Meeting psychosocial needs in multicultural groups

Tom Kitwood's hierarchy of needs is a valuable model for working with people with dementia in multicultural group settings. **Laura Bolton** and **Zara Quail** explain their approach in one London community

Working in a London multicultural community, we are often reminded that the core sense of self in conditions such as dementia is deeply in need of care as cognitive decline erodes both memories and potentially self-esteem. As the stage and screen director Sir Richard Eyre once wrote in relation to his own mother, who had Alzheimer's disease: "We can alleviate physical pain, but mental pain – grief, despair, depression, dementia – is less accessible to treatment. It's connected to who we are – our personality, our character, our soul, if you like" (2011).

Person-centred care must be part of the answer, but there are barriers to providing it for older people living with dementia in multicultural communities such as ours in Camden (see diagram). Social isolation (LBC 2017a), deprivation (LBC 2017b), language barriers, disorientation, reduced mobility, transport issues and different cultural beliefs are some of those barriers. In addition, high levels of carer stress have been observed in these communities, where Care Visions delivers programmes for people with dementia.

Multi-modal groups, activity and therapy

Care Visions is a private social care organisation in which the Healthy Ageing division has been developing person-centred community solutions to respond to the challenges of our ageing society, both in China and the UK. As part of our dementia social care services, we design and deliver multi-modal groups and one-to-one activity and therapy sessions.

Group sessions incorporate non-pharmacological interventions designed with the aim of improving socialisation and where possible outcomes in terms of cognition, mood and sense of wellbeing. Interventions include therapies and activities that stimulate the five senses, cognition and emotion through person-centred care.

The different groups meet once or twice a week with between five and 10 people attending. Most group-based non-pharmacological interventions for dementia have been designed and trialled for country-specific cultural settings (Spector *et al* 2003, Bertrand *et al* 2019, Wong *et al* 2018). Our challenge in an ethnically diverse community affected by the barriers we have described has been how best to deliver person-centred care and create a sense of belonging in a multicultural group therapy setting.

Cultural awareness and inclusivity have been central to the way we design accessible and acceptable care for people living with dementia in medium- and large-sized urban communities. Our

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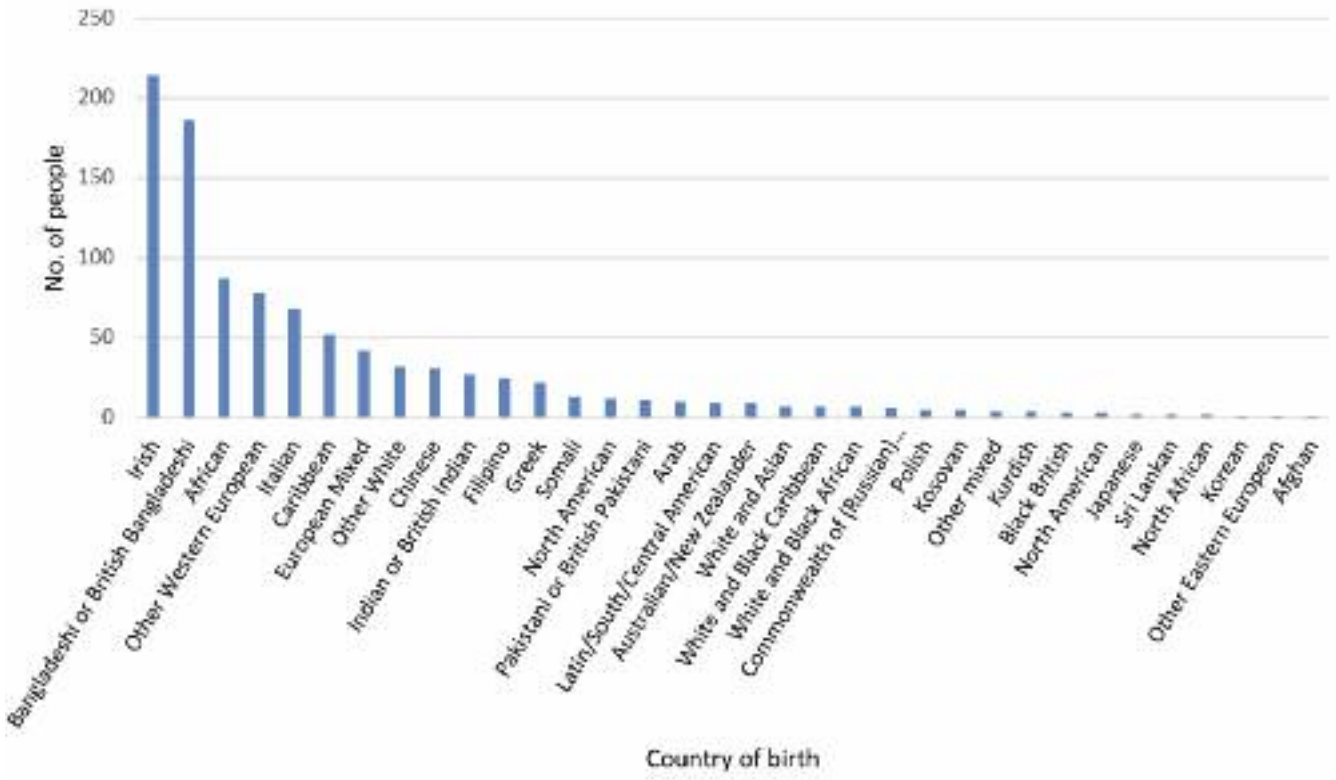
Right: Music therapist Laura Bolton works with a client. Below: Materials prepared for a group session



Estimated number of people by country of birth aged 65 or over in St Pancras and Somerstown and Holborn and Covent Garden wards, Borough of Camden. Data from Census Information Scheme (2011).

group sessions are located at well-known community centres locally and are free to attend. Most importantly, the sessions set out to meet people's psychosocial needs by applying Tom Kitwood's hierarchy of psychological and social needs (1997), a model which is integral to how we embed person-centred care.

Kitwood's hierarchy of needs is often represented as a flower with love at the centre surrounded by petals of comfort, identity, occupation, inclusion, and attachment, and we use it as a base on which to build session activities (Kitwood 1993). This model is particularly applicable in our multicultural context in relation to identity, occupation and inclusion as part of person-centred care to support a sense of personhood through "recognition, respect and trust".

Supporting identity

Identity is fundamental to each person's perception of who they are and their own story. Dementia can affect a person's identity by stripping away the memories that were unique to their sense of self. It can also affect the functional capabilities that were core to a person's identity such us being a good musician, taking care of household tasks or being the main income earner in the home. In a multicultural setting in which participants are distanced from their countries of origin, the sense of loss of identity is compounded by an environment in which other people may look, speak and behave differently from them.

Experiencing cognitive symptoms of dementia with only short-lived memories of the newer country can be a real challenge for those who may rely on familiar prompts from the place they used to call home. Lack of familiarity and discomfort can be barriers to participation in any community activities in settings with which people have no prior connection.

Our own community engagement team is acutely aware of this fact and part of their role is to identify and act on barriers such as language barriers. In such cases, any family members or friends are encouraged to attend with the participant, or a translator is sought, to facilitate translation to ensure a sense of familiarity and inclusion in the activities. If a group member struggles to understand verbal information but can process written information, instructions are always provided in both formats.

Our therapists also help participants build on their personal and cultural identity by talking with them and their families to construct biographical narratives using life story workbooks. Not only does it strengthen identity, it enables people to share their diverse histories and capture the interest of fellow group members.

As well as reinforcing individuals' own experiences, life story work draws out similarities between people from different cultures. For example, group members from several different countries discovered that they had all moved to the UK at a similar time and age, and they had the same number of children and same gender mix of children. This synchronicity provided the opportunity to emphasise similarities between group members regardless of ethnicity.

Sharing different cultures

A popular icebreaker has been to share different spoken and physical greetings from each person's language or culture. It is a learning experience in which participants show high levels of engagement. The same is the case for other activities relating to countries of origin such as those involving food, including looking at photographs of different foods, smelling spices and touching dried foods, stimulating the five senses while reinforcing aspects of each person's own culture or making new connections with others. Background music from the different cultures can intensify the experience and we have observed some dynamic group discussions resulting from memories associated with the activities.

Many people link their identity to occupation, and as one relinquishes an occupation, job or role in retirement,

Group session participants discuss emotions

there may be a need to redefine what a meaningful occupation is. Symptoms of dementia may include apathy and depression (Livingston *et al* 2017), where people experience a lack of motivation and perhaps an accompanying loss of confidence in doing things that they had previously enjoyed or excelled at.

In our group settings we try to find therapeutic activities that will engage group members and help to maintain and cultivate skills, increasing motivation and improving wellbeing. We utilise skills and abilities participants already have and to which they would naturally be drawn, so we encourage them to bring their own hobbies or crafts. It has resulted in some culturally distinctive craft work of great interest - a real discussion point for everyone in the group.

Social inclusion

Social isolation is both a risk factor for and a symptom of dementia (Livingston *et al* 2017). The social lives of people with dementia can be compromised as memory and communication skills diminish, often accompanied by symptoms of depression and a lack of motivation. But Kitwood suggests that personal inclusion can allow a person to "expand" again rather than increasingly withdraw and can be "recognised as having a distinct place in the shared life of the group" (1997).

In designing group sessions, we intentionally ensure that everyone has a chance to participate and express themselves, adapting and giving support as required to facilitate communication, often between people of different languages. In some groups we focus more on non-verbal activities to bridge language barriers; for example, physical activities with a balloon or skittles are easy to demonstrate without words and visual arts-based activities can be communicated pictorially.

Facilitating meaningful interactions between people, regardless of language or verbal ability, can foster confidence in self-expression. Creating a sense of care and belonging generates mutually caring relationships between participants as they celebrate the development and success of fellow group members. Our community engagement team promotes social inclusion by reaching out to community, cultural and religious organisations, ensuring that all member groups in specific wards are contacted and invited to take part.

Person-centred care is at the heart of what we do, even in a group setting. By applying Kitwood's model, we can establish bonds of mutual recognition and belonging highlighting the cultural richness of each person's unique background. In supporting our service delivery, we assess outcomes through participant and facility feedback questionnaires, sessional engagement and mood scores, and interval measurements of Mini Mental State Examination and Geriatric Depression Scale scores to inform intervention acceptability, efficacy and improvement of service delivery.

The Kitwood model is also applicable beyond the confines of the group participant circle. Sustained community engagement is key and is about building long-term relationships with people living with dementia, their significant others and other service providers. Initial engagement should include information and signposting to relevant services as well as keeping communication channels open.

Sensitive engagement, particularly with carers and families, is essential as we often meet them at points of crisis, especially if family members with dementia have not yet accessed or rejected services. Carers often have limited resources which are already stretched and enabling people to attend sessions and accept interventions can present a significant additional challenge.

While considering barriers of accessibility and acceptability, we also need to give people confidence that our sessions are part of a safe and beneficial service. Kitwood's model helps us to do just that. The challenges and barriers faced by older people with dementia are not unique to wards in Camden and inclusive, multicultural models of care are needed worldwide, especially in larger urban centres of global migration. Ultimately, we plan to expand this model to other cities as a way of enhancing identity, occupation and inclusion among groups for whom such needs are too easily overlooked. ■

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