BOOK REVIEWS

HEALTH CARE POLICY, PERFORMANCE AND FINANCE STRATEGIC ISSUES IN HEALTH CARE MANAGEMENT

Huw T. O. Davies and Manouche Tavakoli (Eds.)
Burlington, VT: Ashgate, 2004, 291 pp., $39.00 (hardcover).

What are the current trends and ideas in the organization and delivery of health care that stimulate technological advances, leading to a more effective use of resources? This area of inquiry attracts many participants, and there is merit in providing a forum to share information and ideas.

This book is a product of The Fifth International Conference of Strategic Issues in Health Care Management (2002, University of St. Andrews). Twenty countries were represented at the conference and the 18 articles selected for inclusion were chosen from more than 100 presentations. The participants were economists and individuals interested in research and structure in organization management. The text, annotated with graphs and charts, is organized into four sections: Health Care Policy and Technology Assessment; Policy and Performance; International Policy Innovation; and Organizing Innovation. The editors, members of the faculty at the sponsoring University of Aberdeen, have written a preface that places the articles in a framework citing the contributions of individual chapter authors.

An indication of the relative importance of each section may be discerned from the number of pages per section as well as the number of articles included. Section I (Healthcare Policy and Technology Assessment) is 43 pages and has 3 articles (chapters). Section II (Policy and Performance) is 95 pages and has 5 articles. Section III (International Policy Innovation) is 87 pages and has 6 articles. Section IV (Organizing Innovation) is 143 pages and has 3 articles. In length, Organizing Innovation is first, but in number of articles, International Policy Innovation is superior.

Section I (Healthcare Policy and Technology Assessment) is really the conceptual basis for the sections that follow, yet it is the briefest in ratio of articles to pages. In “Health Technology Assessment: More Questions Than Answers?” the authors undertake a thorough analysis of 64 health technology assessments (HTAs). The study focuses specifically on those HTAs developed by the British National Health Service Program in relation to clinical practice. The authors believe that the designs are often flawed, and there is a lack of emphasis on cost and clinical effectiveness. The article concludes with a recommendation for “more effective alignment of resources and incentives to those who innovate and evaluate in health care, rather than depend on the systematic review of weak primary evidence.” In other words, this approach has not proved useful for the purpose intended, namely, providing guidance to policy makers and clinicians about cost-effective choices or better clinical outcomes.

The second chapter presents a case of local implementation of a health care intervention. “NICE Works: A Case Study of the Local Implementation of NICE Guidelines.” NICE is the acronym for National Institute of Clinical Excellence. The authors conclude that there is a lack of information on how local authorities should implement these strategies. Managers rather than clinicians generally take the lead in implementation. Costs also vary from the national estimate. It appears that more work and understanding are required for practical application.

The final chapter in this section is titled “The Effect of United Kingdom Neonatal Staffing Study Results on the Prior Views of Neonatal Doctors: A Bayesian Analysis.” The study focuses on how an individual’s quantified belief is modified with the introduction of new data. The more strongly a belief is previously held, the more convincing is the need to change to an opposite position. The issue at hand was the “optimal configuration of service for providing neonatal intensive care services.” In other words, the consideration is smaller units versus larger facilities. Previously held beliefs are therefore an indication to predict resistance to change. It should be noted that the hypothesis depends on the clarity of questions used in the survey and may not take into account practices already in place for care of more complex cases at larger units.

Section II, Policy and Performance, begins with a chapter that perhaps has most applicability and relevance to administrators and clinicians concerned with patient care, albeit not long-term care. The title of the first chapter in this section is “Hospital-Physician Relationships: Comparing Administrators’ and Physicians’ Perceptions.” The author, Thomas Rundall, is a professor of organized health systems at the University of California. The article considers the relationship between hospitals and physicians in a sample of West Coast hospitals with the purpose of improving relationships and identifying barriers and key facilitators. The article contains survey questions and identification of the inherent problems in changing to a managed care environment, including the loss of autonomy and a reduction in revenue.

The fifth chapter is called “The Invisible Cost of Repeated Cycles of Organizational Restructuring,” by Jason Nickels. The author postulates that repeated restructuring has a negative effect on morale and performance. The study was conducted in Wales where the document Improving Health in Wales: A Plan for NHS and Its Partners resulted in the ending of five Welsh Health Authorities. Furthermore, this was the seventh restructuring in the last 10 years. The author offers
suggestions on how to manage change by letting employee concerns be heard, providing explicit job expectations, using a facilitator in the early stages of change, and recognizing the anxiety concerned with change. The author supports his conclusions through interviews and observations made by searching the literature. This subject has relevance for the current continuous restructuring of U.S. health organizations. Although the author’s observations may appear self-evident, the difficulty probably comes from the translation of guidance into implementation as well as a lack of awareness or caring for the unintended side effects on individual employees.

The sixth chapter discusses themes for a “System of Medical Error Disclosure: Promoting Patient Safety Using a Partnership of Patient and Provider.” The author, Bryan Liang, is a professor at the University of Houston Law Center, Health and Policy Institute. He advocates the approach of system analysis, rather than the current climate of individual shame and blame, to promote quality of care. He discusses his approach through five principles (themes). These are

1. mutual respect, trust, responsibility, and partnership;
2. system education for providers and patients;
3. clear standard operating procedure;
4. objectivity of disclosure; and
5. communication through mediation.

The author believes that this method will result in fewer malpractice cases because many patients appear to sue because the provider fails to achieve a working relationship with the patient. The article also contains an extensive reference section.

Chapter 7, “Accountability in the Canadian Health Care Systems: Fitting the Pieces of the Puzzle Together,” by Carl-Arly Dubois and Jean-Louis Denis, explores four models of competing accountability. These models are characterized as political, professional, bureaucratic, and managerial. The study, undertaken in three Canadian provinces, shows that multiple forms of accountability are desirable. Each

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REVIEW: CONTINUED

The model has strengths and weaknesses, but the professional and bureaucratic models do not always recognize the requirements or needs of society.

The final chapter in Section II is titled “Building an Organizational Framework for Effective Clinical Governance,” by Elaine Moss and Peter Totterdill. In this article, the setting is the British National Health Service. The authors advocate a more team-oriented approach characterized by employee participation. A focus on meeting short-term targets fails to take into account the values of long-term learning and adaptation. The authors conclude: “...distortions in the implementation of clinical governance result in quality assurance without quality improvement.”

In Section III (International Policy Innovation), Daniellidou, Soutiotis, and Kyriopoulos consider “Roemer’s Law: Does it Apply in Greece?” (Milton I. Roemer, the reader will recall, has stated: “The optimal supply of hospital beds needed by each country, for planning purposes, has been a subject of study and debate everywhere. If there is an assured payment system, it seems that almost any additional hospital beds provided will tend to be used, up to a ceiling not yet determined.”)

The article focuses on examples of change and confirms through statistical analysis that the supply of hospital beds correlates with increased admissions. The Roemer finding is significant, because reduction of hospital beds is one way to control costs. One interesting observation for readers of a long-term care journal is that the elderly are not using facilities at the same rate as their growth in the population. One explanation according to the authors is the Greek tradition of caring for the elderly at home, as well as the growing provision of home health services.

“Reflections of Globalization on Public Health,” by Cilingiroglu and Ozcebe, lists six effects of globalization on health. They are speed and spread of disease, standardization of medical education, availability of dangerous products, changes in health systems, new rules for cross-border flow, and increased inequalities within and among countries that increase health risks. The authors

use health information in Turkey to support their thesis.

Chapter 11, “Opportunity Knocks: Ten Years of Health Care Reform Strategic Policy Implementation and Maori Health Development in New Zealand,” by Stewart, Kaura, and Everritt, focuses on the ascendance of Maori power and the development of Maori co-purchasing organizations (MAPO). The lead author of this chapter is the chief executive officer of the Te Tai Tokerau MAPO Trust. The plan as of 2001 is to establish Primary Health Organizations (PHOs) to reach local health goals. The PHOs will involve the community in the governance and decision-making. The authors are proud of the reforms initiated by the Maori.

Chapter 12, “Reorganizing Health Care Delivery in Hospitals: Structure and Processes to Serve Quality,” by Federico Lega, traces the journey from functional design to a managed care, cost-conscious environment. There is a discussion of both vertical and horizontal integration. Resource pooling receives strong support, as do multidisciplinary work groups. Lega discusses the design of the hospital of the future, which may consist of an emergency room, intensive care unit, and diagnostic services, with more care brought to the home. The author believes that the immediate trend will be to specialize hospitals within a network.

Chapter 13, “Access to Pharmaceuticals in Transition Countries” by Hofmarcher and Lietz of Institute of Advanced Studies in Vienna, whose research was funded by the World Bank, has as its purpose, examining “access, purchasing and market control mechanisms in Slovakia, Georgia and the Ukraine.” The authors note that the high price of drugs, along with co-pay requirements, has an adverse effect. Furthermore, application of quality standards is uneven. This lack of availability certainly would affect the care of the elderly.

Chapter 14, “Health Insurance in Iran: Opportunities and Complexities,” by Mehdi Russel, explores the development of health insurance in Iran as a way to reform the health systems. In these systems, spending constitutes 5.7% of the gross national product. The current
system is characterized by 40 regional health authorities. The emphasis has been on disease prevention and health promotion measures. National health insurance (NHI) in Iran is not new, beginning with railway workers 100 years ago. The author believes that NHI was not implemented at the best time from a socioeconomic standpoint. He concludes with recommendations to improve the system, including development of private services, decentralization, adopting cost control policies, and promoting information and research studies.

In Section IV (Organizing Innovation), Chapter 15, “Improving the Operation of Operating Theatres: Data Triangulation, Change Management and Action Research in Operating Theatres,” was written by Boaden, a lecturer in operations management, and Bamford, a process improvement officer at Manchester Royal Infirmary. It is therefore appropriate that they wish to identify and verify causes of delays in schedules.

The study collected both anecdotal and qualitative data. Anecdotal data were gathered through interviews and focus groups. The comments were then mapped with the frequency of responses added. The problems listed were “theatre porters unavailable, lists arriving late in theatres, inexperienced staff communication between ward and theatre, equipment problems, surgeon unavailable, anesthetist unavailable, inaccurate assessment of operating time, lack of beds, order of lists changed.” These anecdotal observations were then compared to the log maintained on procedures. Although the qualitative and quantitative data results differed from each other, the information identified the perceptions of those involved as well as inhibitions in blaming a senior individual. In response to the observations, the following programs were initiated: tracking the activity of theater porters, holding weekly utilization meetings, enhancing management information systems to give information to the managers and staff members. The concluding section offers a valuable road map for investigating issues in general: evaluate comments in the context in which they are made; use more than one source of data/information; value communication for its power to increase awareness; recognize that some factors may be outside the scope of the investigation; concentrate on what can easily be changed.

Chapter 16, “Job Satisfaction and the Modernization Project: A Longitudinal Study of Two NHS Acute Trusts,” by Fisher, Harris, Kirk, Leopold and Leverment, members of the Department of Resource Management at the Nottingham Business School of Nottingham Trent University, concerns itself with the “best fit” approach of the modernization project proposed for the National Health Service (NHS) and the contrary findings of the Chartered Institute of Personnel and Development (CIPD). The premise of the government is that job satisfaction will improve performance. The survey reveals that there is very little job satisfaction in terms of pay, recognition, flexibility in hours, and access to training and development to have effective managers available to cope with poor performance and in representation by trade unions. The above-mentioned items are part of an official document that was intended to lead to better job satisfaction and therefore work performance. The authors advocate a more decentralized targeted approach with an emphasis on human resources.

Chapter 17, “The Relation Between Patient Volume, Staffing, Workload and Adherence to Selected National Standards and Risk-Adjusted Outcomes in UK Neonatal Intensive Care Units: A Prospective Study,” by Tucker, Parry, McCabe, Nicolson, and Tarnow-Mordi, investigates outcome measures in neonatal units. The authors conclude that there is no difference in outcome between low, medium, and high volume neonatal intensive care units, once adjustments are made for clinical risk and illness severity. This finding contrasts with conventional wisdom and illustrates the value of research in innovating change. This article does have a link to physician beliefs as discussed by Tucker and Parry in Chapter 3.

In conclusion, what is the relevance to the reader of the Journal of Long Term Care Management Journals of a review of conference proceedings focusing on organization? In general, some articles are more relevant to the reader than others. The articles chosen are quite technical in nature and do not address issues of long-term health care except perhaps Chapter 9 and its examination of an unanticipated finding of the application of Roemer’s Law. The international imperative to reduce health cost discussed throughout the conference is appropriate to remember. Methods of research presented are also useful.

Reviewer: Linda K. Scharer, MUP
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THE SUNSHINE ON MY FACE: A READ-ALOUD BOOK FOR MEMORY-CHALLENGED ADULTS
Lydia Burdick (illustrated by Jane Freeman)
Baltimore: Health Professions Press, 2005, 22 pp., $17.95 (hardcover).

Only one of humanity’s great geniuses or great impostors or scam artists could write a four-paged, double-spaced treatise on a book containing a total of one small paragraph (unless it were a Joycean torrent or Shakespearean sonnet, which this is not).

The positives of this work include its size and physical sturdiness. It is large enough to be seen by most seeing-challenged and firm enough to survive being the object of misuse, pulled, dropped, sat on, thrown, and more. It does fit easily on a lap, or two, which tends to promote the opportunity and power of touch and the oft-longed-for comfort of physical proximity.
REVIEWS: CONTINUED

At the base of this work is the profound tragedy and challenge that humans often courageously find themselves facing, both those becoming “memory-challenged” and those who love and care for them. From this vantage point, any such genuine attempt to recognize and support this caring is noble and worthy. You sense throughout this book that the author has carefully covered the many layers of a life’s preferred positive memories, and that they arose from the ashes of painful and at times triumphant personal experience.

The colors in this picture book are of a smooth texture, rich, earthy, and satisfying. Nothing jumps, splashes, or is shocking. The images are friendly, open, and restful. It is a gentle work, the tenderness palpable in word and visual experience. There is no doubt that this is generally a very helpful, useful, user-friendly picture book addressing a seriously debilitating challenge. The author shares the affirming and positive impact that one smile has, as a survivor of such devastating loss knows. For her, that recognition was deeply moving and reward enough for the effort and the risk of this shared reading. Yes, it’s a risk. One can and will never know the reaction, if any, of others, but to those on the often long and lonely journey, it is worth the try. There is no price tag high enough for such intimate personal moments. This echoes and remembers the delicate and at these times elusive meaning of our life, and it interconnects that meaning with that of the family of humanity.

With an affected loved one or client, there is a timelessness about the waiting, observing, and searching for contact accompanying this reading. In contrast, in approximately 5 minutes (or less), I showed my staff each page and read the entire book. At first, it lead to fun, many laughs and some jokes, but soon after progressed to deeper personal sharing of experiences about grandparents, some clients, and, perhaps most important, facing our own fears about ourselves, our futures. Perhaps this is the power of such obvious simplicity, as it tricks us into discovering more about our own lives and our shared humanity.

The constant refrain, and the beginning of all 14 short sentences, the only sentences without compounds or conjunctions or adverbs, is “I love . . .”: I love to eat . . .; I love to watch . . .; I love to talk . . . to go . . . to listen . . . Love can be a complex verb, and bewildering noun, to say the least, but one thing it simply, clearly, and continually remains in this work is courageous.

There is a significant caution with *The Sunshine on My Face*. This book is *not* “for Memory-Challenged Adults.” It is for those with severe, later stages of Alzheimer’s, injury, or dementia. This book runs a high risk of being outright insulting for almost all except those in this category, and therefore, it ought to be used with utmost care. Those familiar with severe Alzheimer’s know that the reader should be prepared for and not surprised by both no reaction, or even a negative reaction to this work, and different reactions at different times.

The book also has limitations by depicting the life of a definite class of society, with a wide range of travel and opportunities: cars, intact nuclear families, houses with porches, ample countryside space. There is little city here. It resonates a life of ample if not unusual privilege. However, more than our actual circumstances, most humans do have deep long-embedded dreams, wishes, and hopeful images from stories, reading, movies, and perhaps that once-in-a-lifetime never-forgotten experience: the farm, the cross-country car ride, the sun-set by a lake, the cup of tea with a loved one of long ago.

What indeed would be more recognizable, more stimulating, more helpful, and intimately satisfying would be the interaction of developing a picture album with clippings of actual and known relatives, friends, and pets, pictures of historical contexts of their lives, places traveled, reflections of activities once pursued, and other lifetime events the person was involved with or connected to. Naturally, this may also produce no observed reaction, but stands a better chance. Perhaps the most compelling element of and argument to support *The Sunshine on My Face* would be for it to serve as a beginning template to stimulate the making of such a personal album.

*The Sunshine on My Face* seems to beckon us to encourage and support that endeavor. Invaluably, it contains hope. Importantly, it reminds us we are not alone. We are surrounded and loved as the sun sets into our common spiritual waters.

**Reviewer: Anthony Donovan, RN**

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**WHY LIFE SPEEDS UP AS YOU GET OLDER: HOW MEMORY SHAPES OUR PAST**

Douwe Draaisma

*New York: Cambridge University Press, 2004, 273 pp. + index, $28.99 (hardcover).*

Any one of us aged past our years as a child will be captured by this book title, but how often is expectation fulfilled? In this remarkable volume, our hope of understanding the impact of time upon memory is amply met.

Douwe Draaisma, an academic psychologist in the Netherlands, has organized a compelling and thorough review of studies in memory. These studies are offered to the reader in understandable terms, thanks to both the author’s clarity of presentation and to the skill of the translators, Arnold and Erica Pomerans.

The overall theme of this work is analysis of the nature of autobiographical memory. The studies analyzed largely consider psychological factors related to our perception of time, and recognize that our sense of time is subjective.
AGING AND MEMORY
We all understand that the impact of the passage of years (i.e., growing older) upon memory is dominant. This is powerfully manifested by Draaisma’s analysis, in his final chapter, of a 16th-century memento mori painting by David Bailly entitled “Vanitas still life with portrait of a young painter.” The following exemplifies the author’s irresistible approach and style:

The still life is a depiction of mortality... The skull dominating all the objects... The empty eye sockets point to the sheet of paper hanging from the extreme edge of the table and bearing the text Vanitas vanitatum, et omnia vanitas. Between head and skull is a recently snuffed candle from which a wisp of smoke is still escaping. Over the table float soap bubbles: vita bolla, life is a soap bubble... underlining the transitory character of earthly things.

If you, reading this review, are tempted (as I trust you will be) to obtain this book, among the first temptations you will face is that of trying to remember your own earliest memories, as I did. So:

I remember lying in a hospital bed, in a darkened room, at age 2½; after a tonsillectomy. My mother is bringing me ice cream.

I remember (age 4½) visiting my mother in the hospital after she gave birth to my brother, and also when she carried him very carefully into our home, wrapped in a blanket.

It is a December Sunday about 3 PM. My father is driving my brother and me down the West Side Highway in Manhattan and we’re just under the George Washington Bridge, listening to a football game on the radio. A voice interrupts the game and says: We’ve just informed that the Japanese have attacked Pearl Harbor. My father says, “That means we’re at war” (age 13).

But enough of that.

EARLY MEMORIES: ARE THEY RELIABLE?
This question has been subjected to studies and analyses, many of them mutually contradictory, over the decades. Freud states that the earliest are screening memories and thus not overtly reliable. Other investigators, using such terms as childhood amnesia, relate the absence of very early memories to matters of immature brain development (i.e., the young brain is incapable of storing memories); or is it a fact that early memories are indeed stored but have become inaccessible. There is a “veil drawn over the first few years.” The investigators Mark Howe and Mary Courage (1993) attribute this to the child’s lack of self-consciousness: As long as there is no “I” or “self,” experiences simply cannot be stored as personal recollections. The human ability to grasp the distinctions between you and me, or between here and there appears to arise not earlier than age 18 months.

Memory and the Sense of Smell
Conventional wisdom holds that smells evoke childhood memories, and are more vivid than memories associated with sight, taste, or sound. True? Much anecdotal evidence is summarized but experimental data are equivocal. Draaisma considers the evolutionary history of brain anatomy to try the case.

Iconic Images
Draaisma uses the term “flashbulb memories” to describe the searing, brilliant images we hold about iconic events we’ve experienced. Researchers are cited who claim that these memories are not reliable, derived from secondary reports on TV, for instance. My own experience (and yours too, I’m sure) is that these are accurate. Where were you when JFK was shot? When Princess Diana was killed? When Malcolm X was murdered? Then, there are more personal and iconic memories (for me, 57 years ago, when I first glimpsed that 16-year-old girl who became my wife; if I were an artist, I could draw a picture from memory of how she looked).

IMMENSE CAPACITY FOR MEMORY
The Pathological Effect of Perfect Memory
Draaisma cites the case of Solomon Sherashevsky, a person with near-absolute graphic memory, studied for more than 3 decades by the Russian physiologist Aleksandr Lurija. The normal human memory span is about seven components, but Sherashevsky’s memory span was essentially unlimited, hundreds of components in words and figures, including immense and complex numerical equations. Further, he could recall these memories months or years later. He could recall a mental map of every route he had taken, a faultless sense of direction. The explanation? Sherashevsky’s memory had a visual basis.
Every word automatically elicited a picture indelibly imprinted on his memory. "When I hear the word green, a green flowerpot appears; with the word red I see a man in a red shirt coming towards me. . . . Take the number 1. This is a proud, well-built man; 2 is a high-spirited woman . . . 6 a man with a swollen foot."

Further, he associated words with colors, tastes, and pain. Recall of old memories was based on his capacity to sense the "taste" of the earlier occasion.

So, are we jealous of Shereshevsky? Draaisma asks: What does living with a near-absolute memory mean? His thoughts were "invariably childishly concrete and visual." He was not able to grasp the concept of the word "nothing" had no sense of metaphor, of poetry, or of abstract thinking.

The Savant Syndrome

Draaisma offers here a fascinating discussion of what, until recently, were termed "idiots savants," but today, in a bow to political correctness, are simply called "savants." The first clinical review of young persons with a perceived low degree of intelligence but remarkable memory was offered in 1887 by an English psychiatrist, J. L. Down (also the definer of Down's syndrome). Down described three categories: those who have prodigious memories (e.g., know the entire bus timetable of a large city by heart); those who he called "calculators" (can say quickly on what day of the week a certain date falls); and those artistically gifted, with perfect pitch and the ability to play musical passages by ear but who cannot read music. More recent studies show that many savants are autistic, and of the 100 or so described in the medical literature to date, the male to female ratio is 6:1. Neurological explanations offered by Draaisma to explain the savant syndrome seem inadequate.

It is now recognized that persons with savant-like abilities are not necessarily of low intelligence; that there exists a spectrum. Draaisma points out, for instance, that the great 19th-century mathematician Carl Gauss was a calculating prodigy in childhood. An earlier instance describing one of these remarkable persons is found in Gentleman's Magazine, an English monthly, in 1754. Draaisma cites here the story of Jedediah Buxton and his savant-like calculating ability. He was capable, as an example, of multiplying three numbers of eight digits each to arrive at the correct 27 digit total, and do so in reverse as well.

I took the occasion to identify references to Buxton in earlier volumes of Gentleman's Magazine, and offer this from 1751:

In a small village called Elmton . . . in Derbyshire lives Jedediah Buxton, about 50 years of age, with [a] rare talent in figures. . . . he is no scholar, not being able to scrawl his own name . . . I met with him by accident. . . . I proped to him the following random question: In a body whose 3 sides are 23145789 yards, 5642732 yards, and 54965 yards, how many cubical 1/8ths of an inch . . . [He] asked which end I would begin at. . . . I chose the regular method and found that in a line of 28 figures, he made no hesitation nor the least mistake . . . [S]ome years ago he measured . . . the whole lordship of Elmton, of some thousand acres and [figured] the contents, not only in acres, roods and perches, but even in square inches; after this, for his own amusement, he reduced them into square hairsbreadths, computing. . . . 48 to each side of an inch . . . Allowing the distance between York and London to be 204 miles, I asked him how many times a coach-wheel turned round in that distance, allowing the wheels' circumference to be 6 yards. In 13 minutes he answered 59840 times.

One more:

In 202,680,000,360 miles, and each mile reckoned to be cubical, how many barley-corns, vetches, peas, wheat, oats, rye, beans, lintels, and how many hairs each an inch long, would fill that space, reckoning 48 hairs . . . he calculated the following result: 14 thousand, 93 mill. 420 thou. 936 quarters, 1 bushel, 1 peck, 1 quartern, 3 pints, and 5 and a quarter solid inches of one sort of grain are contain'd in one solid mile; or 5 thousand, 451 mill., 770 thousand yards in a cubical mile, being 254 millions of millions, 358 thousands, 61 mill. And 56 thousand inches in a cubical mile; and if every hair be an inch long, and 2304 hairs a cubical inch, then 580 thousand, 40 millions of millions, 972 thousand, 673 millions, and 24 thousand, will fill the space of a cubical mile.

It's worth a note in passing that although Buxton couldn't write his name, he was a self-supporting laborer with a wife and children.

Déjà Vu

Charles Dickens wrote: "We have all some experience of a feeling . . . of what we are saying and doing having been said and done before. . . ." Draaisma asserts that experiences of déjà vu involve three illusions. They feel like memories but are nothing of the kind; they make you think that you know what is about to happen when you cannot really predict it; and they conjure up vague anxieties for which there seems to be no good reason.

This experience has been studied and analyzed, interpreted, and misinterpreted throughout recorded history. Draaisma cites the Pythagoreans, circa 500 BC, who looked upon déjà vu as proof of the transmigration of souls. Others have believed déjà vu to be evidence of pre-existence. William James and others believed that the phenomenon could be traced to something actually present in the memory. In schizophrenics, déjà vu episodes can occur so frequently that they may be considered chronic.

Draaisma notes that perhaps one third to one half of persons questioned deny that they've ever had déjà vu. To the contrary, my own informal poll of 10 consecutive colleagues reveals this to be an underestimate. All 10 had personally experienced the phenomenon.

So, what's the explanation for déjà vu? The neurologist Wilder Penfield (1930s) stimulated areas of the brain with an electrode and noted that weak electrical shocks to a portion of the temporal lobe caused some subjects to feel "that they had been in that situation before." More recent studies (1994) invoke interrelated stimuli of the amygdala, hippocampus,
and temporal lobe as a source of the déjà vu phenomenon.

In part, what makes this book so attractive is Draaisma’s fine selection of quotations. Here, we have Dante Gabriel Rossetti in his poem “Sudden Light” (1854):

You have been mine before,—
How long ago I may not know:
But just when at that swallow’s soar
Your neck turned so,
Some veil did fall,—I knew it all of yore.
Had this been thus before?

REMINISCENCES

Investigators from Galton (1879) to P.D. McCormack (1979), as evaluated by Draaisma, have studied what is termed the “reminiscence effect.” This refers to the fact that when older men and women are asked to note memories of importance to them, there is a spike in the earlier years and a low point in the middle years. Why? Perhaps our ability to retain memories is at its peak in early life; or perhaps between the ages of 15 and 25 we have experiences that are more worthwhile remembering; or perhaps it is during these years that formative events more often take place, events that foreshadow and mold our entire adult lives. Draaisma, citing a 19th-century diary focused on reminiscence, suggests that memories of humiliation are especially prominent. Is that so?

In sum, memories and reminiscences are raw material from which each of us creates a narrative or our own life.

WHY LIFE SPEEDS UP AS YOU GET OLDER

In hourglasses, the grains of sand increasingly rub one another smooth until finally they flow almost without friction from one bulb into the other, polishing the neck wider all the time. The older an hourglass, the more quickly it runs. Unnoticed, the hourglass measures out ever-shorter hours.

(p. 201)

This is a clever analogy, but does it answer the question? My own view has been that, proportionately, each moment of time in our later life is just that—much less of a percentage of our total moments, and thus appears shorter. The hour-long afternoon nap we were forced to take as a child took forever. Now, it’s gone in a flash. A different view holds that “the apparent length of a period seems to be defined, in retrospect, by the number of . . . intense” experiences. When we are young, these experiences are far more common than for those of advanced age.

Several common uses of language allow us to recognize the changing speed of time. Time can crawl or fly, speed up, slow down, stand still. Why does time speed up (or do we mean, why does time slow down) as we age? Draaisma isn’t at all sure that a definitive explanation exists. However, as you focus on this clever and highly engaging work, you will find that time does not drag.

Reviewer: Philip W. Brickner, MD
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SOCIAL WORK AND HEALTH CARE IN AN AGING SOCIETY: EDUCATION, POLICY, PRACTICE, AND RESEARCH

Barbara J. Berkman (Ed.) and Linda Krogh Harootyan (Assoc. Ed.)
New York: Springer Publishing Company, 2003, 408 pp., $52.95 (hardcover).

Berkman and Harootyan have assembled 16 articles, based largely upon research of the Hartford Geriatric Scholars Work Fac-

ulty Program, for the purpose of integrating “the concepts of aging and health care . . . in social work educational programs, social-work policy considerations, social work practice, and social work research” (p. 6). Each article of Social Work and Health Care in an Aging Society is divided into sections on current research needs, future research needs, policy implications, integrating knowledge into the curriculum, and the subject’s significance to gerontology, health care, and health professionals. This format allows the volume to be of value to a variety of users, while unifying diverse topics under an overarching theme. Subject matter varies greatly and includes dementia, home health care, case management, developmental disabilities, empowerment, elder mistreatment, geriatric assessment, cultural considerations, and social ties. In order to convey the depth as well as breadth of the volume, this review will explore three articles in detail. The first of the examined articles focuses on improving professional practices relating to late-life depression. The other two pertain to grandparents who are the primary caregivers of their grandchildren.

Approximately 10% to 15% of older adults in the community experience late-life depression, whereas 30% to 50% of residences within long-term care (LTC) settings may be affected (pp. 15–16). In light of these statistics, the import of an article on “Late-Life Depression in Nursing Home Residents: Social Work Opportunities to Prevent, Educate, and Alleviate” is self-evident. The author, Margaret E. Adamek, considers issues related to both the diagnosis and treatment of depression. She argues that diagnostic limitations are a “primary impediment” to reducing rates of depression, and identifies multiple causes of this impediment: misperceptions by both the public and professionals of what constitutes “normal” behavior; “lack of geriatric mental health expertise among LTC staff”; differing diagnoses between disciplines; inadequate diagnostic tools; and the complexity of LTC residents’ medical and social situations.

Adamek suggests that these limitations could be remedied through greater
attention to the psychosocial needs of LTC residents, improved sensitivity and comprehensiveness of assessments, and greater inter-disciplinary co-operation in care delivery, among other measures. Adamek also presents a “brief review of empirical treatments for late-life depression, as well as emerging knowledge about less common approaches.” The review ultimately stresses the need for improved empirical evaluations of non-pharmacologic inventions and a better understanding of the psychosocial factors involved in depression, while providing numerous suggestions for moving in this direction.

Both **Grandparents Raising Grandchildren**, by Nancy P. Kropf and Scott Wilks, and **Strains and Gains of Grandmothers Raising Grandchildren in the HIV Pandemic**, by Cynthia Cannon Poindexter and Nancy Capobianco Boyer, are timely contributions to a subject that has received increased academic attention within the past several years. Kropf and Wilks note that the approximately 2.4 million grandparent caregivers in the United States often become involved in social service networks of various types (p. 177), yet many underuse social services because of impediments to access or insufficient responsiveness to the complicated situations and multiple needs of grandparent caregivers on behalf of service providers. **Grandparents Raising Grandchildren** provides a broad overview of the challenges facing this population as well as research and policy implications. In addition, a program developed by Kropf specifically to aid caregiving grandmothers is described. The intervention *Let’s Talk* uses audiotapes to “promote health, well-being, and care-giving competence,” but evaluations of its efficacy are not yet complete.

Poindexter and Boyer present narratives of grandmothers who raise their grandchildren in order to explore the difficulties presented by their children or grandchildren who are HIV positive. These strains include “feeling burdened by the uncertain trajectory of the disease” and the need to guard “against HIV-related discrimination” in addition to challenges that face all caregiving grand-

**TRAUMA AMONG OLDER PEOPLE: ISSUES AND TREATMENT**

Leon Albert Hyer and Steven James Sohme
Philadelphia: Brunner-Routledge, 2001, 322 pp., $44.95 (hardcover).

In *Trauma Among Older People: Issues and Treatment*, Leon Albert Hyer and Steven James Sohme explore the often-overlooked territory of posttraumatic stress disorder (PTSD) in the older adult. The authors present a worthy review of the literature on PTSD and its relation to memory processes. This tome would be a valuable reference source for gerontologists, counselors, psychologists, traumatologists, and anyone with a professional interest in the relation between trauma and senescence. The authors also present an in-depth discussion of the role of autobiographical memory in the construction of selfhood and the ways in which it is impacted by the aging process and by PTSD.

Phase-oriented trauma treatment as set forth by pioneers in the field, such as Judith Hermann, has been a prevalent treatment model in the field of PTSD treatment during the last several decades. It involves an initial stabilization stage in which safety within the therapeutic context is established in order to allow the client’s defensive mechanisms to recede. Furthermore, the therapist aids the client in reducing symptoms and correcting trauma-related cognitive distortions. Stabilization is widely viewed as a prerequisite to dealing with traumatic memory. It is only after this initial phase is completed
that the process of integrating traumatic memories can be initiated. Traumatic memory is characterized by its exclusion from the narrative that forms the conception of self, which is to say, traumatic memories are often imagistic or body memories as opposed to conscious memories. PTSD therapy eventually is aimed at including these nonsymbolic memories into the story that persons tell themselves about who they are.

Hyer and Sohle argue that current therapeutic techniques must take into account the older client’s needs. They propose a six-part treatment model, similar to the phase-oriented model mentioned above, that focuses on tackling the requisite normalizing and social support issues before delving into trauma issues. Hyer and Sohle advise against exceeding the therapeutic window. They further argue that a solid understanding of personality should ground treatment of those suffering from trauma. They stress the value of integrating positive core memories (PCMs) that are not linked to the trauma into the self-narrative of the traumatized. Among the treatments proposed and discussed by the authors are exposure and assimilative techniques, relaxation, re-narration, anxiety management training (AMT), and eye movement desensitization and reprocessing (EMDR). The authors propose addressing the issue of grief in the treatment of PTSD—PTSD has grief as one of its components. This is in line with their firm conviction that trauma cannot be treated without taking into account the individual’s self-concept. Hyer and Sohle view PTSD as a biological dysfunction in which stress-related neurohormones are released. The authors also stress the subjective nature of trauma: It is not the event that determines traumatic impact, but the way that it has been evaluated/perceived by the individual.

Hyer and Sohle propose an integrated treatment model that would transcend the limitations of specific theoretical models by combining biological, psychological, and psychosocial treatments. An integrated treatment is one that takes into account the intrapsychic, biobehavioral, cognitive, and affective patterns of the individual. As Hyer and Sohle state:

Therapy programs of PTSD are effective when used as an integrative program... good therapy is integrative. Psychotherapy of any form requires an order, more so with PTSD as there is such variance. It is in the venues of the interactive/intrapsychic/biobehavioral/cognitive/affective patterns directed by the person that a holistic sense evolves. It is best done with a vision of the person and goals that are serving this end. This is possible because the person is a covariance structure of domains that are integrated: If A is present, then B follows, etc. For some, just some movement is necessary. An intervention at any point in the system is all that is necessary to start the ball rolling. (p. 126)

Primarily, treatment must stabilize current disturbances and only then go on to address social supports/coping mechanisms and trauma-specific issues. The stabilization process includes treating co-morbid disorders, health concern, and stressors. The importance of the therapeutic relationship in the effective treatment of trauma is highly emphasized. The next step of treatment involves ensuring that the client’s social supports and internal coping skills are in place. Assessing the client’s personality style is crucial in dealing with avoidance and other symptoms that may arise in PTSD therapy. The last two steps in Hyer and Sohle’s model involve dealing with the client’s memories. In the fifth step, the therapist aids the client in the process of re-narration around PCMs. According to Hyer and Sohle, these are the memories that constitute a sense of self. Given the fact that later life is naturally the time in which people reevaluate their life histories and, as Hyer and Sohle note, “history and identity are both made and discovered” (p. 219), older clients can be particularly adept at undertaking this stage in the treatment.

It is only in the last phase that the authors encourage therapists to deal with traumatic memory. This type of memory is one that has not been incorporated into preexisting narratives. The task of the therapist is to aid the client in integrating this memory. As Hyer and Sohle state:

... a trauma memory represents rogue schemas and are not narrativized. The therapeutic task is to bring this implicit memory (easily triggered by emotional states, interpersonal contexts, external stimuli, and language cues) into explicit consciousness and have it experienced in language that subverses the overall narrative. Ultimately, for change to occur, the narrative of one's life must be made coherent and understandable. For a trauma victim this means encompassing the trauma experience (Antonovsky, 1987). The trauma memory must be integrated or excised. It has also been suggested that transformation occurs only when the client's own interpretation of the good coming from negative events is realigned and incorporated into positive/balanced life narratives (Tedeschi & Calhoun, 1995). (p. 192)

Both anxiety management and EMDR are techniques recommended to attain the aforementioned goal. The authors present detailed step-by-step instructions on the application of both AMT and EMDR and advocate their use as effective techniques in the deconditioning of trauma memories.

Hyer and Sohle admit that in the older person this type of integration of the traumatic memory may not actually happen, because the traumatic memory may have become irrelevant to the person. In this case, they suggest redirecting the therapy toward symptom reduction and emotional support.

Each chapter on the different phases of the six-plan treatment is complemented by helpful summary boxes covering guidelines/principles for each aspect of treatment. These will be of particular use to clinicians in need of detailed guidance. Case studies and clinical vignettes are few and far between. The presentation of the book tends to be schematic and concise and this makes it suitable as a reference volume.

The authors’ seeming atheoretical stance and introductory presentation of the issues related to aging and trauma may make this tome more appropriate for readers just beginning their studies of PTSD than for those who already possess some familiarity with the topic. The authors summarize an abundance of PTSD-related research and draw from others’ studies.
rather than from their own. At times, Hyer and Sohnle's stilted writing style poses an obstacle and the reader often finds herself trying to make sense of ambiguous phrases such as "this provides for the person to alter the narrative, the one truth that (in PTSD) is most noxious. The person takes command and thinks differently." The cursory presentation of a vast array of trauma-related issues serves as a good introduction to those just beginning their study of PTSD treatments but the authors do not offer an original contribution to the field.

The authors propose an integrated treatment model that takes into account the interrelation between PTSD and aging older clients. The authors stress considering the personality, memory, and familial history of the older client. Their emphasis on the treatment of the whole person presents a refreshing departure from therapeutic approaches emphasizing the prescriptive role of diagnosis. Given the current scarcity of literature on this particular topic this book is a welcome addition to the field.

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