5	17.9	4	14.3	12	42.9	5	17.9	2	7.1
3	There is no hope for people with dementia.	0	0.0	2	7.1	2	7.1	13	46.4	9	32.1	2	7.1
4	People with dementia are unable to make decisions for themselves.	0	0.0	3	10.7	7	25.0	12	42.9	4	14.3	2	7.1
5	It is important for people with dementia to have stimulating and enjoyable activities to occupy their time.	13	46.4	12	42.9	1	3.6	0	0.0	0	0.0	2	7.1
6	Dementia sufferers are sick and need to be looked after.	3	10.7	6	21.4	9	32.1	7	25.0	1	3.6	2	7.1
7	It is important for people with dementia to be given as much choice as possible in their daily lives.	11	39.3	14	50.0	1	3.6	0	0.0	0	0.0	2	7.1
8	Nothing can be done for people with dementia, except for keeping them clean and comfortable.	1	3.6	2	7.1	1	3.6	13	46.4	9	32.1	2	7.1
9	People with dementia are more likely to be contented when treated with understanding and reassurance.	7	25.0	16	57.1	3	10.7	0	0.0	0	0.0	2	7.1
10	Once dementia develops in a person, it is inevitable that they will go down hill.	0	0.0	9	32.1	7	25.0	10	35.7	0	0.0	2	7.1
11	People with dementia need to feel respected, just like anybody else.	17	60.7	9	32.1	0	0.0	0	0.0	0	0.0	2	7.1
12	Good dementia care involves caring for a person's psychological needs as well as their physical needs.	19	67.9	7	25.0	0	0.0	0	0.0	0	0.0	2	7.1
13	It is important not to become too attached to residents.	2	7.1	7	25.0	6	21.4	7	25.0	4	14.3	2	7.1
14	It doesn't matter what you say to people with dementia because they forget it anyway.	1	3.6	0	0.0	1	3.6	14	50.0	10	35.7	2	7.1
15	People with dementia often have good reasons for behaving as they do.	2	7.1	16	57.1	6	21.4	2	7.1	0	0.0	2	7.1
16	Spending time with people with dementia can be very enjoyable.	8	28.6	16	57.1	0	0.0	2	7.1	0	0.0	2	7.1
17	It is important to respond to people with dementia with empathy and understanding.	10	35.7	16	57.1	0	0.0	0	0.0	0	0.0	2	7.1
18	There are a lot of things that people with dementia can do.	10	35.7	12	42.9	4	14.3	0	0.0	0	0.0	2	7.1
19	People with dementia are just ordinary people who need special understanding to fulfil their needs.	14	50.0	12	42.9	9	0.0	0	0.0	0	0.0	2	7.1

Appendix 6c

Frequency Distribution: IPQ-RH

Appendix 6c: Frequency Distribution of Responses to IPQ-RH items: Total Sample (n = 73)

	ITEM 'This illness' refers to dementia in this instance	RESPONSE											
		Strongly Disagree		Disagree		Neither agree nor disagree		Agree		Strongly Agree		Missing Values	
		N	%	N	%	N	%	N	%	N	%	N	%
1	This illness will last a short time	39	52.7	31	41.9	3	4.1	0	0.0	0	0.0	0	0.0
2	This illness is likely to be permanent rather than temporary	5	6.8	1	1.4	1	1.4	31	42.5	35	47.9	0	0.0
3	This illness will last a long time	4	5.5	4	5.5	13	17.8	27	37.0	19	26.0	0	0.0
4	This illness will pass quickly	40	54.1	22	29.7	6	8.1	1	1.4	4	5.4	0	0.0
5	I expect this illness to last for the rest of one's life	3	4.1	0	0.0	4	5.5	33	45.2	33	45.2	0	0.0
6	This illness is very unpredictable	2	2.7	2	2.7	2	2.7	45	61.6	22	30.1	0	0.0
7	The symptoms come and go in cycles	3	4.1	7	9.6	20	27.4	34	46.6	9	12.3	0	0.0
8	This illness goes through cycles in which is gets better or worse	5	6.8	9	12.3	15	20.5	35	47.9	9	12.3	0	0.0
9	This illness has serious financial consequences	6	8.2	6	8.2	21	28.8	29	39.7	11	15.0	0	0.0
10	This illness strongly affects the way a patient sees himself as a person	1	1.4	1	1.4	12	16.4	40	54.8	19	26.0	0	0.0
11	This illness causes difficulties to those close to the patient	3	4.1	2	2.7	2	2.7	25	34.2	41	56.2	0	0.0
12	This illness is very serious	2	2.7	6	8.2	17	23.3	28	38.4	20	27.4	0	0.0
13	The course of this illness depends on me	16	21.9	24	32.9	25	34.2	7	9.6	1	1.4	0	0.0
14	I have the power to influence this illness	12	16.4	25	34.2	21	28.8	13	17.8	2	2.7	0	0.0
15	What I do can determine whether this illness gets better or worse	12	16.4	24	32.9	27	37.0	7	9.6	3	4.1	0	0.0
16	The negative effects of this illness can be prevented or avoided by treatment	5	6.8	18	24.7	31	42.5	17	23.3	2	2.7	0	0.0
17	Treatment can control this illness	0	0.0	14	19.2	30	41.1	24	32.9	5	6.8	0	0.0
18	Treatment will be effective in curing this illness	20	27.4	35	47.9	15	20.5	1	1.4	2	2.7	0	0.0
19	This illness is a mystery to me	17	23.3	26	35.6	19	26.0	8	11.0	3	4.1	0	0.0
20	I don't understand this illness	11	15.0	37	50.7	18	24.7	7	9.6	2	2.7	0	0.0
21	The symptoms of this illness are puzzling to me	13	17.8	33	45.2	18	24.7	7	9.6	2	2.7	0	0.0
22	When I think about this illness I get upset	7	9.6	19	26.0	23	31.5	20	27.4	4	5.5	0	0.0
23	I get depressed when I think about this illness	8	11.0	25	34.2	25	34.2	12	16.4	3	4.1	0	0.0
24	This illness makes me feel afraid	9	12.3	19	26.0	22	30.1	21	28.8	2	2.7	0	0.0
25	Thinking about having this illness makes me feel anxious	9	12.3	24	32.9	16	21.9	21	28.8	3	4.1	0	0.0
26	This illness makes me feel angry	8	11.0	18	24.7	22	30.1	22	30.1	3	4.1	0	0.0

Appendix 7a

Normality of Distribution:
Skewness and Kurtosis

APPENDIX 7a: NORMALITY DISTRIBUTION (SKEWNESS & KURTOSIS)

Measure		Gp. +	Mean	S.D	Skew (S.E.)	z-score	Kurtosis (S.E.)	z-score	K-S ++	p-value	Sig
ADQ-19	ADQ Total	All	75.19	6.34	-0.258 (0.287)	-0.90	-0.549 (0.566)	-0.97	0.095	0.20	No
		1	75.39	5.84	0.017 (0.357)	0.48	-0.361 (0.702)	-0.51	0.082	0.20	No
		2	74.85	7.21	-0.474 (0.456)	-1.04	-0.904 (0.887)	-1.02	0.120	0.20	No
	ADQ Hope	All	28.39	4.50	-0.625 (0.287)	-2.18	0.884 (0.566)	1.56	0.138	0.003	No
		1	28.57	3.66	-0.333 (0.357)	-0.93	-0.254 (0.702)	-0.36	0.111	0.200	No
		2	28.08	5.72	-0.627 (0.456)	-1.38	0.455 (0.887)	0.51	0.209	0.008	No
	ADQ P.C.	All	46.77	4.34	-0.017 (0.287)	-0.06	-0.608 (0.566)	-1.07	0.087	0.200(*)	No
		1	46.77	4.34	0.094 (0.357)	0.03	-0.701 (0.702)	-0.99	0.091	0.200(*)	No
		2	46.77	4.42	-0.203 (0.456)	-0.45	-0.310 (0.887)	-0.35	0.111	0.200(*)	No
KOAP	KOAP Total	All	140.16	13.63	0.270 (0.289)	0.93	0.193 (0.570)	0.34	0.095	0.200(*)	No
		1	139.43	14.03	-0.012 (0.361)	-0.03	-0.185 (0.709)	-0.26	0.105	0.200(*)	No
		2	141.38	13.09	0.946 (0.456)	2.07	0.995 (0.887)	1.12	0.151	0.169	No
IPQ-RH	Time: Acute/ Chronic	All	21.02	3.03	-0.825 (0.295)	-2.80	0.870 (0.582)	1.49	0.126	0.011	No
		1	20.98	2.95	-0.514 (0.365)	-1.41	-0.320 (0.717)	-0.45	0.122	0.119	No
		2	21.08	3.23	-1.324 (0.472)	-2.81	3.010 (0.918)	3.28	0.202	0.012	No
	Time: Cyclical	All	11.07	2.27	-0.308 (0.295)	-1.04	0.295 (0.582)	0.49	0.173	**0.000**	**p ≤0.001**
		1	11.10	2.32	-0.182 (0.365)	-0.50	-0.620 (0.717)	0.86	0.175	0.002	No
		2	11.04	2.22	-0.606 (0.472)	-1.28	0.055 (0.918)	0.06	0.167	0.081	No
	Conseq.	All	15.48	3.06	-1.428 (0.295)	**-4.84**	3.708 (0.582)	**6.37**	0.188	**0.000**	**p ≤0.001**
		1	15.53	2.97	-1.206 (0.365)	**-3.30**	2.903 (0.717)	**4.05**	0.230	**0.000**	**p ≤0.001**
		2	15.41	3.28	-1.804 (0.472)	**-3.82**	5.636 (0.918)	**6.14**	0.028	0.009	No
	P. Control	All	7.47	2.43	-1.010 (0.295)	**-3.42**	-0.377 (0.582)	-0.65	0.106	0.062	No
		1	7.24	2.27	-0.100 (0.365)	-0.27	-0.289 (0.717)	-0.40	0.131	0.066	No
		2	7.88	2.69	-0.249 (0.472)	-0.53	-0.371 (0.918)	-0.40	0.162	0.104	No
	T/ment Control	All	8.27	2.00	0.488 (0.295)	1.65	1.010 (0.582)	1.74	0.103	0.082	No
		1	8.24	2.14	0.679 (0.365)	1.86	1.556 (0.717)	2.17	0.123	0.115	No
		2	8.33	1.76	-0.245 (0.472)	-0.52	-1.088 (0.918)	-1.19	0.161	0.107	No

	Gp. +	Mean	S.D.	Skew (S.E.)	z-score	Kurtosis (S.E.)	z-score	K-S ++	p-value	Sig.
Illness Coher.	All	7.09	2.67	0.460 (0.295)	1.56	0.441 (0.582)	0.76	0.143	0.002	No
	1	7.00	2.42	0.640 (0.365)	1.75	1.781 (0.717)	2.48	0.160	**0.008**	**$p \leq 0.001$**
	2	7.25	3.11	0.247 (0.472)	0.52	-0.599 (0.918)	-0.65	0.122	0.200(*)	No
Emo. Reps.	All	14.18	4.32	-0.237 (0.295)	-0.80	-0.132 (0.582)	-0.23	0.090	0.200(*)	No
	1	14.57	3.98	-0.512 (0.365)	1.40	-0.043 (0.717)	-0.06	0.092	0.200(*)	No
	2	13.50	4.87	0.172 (0.472)	0.36	0.050 (0.918)	0.05	0.139	0.200(*)	No

+ In the group column 'All' represents the whole sample, '1' represents the psychiatric group and '2' represents the general medical group.

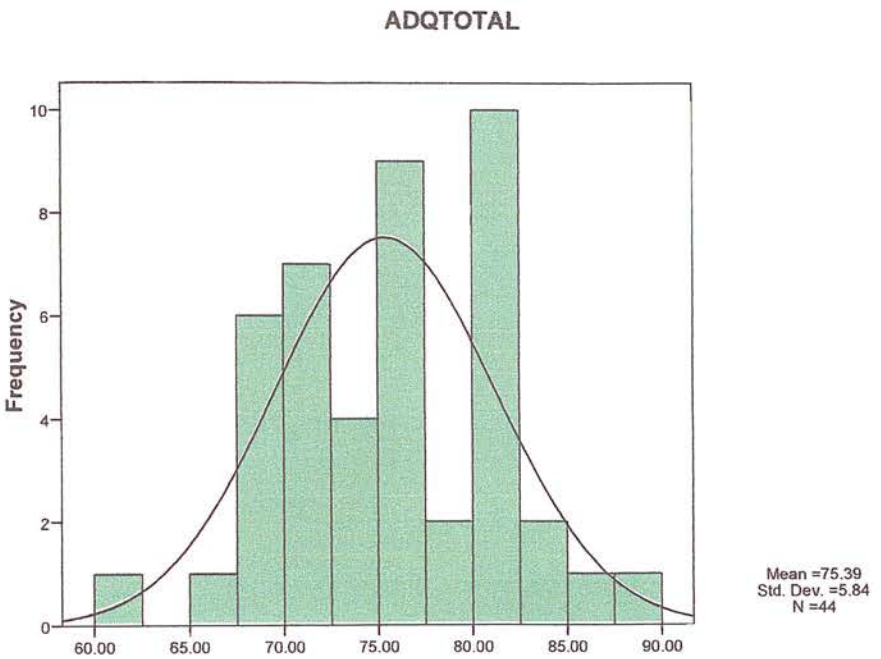
++ Kolmogorov-Smirnov tests were carried out in order to determine whether or not the distribution of scores on each item differed significantly from a normal distribution.

Appendix 7b

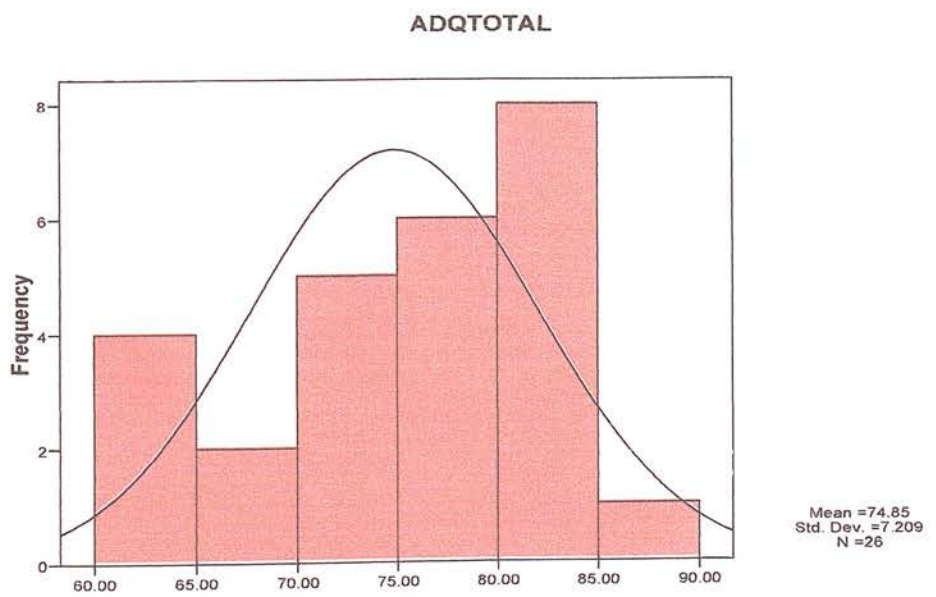
Normality of Distribution:
Histograms

APPENDIX 7b: NORMALITY OF DISTRIBUTION (HISTOGRAMS)

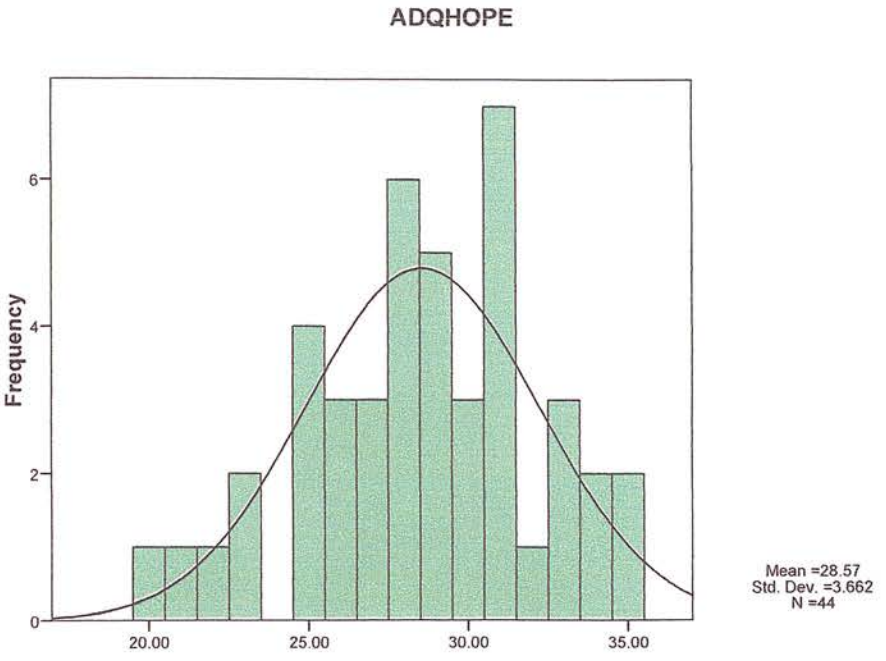
ADQ Total Score Distribution (Psychiatric Group)



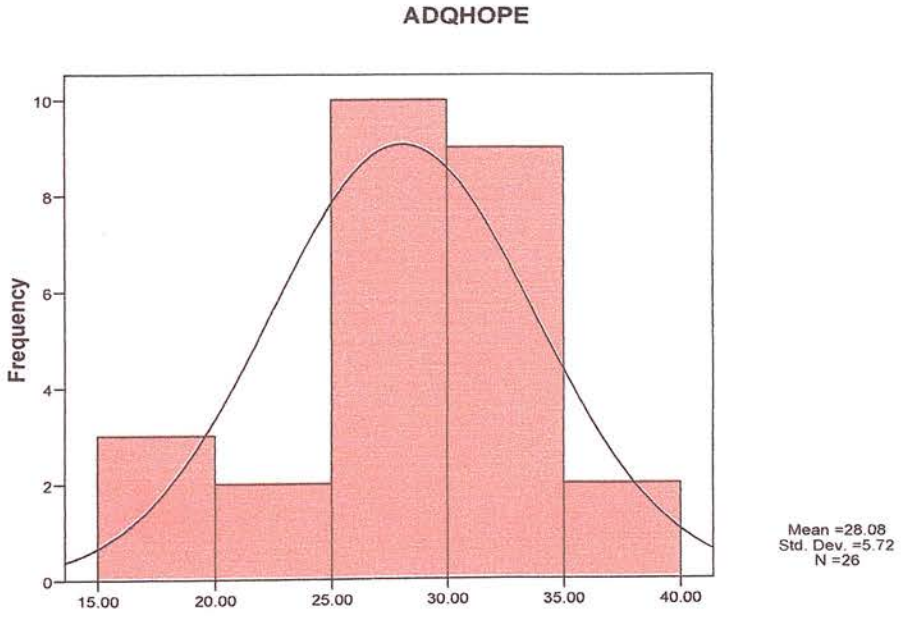
ADQ Total Score Distribution (General Medical Group)



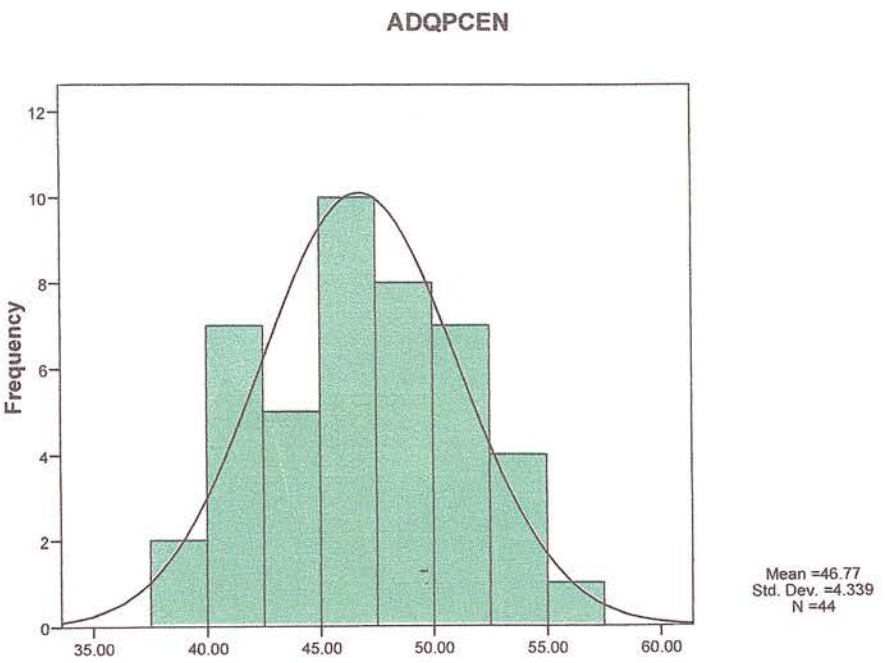
ADQ 'Hope Sub-scale' Distribution (Psychiatric Group)



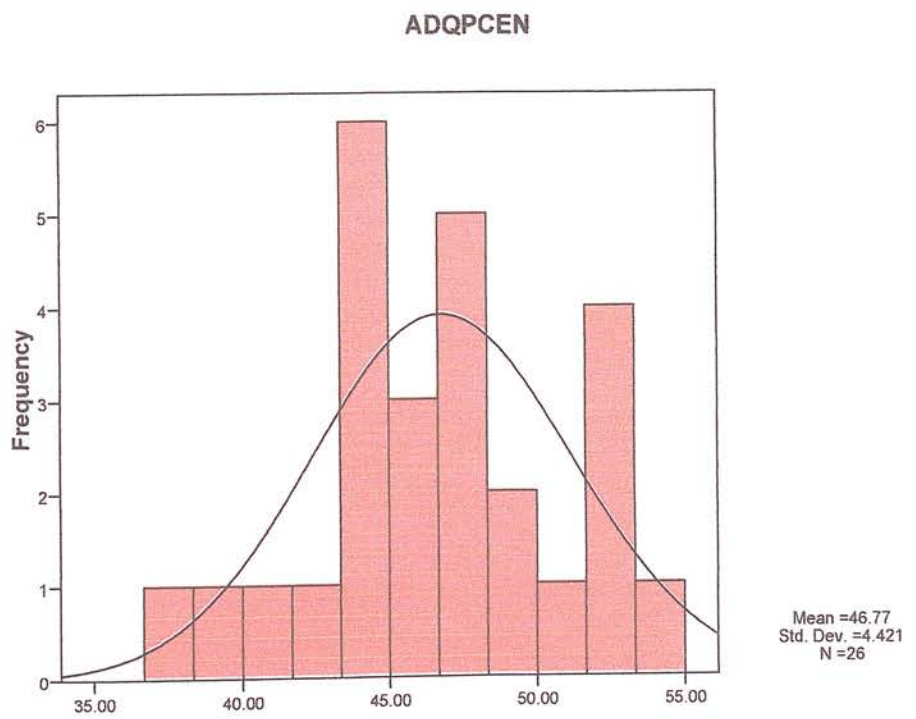
ADQ 'Hope Sub-scale' Distribution (General Medical Group)



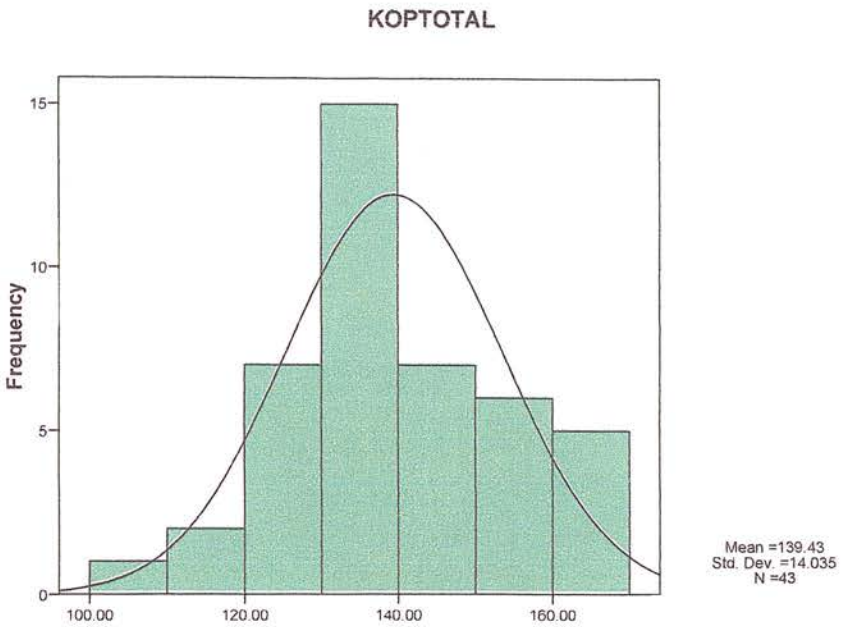
ADQ 'Person-Centred Sub-scale' Distribution (Psychiatric Group)



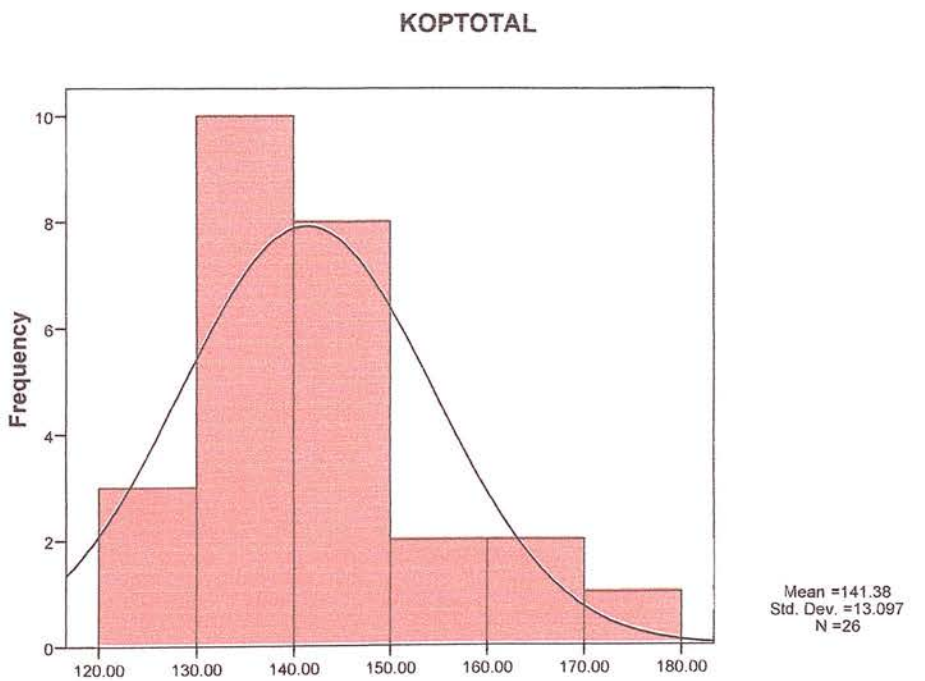
ADQ 'Person-Centred Sub-scale' Distribution (General Medical Group)



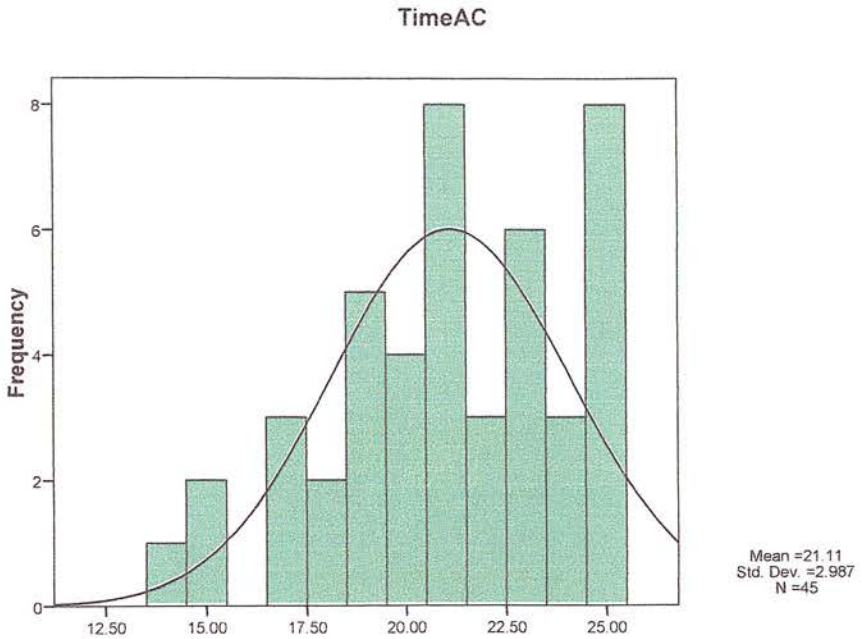
KAOP Total Score Distribution (Psychiatric Group)



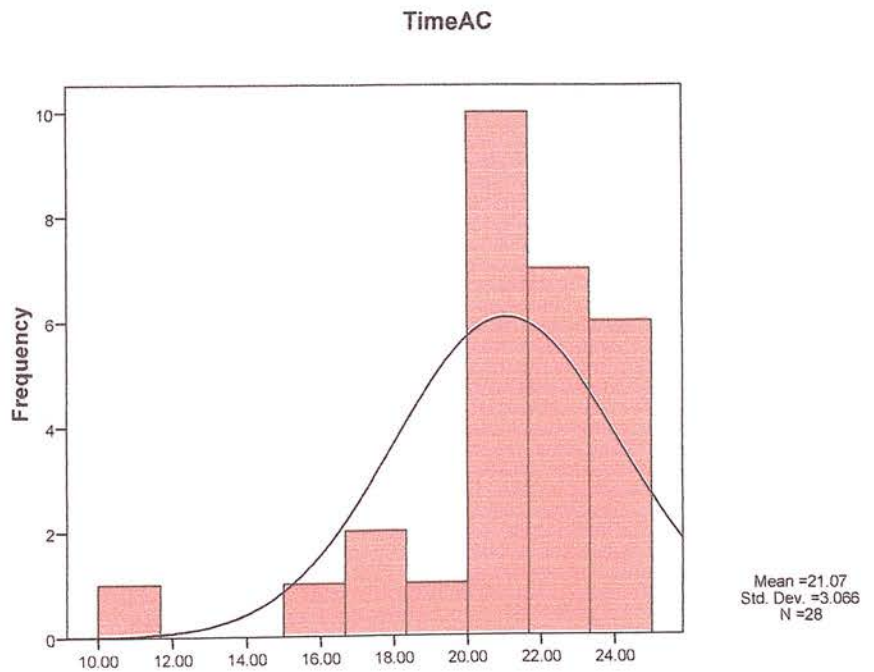
KAOP Total Score Distribution (General Medical Group)



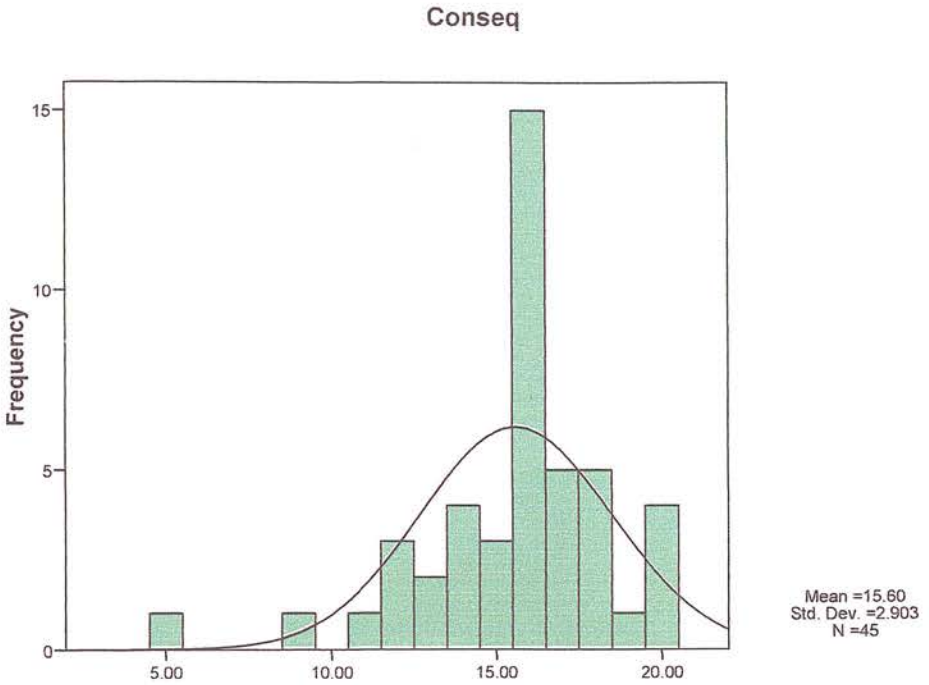
IPQ-RH 'Timeline Acute/Chronic' Subscale Distribution (Psychiatric Group)



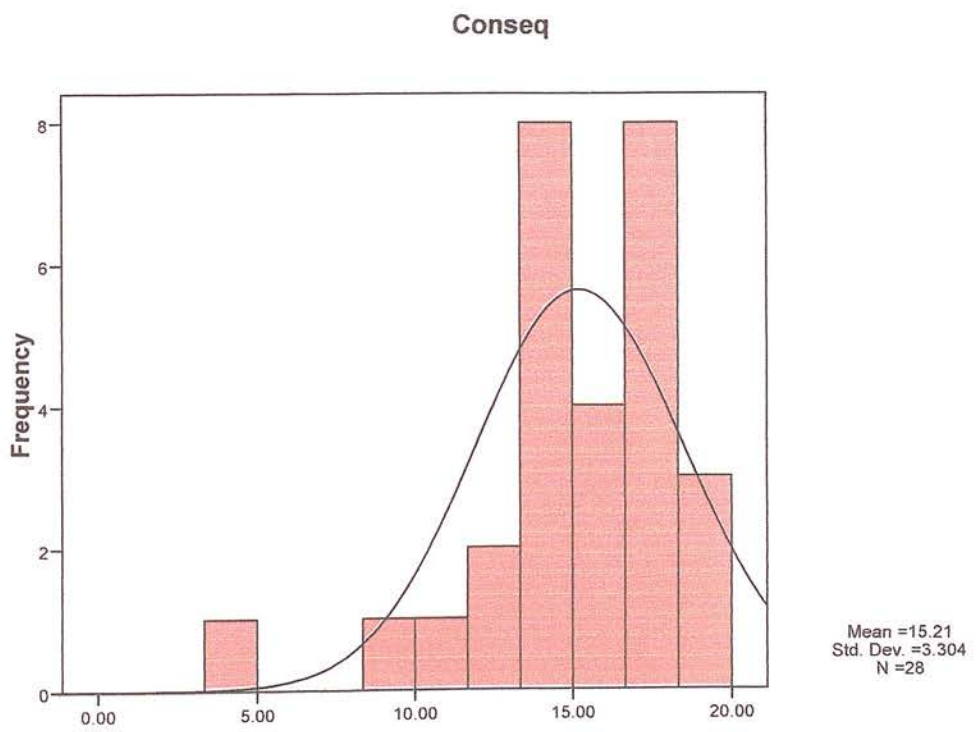
IPQ-RH 'Timeline Acute/Chronic' Subscale Distribution (Medical Group)



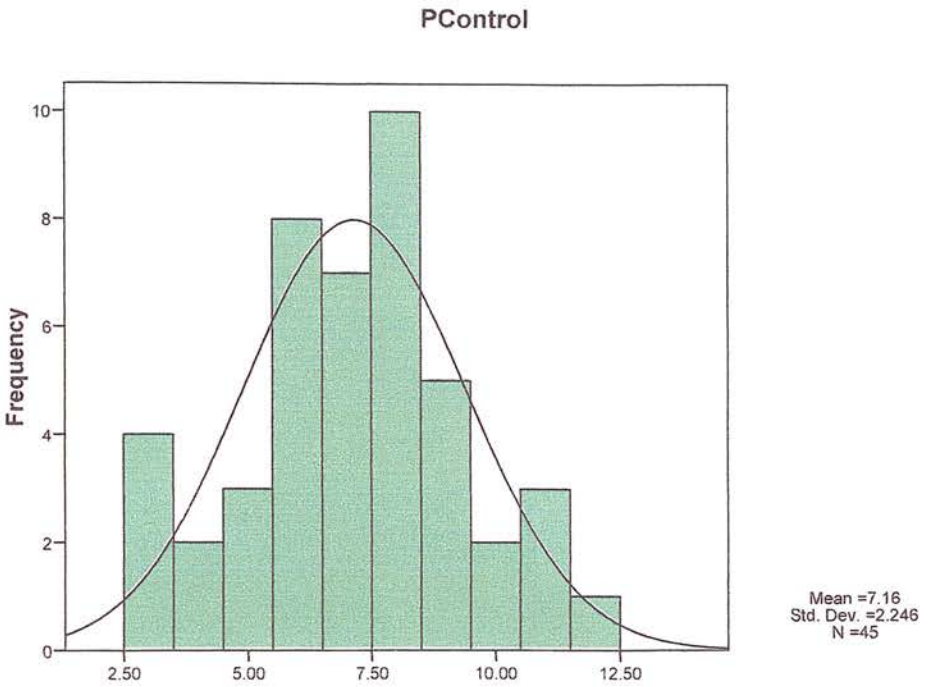
IPQ-RH 'Consequences' Subscale Distribution (Psychiatric Group)



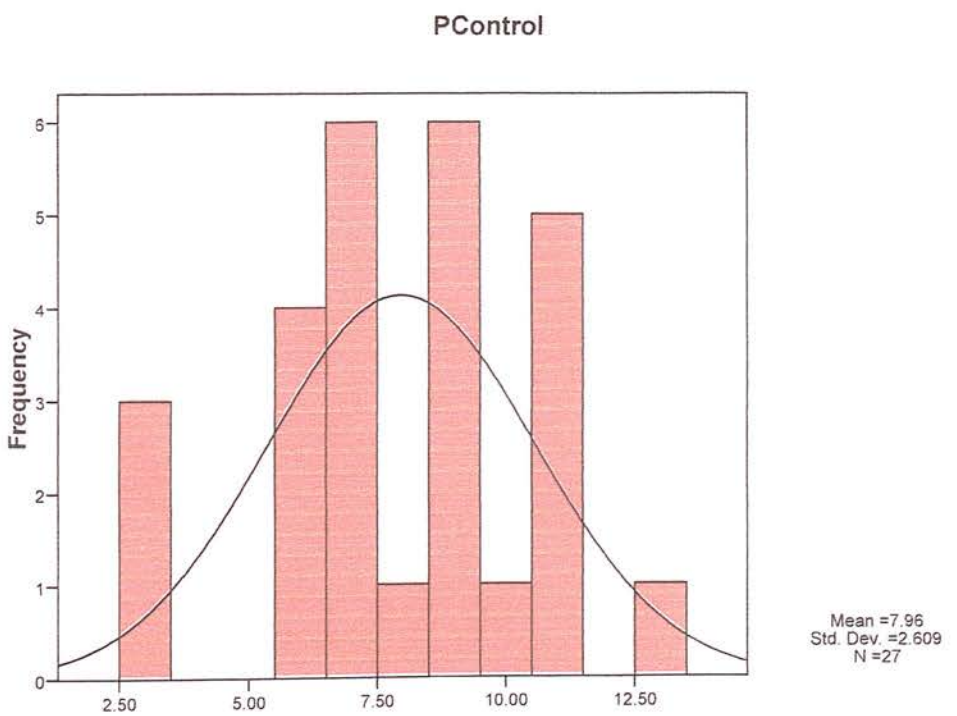
IPQ-RH 'Consequences' Subscale Distribution (Medical Group)



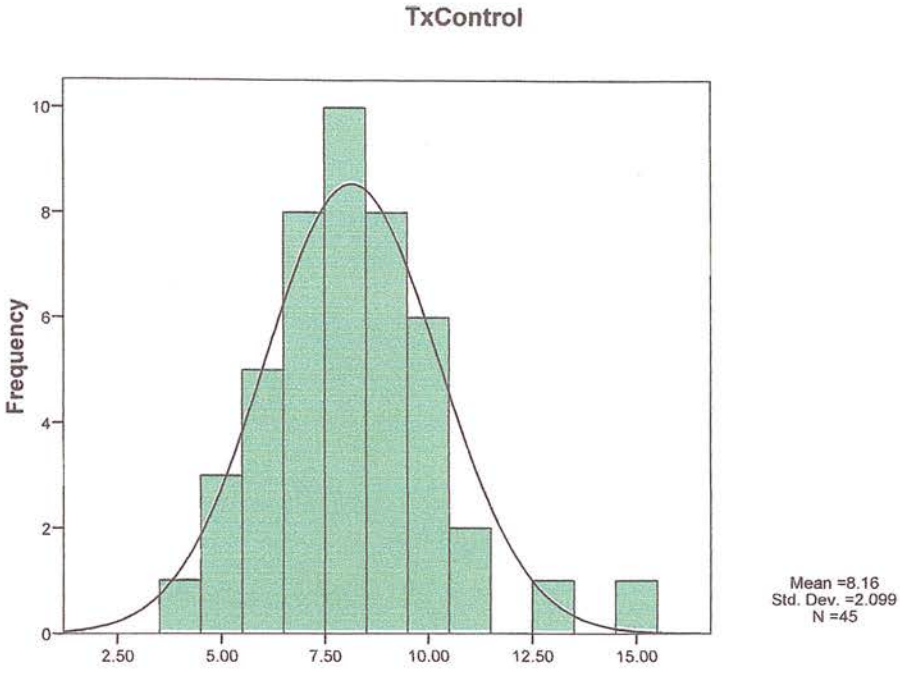
IPQ-RH 'Personal Control' Subscale Distribution (Psychiatric Group)



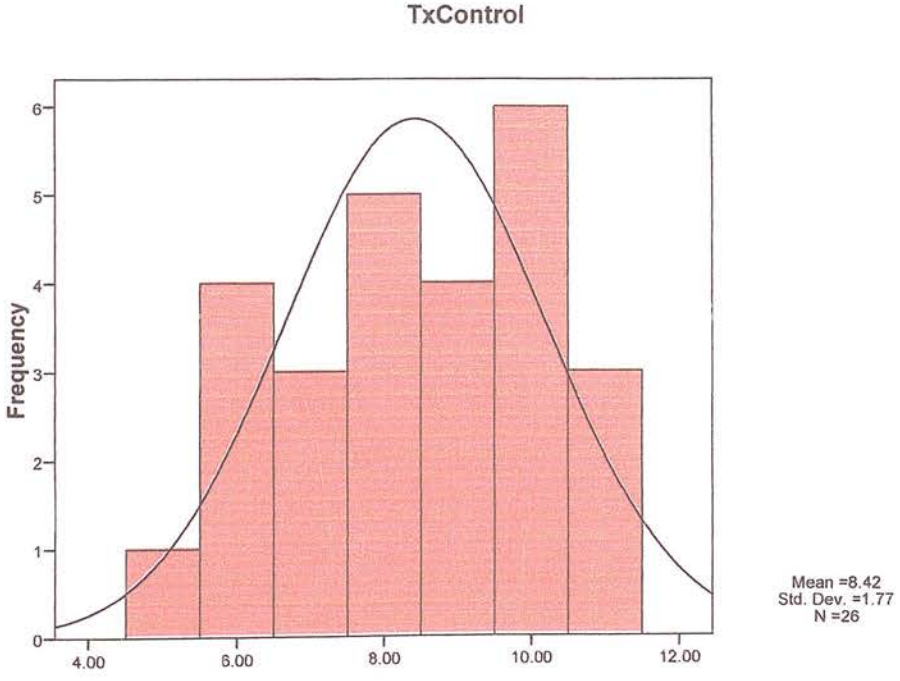
IPQ-RH 'Personal Control' Subscale Distribution (Medical Group)



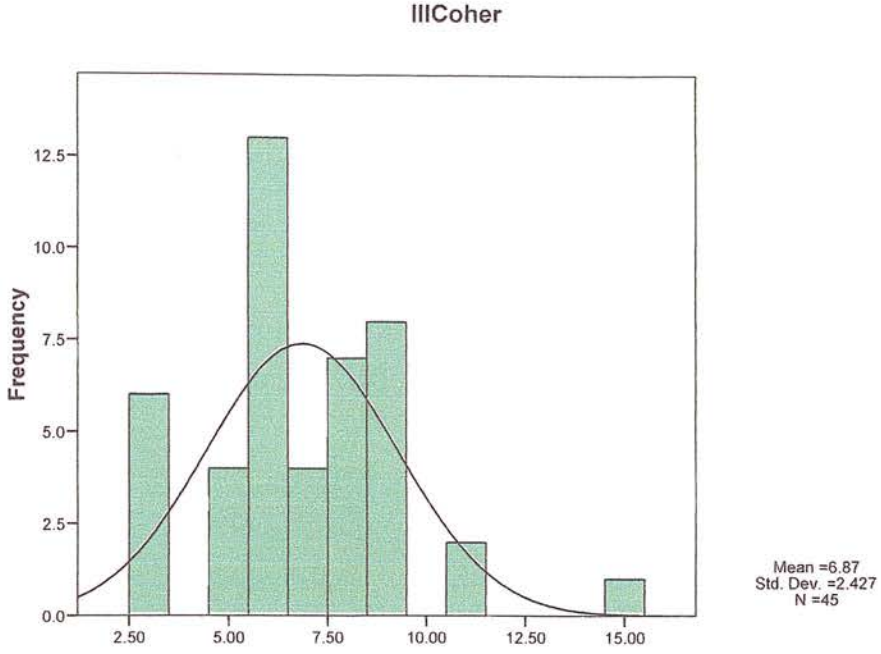
IPQ-RH 'Treatment Control' Subscale Distribution (Psychiatric Group)



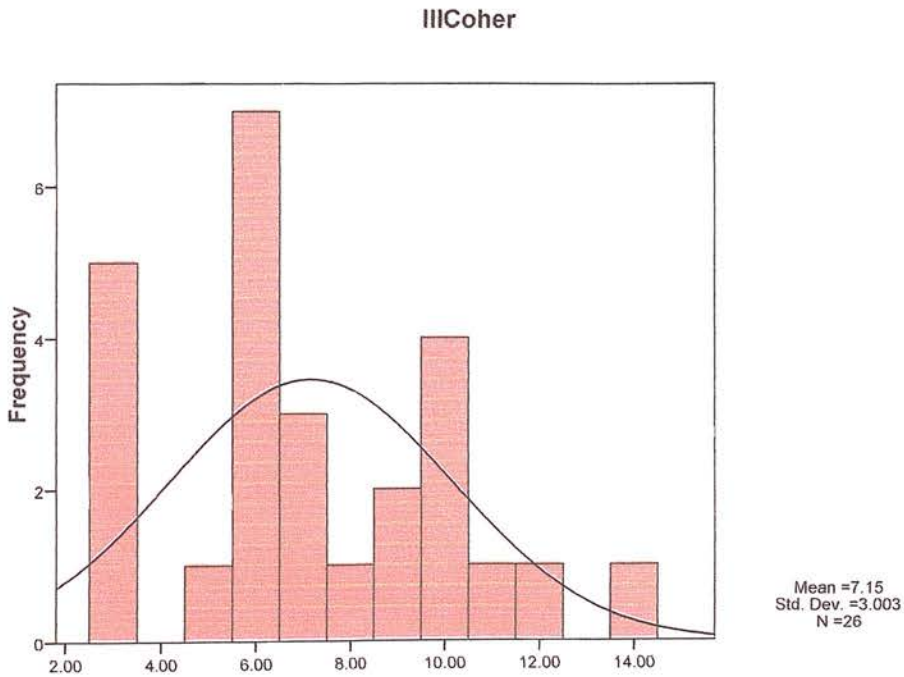
IPQ-RH 'Treatment Control' Subscale Distribution (Medical Group)



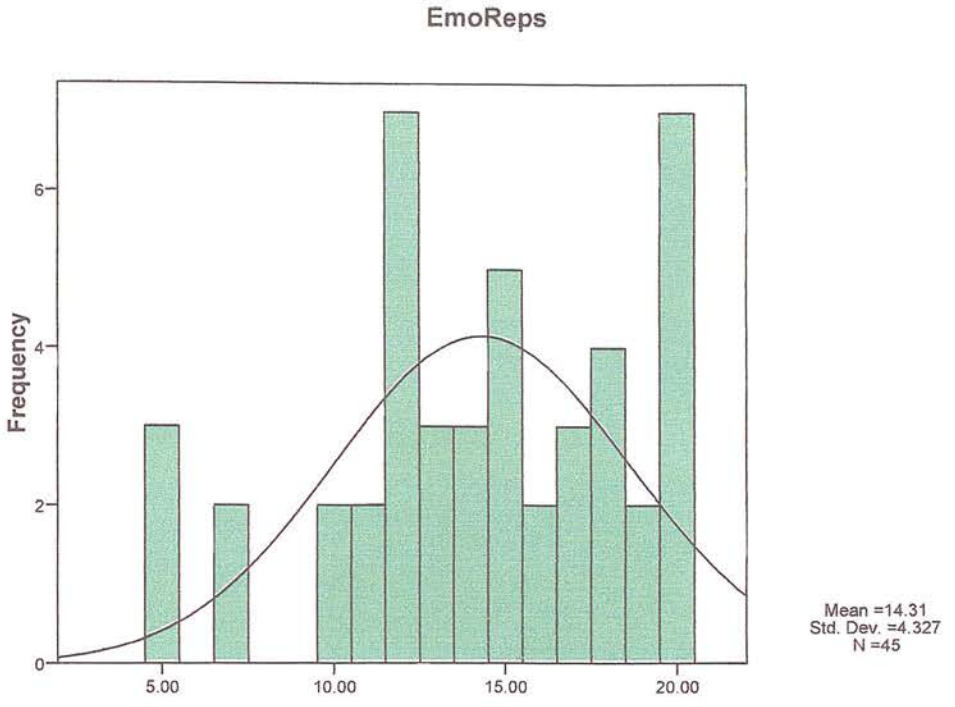
IPQ-RH 'Illness Coherence' Subscale Distribution (Psychiatric Group)



IPQ-RH 'Illness Coherence' Subscale Distribution (Medical Group)



IPQ-RH 'Emotional Rep.' Subscale Distribution (Psychiatric Group)



IPQ-RH 'Emotional Rep.' Subscale Distribution (Medical Group)