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# Putting it all to use

**R**ECALL heading as a bleary-eyed first-year undergraduate towards my umpteenth early-morning cognition lecture, and wondering whether I would ever use all this theory I was learning. Now, six months into my post as an assistant psychologist working with young adults who have an acquired brain injury, I am poring back over my cognitive psychology books and journals to learn more about the application of those models and theories.

I am finding that working with this group is a fascinating way of learning in depth about cognition. Their rehabilitation involves neuropsychological assessment and intervention. Cognitive processes – attention, memory, visual processing, information processing and executive functioning – are all looked at in detail; once unfamiliar cognitive terminology starts to roll easily off the tongue.

I mainly use standardised tools assessing working memory, visual and auditory memory, IQ, problem-solving skills, and so on. The report writing and evaluation of these assessments requires a firm knowledge and understanding of cognitive theory. Describing a client's ability to manipulate information in working memory makes use of Baddeley and Hitch's model; a client's inability to process the global aspects of a design while simultaneously processing the internal aspects of a design reflects gestalt ideas of perception.

Cognitive rehabilitation in one-to-one sessions involves developing use of compensatory cognitive strategies with clients, and encouraging clients to practise these strategies, to complete cognitive exercises such as problem-solving puzzles or recalling word lists – e.g. using Miller's 'chunking' or Craik and Lockhart's 'elaborative rehearsal' – before transferring these skills to everyday practical situations. Information and strategies are also fed back to staff; for example, how best to work with a client who is unable to remember instructions for longer than a minute.

#### Associate Editor: NICOLA HILLS

Articles, news, tips, quotes, cartoons and other contributions for the 'Students' page are most welcome.

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BY EMMA SHEPHERD

It's not all about cognition. Damage to the frontal lobes of the brain can affect social skills, behaviour and personality. It can be extremely challenging dealing with verbal and physical aggression, mood



Will you ever use all that theory?

swings and lack of insight into difficulties. A cognitive-behavioural approach is often adopted, including using positive reinforcement or a token programme based on Skinner's laws of operant conditioning.

My work with people who have an acquired brain injury has highlighted cognition in a way that I had not experienced in my previous positions in mental health and learning disability work. I have found it varied and rewarding and would recommend it to anyone interested in linking those early morning lectures to application in clinical practice.

■ *Emma Shepherd is an assistant psychologist at the Queen Elizabeth Foundation Brain Injury Centre in Surrey.*

## 'DON'T BE AFRAID TO FAIL' says LOUISE CIMA

MY first project towards my PhD involved asking people with dementia and their spouses (carers) about their views on a discussion group for dementia sufferers. Separate focus groups were conducted to allow participants to speak freely without their spouse being there. The groups went well, and as the participants left, they thanked me with warm smiles. I was so excited at beginning my first piece of 'real' research and was eager to sit down and begin the laborious process of transcription.

So I read and re-read the transcriptions, but as I did so, became more and more deflated. Firstly, there was a distinct lack of real content and discussion between the participants with dementia, which meant that comparing answers between the groups would be pointless. On top of that, the carers' transcriptions revealed negative connotations regarding a support group for their spouses. I had not picked up on this during the group, so the issues had not been explored. This meant that my analysis became focused on my shortcomings as facilitator as opposed to my original premise.

At the time I felt like ironing my hands in the style of Dobby the house-elf in Harry Potter! However, as I prefer mental pain, I instead began to appraise my own work critically. This proved extremely worthwhile – it allowed me to appreciate where I had gone wrong and put the experience into perspective.

There is a lot of pressure – whether real or perceived – on PhD and even third-year students

to produce new and exciting research. What is sometimes forgotten is that a PhD is essentially a learning exercise in conducting good-quality research. As in all areas of learning, mistakes occur. It is learning to view these setbacks positively and to recognise them as valuable lessons that allows students to progress as researchers. I would advise students in similar situations to collaborate with other researchers in the field who may be able to highlight any subconscious assumptions in the research at the outset. It is always easier for other people to see them!

Indeed, since my failed project, many psychologists I know have confessed to similar experiences. Unfortunately, research that falls at the first hurdle or that doesn't produce the expected – or significant – results is often buried in a filing cabinet drawer somewhere. At a time when eager PhD students are vying to get published, this can leave researchers feeling inadequate for not producing groundbreaking research at the first attempt. But in clinical settings, knowing what doesn't work is sometimes as useful as knowing what does.

As research degrees become a more popular alternative to the traditional clinical route, perhaps an emphasis on clinically relevant research will emerge. But I think that all research is useful to someone, somewhere. On that note, good luck to all research and clinical students in their chosen field!

■ *Louise Cima is an assistant psychologist at the Kingshill Research Centre, Victoria Hospital, Swindon.*