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Working With Older People

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Psychology Specialists Working With Older People

AIMS

- ◆ to promote opportunities for the exchange of knowledge and expertise between members;
- ◆ to promote a greater appreciation of psychological factors in ageing;
- ◆ to advise and participate in matters of teaching and training;
- ◆ to stimulate research and disseminate research findings;
- ◆ to act in an advisory capacity on issues relating to the well-being and provision for care for older people;
- ◆ to foster an exchange of information and ideas with other professional and voluntary groups.

EDITOR

Dr Arlene J. Astell

School of Psychology, University of St. Andrews, Fife, Scotland, KY16 9JU.

E-mail: aja3@st-andrews.ac.uk

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Letter from the Chair

Sinclair Lough

THIS IS MY FIRST Chair's Letter since being elected at the AGM back in July. At present the role seems quite daunting, especially since I'm following in the footsteps of Steve Boddington who has done such an excellent job over the past two years. Steve and I met for the handover only a couple of days ago, therefore, I am still trying to get to grips with the tasks at hand. I am hoping that matters will become clearer and more focussed after our three-day strategy meeting next week and that my next letter will be much more informative. High on our list is trying to establish a mechanism for liaison with the DCP regarding membership and finance. So for the moment it's just 'Hello' and wish me luck.

Sinclair

Following a survey of the membership on the issue of keeping separate and distinct provision for older people – To Merge or Not to Merge? – the Committee proposed the following resolution which was passed by the membership at the AGM at the PSIGE Annual Conference in Nottingham:

‘Psychological provision for older people with mental health needs is best met by fully resourced specialist services specifically catering for older people. As such PSIGE commends the CSIP Age Equality document to Government departments, commissioners and service providers. This recommends optimum provision through access to both generic services and specialist services according to need.’

6th Annual Stroke Conference



“Innovations in Stroke Care”

25th October 2007
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Letter from the Editor

Arlene Astell

I AM DELIGHTED TO welcome you to this bumper edition of the *PSIGE Newsletter* crammed full of goodness from the Annual Conference in Nottingham. Before I whet your appetite with a taster of what's in store, however, I would like to start by extending my heartfelt thanks to my predecessor, Romola Bucks. Romola was already well known to many of the PSIGE membership from her many conference presentations and publications, including her work on memory clinics and the Bristol Activities of Daily Living Scale (BADL), before becoming Newsletter Editor. I am sure everyone will join with me in thanking her for the fantastic job she did as Editor of the Newsletter and in wishing her well in her new post in Australia.

For my first edition I have been very fortunate to receive such a wealth of papers from this year's Conference presenters and I would like to thank everyone for their efficiency and patience as I bumbled about trying to put it all together. Thanks also to Romola for answering all of my e-mails and Martin Reeves at the British Psychological Society for being the most reassuring voice at the end of the telephone.

This edition opens with Susan Pooley's prize-winning article based on her dissertation on the benefits of companion pets for older people living in care facilities. We will be running this competition again next year so look out for further details. Susan's paper is followed by a report of Marie Oldfield and Chris Clarke's research examining the role of social coherence in late-onset mood problems, a timely piece given the publication in August of Age Concern's Mental Health Enquiry, which highlighted under-recognition and lack of available treatment for mental health problems in those over 60.

The next paper by Amy Wood-Mitchell and the other members of the Newcastle-upon-Tyne Challenging Behaviour Community Team, should prove extremely valuable reading for anyone who provides or is thinking of setting up a specialist service to respond to challenging behaviour referrals. This is followed by a reflective piece by Stéphane Duckett on the need for 'ecological' formulations to avoid ageism in our work with older people. Margaret Muir then describes her doctoral work in Australia developing activity programmes for nursing home residents with dementia based on Gestalt principles.

This contrasts nicely with the next paper which describes the development of an Eye Movement Desensitisation and Reprogramming (EMDR) service for older people in Coventry, which includes a brief synopsis with references about EMDR for readers who may be interested to find out more. This is followed by Glynice Smith's article describing the experience of dementia care services from the perspective of a daughter attempting to look after her mother and the commitment she made just before her mother died to use her experience to improve the lot of other vulnerable people. This is complemented by Camilla Dyer's synopsis of her research investigating adjustment and family functioning post-stroke.

The final two papers both tackle issues that most people find difficult to deal with. Caroline Knight and her colleagues describe the development of a standardised measure for assessing challenging sexual behaviour. This is followed by Sarah Head and Ally Taft's thought-provoking article about keeping older people safe. The article does include distressing examples of situations where older people were not kept safe but also contains very useful advice and

guidance on how psychologists can play an important role in making care environments safe for vulnerable older people. The authors of these and all of the other conference papers would be delighted to respond to enquiries from readers about their work and many would be prepared to give talks, workshops and training.

This edition is rounded off by the thoughts of conference attendees who were awarded bursaries by PSIGE. This year saw a much larger number of bursaries awarded with the scheme extended beyond Assistants and trainees to newly-qualified staff and others unable to secure funding. I hope that their reflections and the diversity of papers from the conference encourage even more people to come to next year's conference in York, if only for the spectacle that is the PSIGE Ceilidh!

Arlene Astell

Editor, PSIGE Newsletter.

Maintaining affectional bonds: The significance and meaning of companion animals for pet owners living in homes for older people

Susan Pooley

Companion animals have been found to promote well-being in older people by an increasing number of researchers. However, few and limited theoretical explanations for why and how these benefits occur have been developed. By investigating the significance and meaning of companion animals for pet owners living in homes for older people the aim of this research was to explore the consequences for pet owners of living with companion animals in homes for older people and develop a theoretical model to explain the role of the human-animal bond in a specific context. An initial theoretical model describing how this context shapes the significance and meaning of the human-animal relationship was developed using a grounded theory approach. Data from nine interviews with pet owners, seven interviews with managers and observations showed that companion animals help to ameliorate the losses associated with living in homes for older people by enabling their owners to maintain affectional bonds. Pet owners' understanding of the relative importance of animals, pet characteristics and features of human-animal relationships influenced the degree to which companion animals could enable their owners to maintain affectional bonds. These results are discussed in relation to theoretical understandings of the human-animal bond.

THE IMPORTANCE OF addressing the psychological needs of older people in areas other than mental health has been clearly acknowledged in the National Service Framework for Older People (NSFOP; Department of Health, 2001). Age Concern and the Mental Health Foundation (2006) conducted an Inquiry into Mental Health and Well-Being in Later Life, which identified having pets as one of the eight factors promoting well-being in older people. Being isolated from your family was one of the eight factors likely to reduce well-being.

People who are older, more ill and lacking in informal resources of support and care are most likely to enter residential homes (Baggett, 1989). Relocation is often preceded by a crisis (Chenitz, 1983), such as the death of a spouse (Reinhardy, 1993), and can lead to social isolation (Cohn & Sugar, 1991). Relocation for the first time (e.g. from home to a residential home) has been found to elicit the most stress with poten-

tially the worst adverse effects (Rosswurm, 1983). Older people relocating from home to a residential home can experience a significant decrease in functional health (Lawton & Cohen, 1974), and between 50 and 75 per cent of older people with a medical illness have been found to be depressed (King & Johnson, 2002).

Benefits of relocation have also been found, such as health benefits (Borup, 1982) and improved family relations (Smith & Bengston, 1979). Successful relocation is associated with perceived control over (Reinardy, 1992) and preparation for (Petrou & Obenchain, 1987) the move. However, older people often do not have a choice; Reinardy (1992) found that 59 per cent of older people who had moved into a nursing home did not believe they had a choice.

Even though pets have been found to promote well-being in older people, each year an estimated 140,000 pets are given up by pet owners moving into homes for older

people, and 38,400 of these are put down (Anchor Housing Trust, 1998). McNicholas *et al.* (1993) found that managers of residential homes were often unaware of the emotional, psychological and physical responses to pet loss, even though most of them reported problems in adjustment when an older person had lost their pet on admission. They also found that older people are most vulnerable to the negative effects of pet loss (i.e. emotional, psychological and physical distress), and that this adversely affects their adjustment to their new home.

The World Health Organisation has endorsed the view that the human-animal bond has therapeutic value, and that this should be taken into account when developing legislation for housing and residential care (McBride, 2005). At present in the UK, unlike in some other countries, legislation does not protect the rights of older adults to be pet owners when they live in long-term care homes (SCAS, 1999). The NSFOP (DoH, 2001) has focused on rooting out discrimination and health promotion as key targets. Lack of legislation protecting the rights of older adults as pet owners provides opportunities for discrimination and ignoring the benefits of pet ownership.

In discussing pets in social housing, Dono and Ormerod (2005) state that health and safety concerns are often cited as reasons for not allowing pets. They suggest that, as in other housing settings, problems can be minimised by routine hygiene maintenance and clearly stated policies regarding keeping pets. In their study of pets in residential care, McNicholas *et al.* (1993) found that the managers of residential homes that did accept pets reported no resulting illnesses or other problems.

Pet ownership benefits

In their review of the literature on the benefits of pet ownership for older people, Dono and Ormerod (2005) argue that the human-animal bond is especially important for older people due to the challenges associated with

older age, such as the death of partners and health problems. It can lead to 'social isolation, loneliness and a greater dependency on existing relationships to fulfil social and emotional needs' (p.24) – such as a relationship with a pet. Older pet owners spend up to 80 per cent of their time with their pet, far exceeding time spent with friends or relatives (Lago & Miller, 1989). Peretti (1990) found that 75 per cent of older men and 66 per cent of older women said that their pet was their only friend.

In addition to psychological benefits of pet ownership, health benefits have also been found. Being a pet owner can improve cardiovascular health (Friedman *et al.*, 1980), survival following myocardial infarction (Friedman & Thomas, 1995), and reduce risk factors for coronary heart disease (Anderson *et al.*, 1992). However, according to Dono and Ormerod (2005), much of the literature on the potential benefits for humans of pet ownership and contact has not focused on theory development or testing.

McNicholas and Collis (1995) suggested three main ways in which pet ownership is associated with improved human psychological and physical health. The first is that healthier people are more likely to have pets, which has had mixed support in the literature. Secondly, that owning a pet facilitates human interaction (the social catalyst theory), which improves well-being by reducing social isolation by providing a point of contact (e.g. sharing an interest in animals, dog walking). Thirdly, that pet ownership directly and positively affects human well-being by reducing stress due to the supportive relationship between person and pet. This is hypothesised to help older people manage the loss, loneliness and boredom many experience, and by providing them with opportunities to be nurturing. The supportive human-animal relationship is hypothesised to provide health benefits similar to those derived from close human relationships.

Pet attachment

Research on pet ownership and attachment has been criticised for being anecdotal, ungeneralisable and flawed (Marx, 1984). However, there is some support for the theory that it is the quality of the human-animal bond that confers psychological and physical health benefits. Garrity *et al.* (1989) explored pet ownership and pet attachment as factors supporting the health of older people. Strong pet attachment was associated with a reduced incidence of depression, but pet ownership *per se* was not associated with either emotional or physical health status. Strong pet attachment had a statistically significant direct, as opposed to a buffering, effect on depression. However, for older people who had recently lost a partner, both pet ownership and strong pet attachment were associated with a reduced rate of depression. Also, among elderly pet owners who had minimal confidant support, those who were more attached to their pets reported less recent illness than those who were less attached. These last two findings suggest that pet owners who have experienced a distressing loss or are isolated – i.e. those who are most in need of supportive companionship – are most likely to benefit from pet ownership.

Rynearson (1978, p.550) suggested that human and pet constitute significant attachment figures for one another because of 'their commonality as animals'. He referred to the importance of attachment in all social animal species. He argued that humans and animals are likely to seek each other out under two main conditions: at times of stress and when the person has learned to distrust other people. Referring to the latter, he argues that it is the 'pet's pre-verbal attachment attitude that satisfies the human's regressed need for nurturance'.

Kidd and Kidd (1987) have argued that it is difficult to formulate a comprehensive theory of the human-animal bond due to the linguistic, cultural and social differences between human beings and other animals. Stern (1996) suggested that the human-pet

relationship is no less complex than relationships between people. He argued, in discussing pet owners' reactions to pet loss, that it is the practical and psychological elements that defined the pet owner's relationship with their pet that determine the strength of pet attachment and, therefore, the grief reaction to pet loss.

Rationale for this research

Without a better understanding of the role of companion animals for older people – especially in potentially socially isolating environments such as homes for older people (Wenger, 1997) – the negative impact of pet loss, and the missed opportunities for the improved psychological well-being afforded by pet ownership, are likely to continue. This research, therefore, set out to produce an explanatory model that aimed to improve our understanding of the psychological benefits of pet ownership by investigating the significance of companion animals for older people who move with them into homes for older people.

Methods

A grounded theory methodology was used due to its flexible approach to exploratory research and because it was specifically developed as a method of theory generation (Glaser & Strauss, 1967). No specific hypotheses or propositions were tested. Instead, six initial areas of interest were investigated, including the pet owner's relationship with their companion animal; how the person came to live in the home for older people; and the role of the companion animal in their lives at the home.

Semi-structured interviews were conducted with nine older adults living in nursing, residential and sheltered housing with a companion animal (mammal or bird) in the south-east of England. Three pet owners were interviewed in the first stage, which included coding and initial model development. Subsequent pet owners were theoretically sampled to test and expand the model. The managers of the homes where

the pet owners lived were also interviewed, and observations in the homes were also conducted, both as a means of obtaining an alternative perspective on the focus of the study and contextual information. Interviews were conducted using interview schedules developed by the researcher that were piloted on three additional older adults. Demographic information was also collected. Observations were conducted in communal areas on the basis of participant observation.

Pet owners were interviewed where they lived for up to two hours. Manager interviews lasted one hour, as did observations. Interviews were recorded and interview transcripts and observations were analysed using grounded theory methods, including several stages of coding, memo writing and constant within and between case comparisons. Quality assurance strategies were informed by Elliott *et al.* (1999, in Willig, 2001).

Results

Both pet owners' and managers' descriptions of their experiences suggested that companion animals' greatest significance for older people living in that context was their ability to ameliorate the losses older people had experienced by enabling the older person to maintain affectional bonds. To different degrees and in different ways, they seemed to look to their companion animals to fulfil their unmet relational needs. A brief description of the model's higher-order categories follows with illustrative quotes from pet owners and managers.

Losses associated with living in a home for older people

All pet owners described losses they had experienced prior to, and as a result of, living in a home for older people, and for some this was distressing, *'I'm just [looking tearful] ... sorry, I'm just thinking about all that I've lost'* (Mrs Frome). The data suggested three categories of losses associated with living in a home for older people – loss of self-care ability, loss of control, and loss of

meaningful connectedness. The number, significance and meaning of the losses appeared to influence the ways in which, and the degrees to which, the pet owner looked to their pet to compensate them for those losses, *'It takes the place of the people that have died'* (Mrs Thomas).

Maintaining affectional bonds

All pet owners described how their companion animals helped them maintain affectional bonds following losses experienced before and as a result of moving to a home for older people, e.g. *'She's a comfort to me. I had to sell my home and all my possessions. Sasha is all I've got left. Something is always there with her around. She is my constant companion'* (Ms Woods). Three categories regarding maintaining affectional bonds were identified: maintaining a sense of self-continuity; substituting lost or absent relationships; and building new relationships.

Companion animals helped their owners maintain a sense of self-continuity by acting as a link between their life at their former home and in their current home. When the companion animal had been shared with a deceased spouse, the companion animal also acted as a link with that lost loved one by reminding the pet owner of when their spouse was alive.

All of the pet owners lived alone, and for many of them their companion animal seemed, to a greater or lesser degree, to act as a substitute for lost or absent relationships. Some pet owners described their pet as the centre of their lives, and valued them for the affection, companionship, comfort, and sense of safety or security they provided. Companion animals also seemed to be important because they helped the pet owner keep parts of themselves that they valued alive, such as their role as a carer.

Nearly all of the pet owners spoke of how their companion animal had helped them make friends with staff and other residents. Many pet owners spoke of sharing their pet with other residents living in the home. Many pet owners spoke of their pleasure at

the care that staff showed towards their pet, which seemed to make the pet owner feel more cared for themselves. However, sometimes having a pet in a home for older people was not easy for pet owners. For example, some pet owners worried about their pet running away, especially when they first moved in, some worried about needing the approval of other residents to keep their pet, and some worried about other residents over-feeding their pet without their knowledge. It also seemed that having something that other residents did not have could excite envy.

Depending on their understanding of the relative importance of animals, both pet owner and manager interviews suggested companion animals take on increased significance and meaning for older people due to the losses they had experienced and due to the context in which they were living, *'I can't go on enough about the role of animals in this sort of environment. It is tremendous'* (Manager 1). For pet owners who had lost their self-care ability, lost control over their lives (i.e. lived in a residential or nursing home), and lost a meaningful connectedness to valued aspects of their lives (e.g. death of spouse, loss of home, etc.), being able to keep their companion animal seemed to take on an increased significance and meaning, *'[Name of dog] is sort of keeping her [resident] alive'* (Manager 2). For Mrs Woods, her dog was *'all I've got left'*. By contrast, for pet owners like Mrs Thomas, who had not sold a home and had moved with her husband to sheltered housing, and due to her perception of animals being of lesser significance than humans, and having adopted an older animal, the significance appeared to be of a lesser depth and quality, *'I mean, she's just a cat.'*

Discussion

The importance of the close relationships companion animals provided to older people in the absence of other close relationships in their daily lives was the overarching finding of this research. In the context of homes for older people, and in view of the losses associated with that

context, the significance and meaning of companion animals appeared to be increased.

The finding that companion animals, to different degrees, appeared to act as substitutes for lost or absent relationships, has several implications. One implication is that companion animals compensate people for deficiencies in their human relationships – the so-called compensation hypothesis (Harker *et al.*, 2000). This has mixed support in the literature. Harker *et al.* (2000) investigated the influence of current relationships upon pet acquisition, testing the hypothesis that people are motivated to acquire pets when there is a deficiency in their current human relationships. Their results supported their hypothesis. However, Bonas *et al.* (2000) found no support for the compensation hypothesis when they compared human-human and human-animal relationships in the family context. Although they found that the overall componential structure of support in human-human and human-animal relationships was similar (based on Weiss, 1974), they found that individuals who typically perceived a high level of social provision from people, also perceived a high level of social provision from pets. This study suggests that it is in the absence of close human relationships – i.e. substitution rather than compensation – that individual companion animals can provide older people with an outlet for their unmet relational needs.

The finding that the significance and meaning of companion animals for older people is influenced by older people's relational losses was also found in a sample of older people living in the community. Enders-Slegers (2000) found that the absence of close human relationships elevated companion animals to the status of what has been described as a primary relationship (Weiss, 1988). They also found that the most important social provision provided by pets to older people was attachment and emotional closeness, followed by opportunity for nurturing.

The results also suggest that the absence of close human relationships on a daily basis increased the significance and meaning of companion animals to their owners. Research has found the quality (i.e. significance and depth of feeling) of the human-animal relationship to be the key variable that influences that relationship's ability to confer the health benefits attributed to social support and human relationships (e.g. Garrity *et al.*, 1989). Bonas *et al.* (2002) also argued that the differential social provisions afforded by different species attests to the importance of the quality of the human-animal relationship. This suggests that pet owners living in homes for older people, because of their likelihood of having close relationships with their companion animals, are particularly likely to reap the health benefits associated with close relationships.

A better understanding of the specific kinds of relational losses older people have experienced, and how these influence the significance and meaning of companion animals to them, would further our understanding of the ways in which companion animals meet older people's relational needs. For example, seven out of nine pet owners were childless, and some pet owners suggested that this affected their understanding of their relationship with their pet. It is not clear from the model how loss of a spouse is distinct from absence of a child, although they are clearly different kinds of relational absence. A further limitation of this study is that no distinction was made in terms of age of pet owner, thereby down-playing cohort differences. Pet owner ages ranged from 60 to 89, and research has suggested that there are important differences between people in their 60s to people in their 80s that influence the human-animal relationship (McNicholas, 2004).

Conclusion

The results of this research add to the increasing body of evidence that has found that companion animals can promote psychological well-being in older people. Data from interviews suggested that companion animals help their owners maintain affectional bonds in contexts that are experienced as socially isolating by many older people. By focusing on pet ownership in homes for older people, this research attempted to provide a better understanding of how and why the psychological well-being of older people can be influenced by moving and living with companion animals in those contexts, which has implications for health promotion and policy.

Author's Note

This article was supervised by Sue Holttum, Dr Paul Camic and Dr June McNicholas.

Correspondence

Dr Susan Pooley

Child and Adolescent
Mental Health Services,
St. Peter's Hospital,
Guildford Road,
Chertsey,
KT16 0PZ.

E-mail: Susan.Pooley@asph.nhs.uk

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Clinical case study informed by Psychodynamic ideas

Malini Maharasingam

Malini's contact details were accidentally omitted. They are as follows:

Malini Maharasingam
 17 Thorne Close
 Langthorne Road
 Leytonstone E11 4HU.
 Tel: 020 8535 6476
 E-mail: malini.maharasingam@nelmht.nhs.uk

Late onset mood problems: A positive approach

Marie Oldfield & Chris Clarke

This study investigated the role of Sense of Coherence (SoC) in late onset mood problems. The results suggested that SoC should be considered when formulating late onset mood problems and highlighted the need for further research investigating the application of positive psychology to older people.

THERE IS A DEARTH of positive psychology research that addresses older people. Perhaps this reflects an assumption that older people do not demonstrate strength or resilience. Yet older people are superior at regulating their emotions and express less negative affect than their younger counterparts (Carstenson, 1995). However, there is still a significant prevalence rate of late onset mood problems. The recent *Mental Health and Well-Being in Later Life* report (Age Concern, 2007) suggested 'one-in-four people over 65 and two-in-five people over 85 are suffering depression or serious symptoms of depression.' However, the psychological mechanisms underpinning late onset mood disorders are still relatively poorly understood.

Erikson (1963) proposed that mood problems in later life are due to the unsuccessful negotiation of his eighth psychosocial crisis: ego integrity vs. despair and disgust. Ego integrity is represented by an individual's acceptance of their life without regret and with a sense of worth leading to wisdom (Erikson, 1963).

If one is unable to achieve ego integrity then they are likely to face despair. Despair is characterised by fear of death (Erikson, 1963). This inability to face one's own mortality is the result of regret and feeling that life is too short to fulfil ambitions (Erikson, 1963). Ego integrity has been shown to be negatively correlated with levels of depression and positively correlated with hope in older people, with Sense of Coherence (SoC) being used to operationalise ego integrity (Chimich & Nekolaichuk, 2004).

SoC is a psychological construct relating to how meaningful, manageable and comprehensible one perceives their life to have been (Antonovsky, 1987) and is related to health and functional status in older people (Sarvimaki & Ojala, 1994). SoC can be conceptualised as a mediator against adversity in a working age population (Kamel Gana, 2001) however, the role of SoC as a mediator of the impact of life events on older people has not yet been studied.

Research suggests that adverse life events contribute to mood problems in late life (Holohan, Holohan & Belk, 1984). However, several studies have demonstrated that it is the interaction of a combination of factors that is of importance in the development of late onset mood problems (Cutrona, Russell & Rose, 1986; Mazure *et al.*, 2002). The primary aim of this study was, therefore, to investigate the hypothesised mediating role of SoC in relation to the impact of recent adverse life events on late onset mood problems was.

Method

This was a cross sectional, quantitative study. Following ethics committee approval 38 people (18 male, 20 female, mean age=76.34 years, *SD*=8.65 years, age range=60–94 years) were recruited from local services. The sample comprised clinical and non-clinical community dwelling older people who did not experience significant cognitive decline and had not experienced mood problems prior to being 60-years-old. A community population was accessed to maximise inclu-

sion of people experiencing sub clinical or undetected mood problems.

Three self-report measures were administered: the Sense of Coherence Scale (Antonovsky, 1987); the Social Readjustment Rating Scale (Holmes & Rahe, 1967) and the General Health Questionnaire (Goldberg & Hillier, 1979). Baron and Kenny's (1986) model of mediation was used to analyse the data.

Results

The first step of establishing mediation using the Baron and Kenny (1986) model is to explore the relationships between all variables. A significant correlation between SoC and late onset mood problems ($r=-0.71$, $N=38$, $p<0.001$, two-tailed) was found. The higher a participants' SoC the less likely they were to experience late onset mood problems.

There was also a significant positive correlation between life events and late onset mood problem ($r=0.35$, $p<0.03$, two-tailed, $N=38$). In this sample a greater number of life events were associated with increased severity of late onset mood problem.

Using regression and correlational analyses, no significant relationship between SoC and life events was found. Therefore, SoC could not be conceptualised as a mediator of the impact of recent adverse life events on late onset mood problems in this sample, as life events scores did not affect the proposed mediator; SoC.

Regression analyses did allow the predictive value of SoC and life events to be explored. In a hierarchical multiple regression (see Table 1), life events scores were entered first and explained 11 per cent of the variance in late onset mood problems ($F=5.51$, $p=0.24$, $N=38$). When SoC was added second 61 per cent of the variance in late onset mood problems was explained ($F=29.72$, $p<0.001$, $N=38$).

Discussion

In this sample SoC was not a mediator of the impact of life events on late onset mood problems. However, the highly significant correlation between SoC and late onset mood problems and the predictive value of SoC highlights the importance of considering SoC when formulating late onset mood problems.

Current psychological interventions often focus on reducing or removing factors thought to precipitate and maintain psychological ill health, such as dysfunctional assumptions and negative automatic thoughts (Fennell, 2002). However, the findings of the current study suggest that there is an argument for considering a positive psychology model in respect of interventions for late onset mood disorders. SoC could be examined alongside other factors important for maintaining and promoting psychological health in older people such as social support (Woods, 1999), physical activity (Almeida *et al.*, 2006). Taken together there is a strong case for further exploration of the application of positive psychology to older people.

Table 1: Multiple regression of predictors of late onset mood problems.

Variable	Multiple R	B	Standard Error B	Beta	t	Sig
Life Events Scores	0.34	0.17	0.05	0.37	3.11	0.004
SoC	0.79	-0.34	0.05	-0.71	-6.86	0.001

A number of participants in this sample experienced mood problems in the absence of life events. Therefore, the presence of life events alone did not provide an adequate explanation of the aetiology of late onset mood problems. Future research should aim to further understand the array of psychosocial factors that need to be considered when conceptualising late onset mood problems.

A further finding was the relationship between chronicity and increased severity of late onset mood problems. This has implications for improving the recognition of mood problems and ensuring rapid intervention is available to prevent older people's psychological health deteriorating.

A number of the participants in this study who experienced late onset mood problems did not receive professional support. This again is in line with the Age Concern inquiry into *Mental Health and Well-Being in Later Life* (Age Concern, 2007), which estimated that '3.5 million older people who experience mental health problems do not have satisfactory services and support.' This further highlights the need to improve recognition of mood problems.

In summary, this study did not reveal a mediating role for SoC on life events in the development of late onset mood problems. However, there was a significant inverse relationship between SoC and late onset mood problems, indicating that SoC should be considered when formulating late onset mood problems. Future research is necessary to further our understanding and explore the clinical utility of SoC from a positive psychology perspective.

Correspondence

Marie Oldfield

Clinical Psychologist
Greater Glasgow & Clyde NHS.
E-mail: marie.oldfield@ggc.scot.nhs.uk

Chris Clarke

Clinical Psychologist
University of Hull.

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Dementia in Younger Adults: Science, Services & Experiences

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Programme

		1.30pm	Welcome Back Dr Rachel Pendry, Chartered Clinical Psychologist, NHS Fife
10.00 am	Welcome & Introduction Chair: Dr Gary Stevenson, Consultant Psychiatrist, NHS Fife		
		1.40pm	Services for Younger People with Dementia: A Global Snapshot Connie MacFarlane & Dr Arlene Astell, Dementia Research Group, St Andrews
10.15am	“Speaking for Ourselves” Scottish Dementia Working Group		
		2.00pm	Young-onset Dementia in Scotland—Challenges and Opportunities Professor June Andrews, Director, DSDC, Stirling
10.45am	“Genes, the Environment and Early Onset Dementia: What We Know and Where Next” Professor Lawrence Whalley, Professor of Mental Health, Aberdeen		
		2.30pm	Alzheimer Scotland and Service Provisions Jim Jackson, Chief Executive, Alzheimer Scotland
11.15am	Neuropsychology of Young-onset Dementias Dr Thomas Bak, Consultant Neuro Psychologist, Edinburgh		
		3.00pm	Service Snapshots ♦ Fife, Suzanne Croy, Nurse Co-ordinator ♦ Falkirk, Sheena Short, Project Worker ♦ Lanarkshire, Karen Reid, Service Manager ♦ Lothian, Evelynne Roarty, Service Manager
11.45am	Neurological Evaluation of Cognitively-impaired Younger Adults Dr Martin Zeidler, Consultant Neurologist, NHS Fife		
		4.00pm	Conference Summary Dr Gary Stevenson, Consultant Psychiatrist, NHS Fife
12.15pm	LUNCH		
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Treating challenging behaviour in care settings: Audit of a community service using the neuropsychiatric inventory

Amy Wood-Mitchell, Lorna Mackenzie,
Malcolm Stephenson & Ian A. James

THE CHALLENGING BEHAVIOUR COMMUNITY TEAM (CBCT) in Newcastle-upon-Tyne provides input primarily into care homes in the community. It aims to reduce challenging behaviour within homes (residential, nursing, Elderly Mentally Infirm, Elderly Mentally Severely Infirm) and prevent unnecessary transfers and hospital admissions. In keeping with NICE (2006) guidelines, the team uses an idiographic formulation model (James, Mackenzie, Stephenson *et al.*, 2006) in order to develop targeted bio-psychosocial approaches. It aims to minimise pharmacological use by employing psychosocial approaches before psychotropic medication is prescribed in line with current medical guidelines (Howard *et al.*, 2001; Sink *et al.*, 2005). Where psychotropic medication is required (e.g. psychosis, depression), the formulation assists with the tailoring of the approach to meet the needs of the individual (Gill *et al.*, 2005). The development and modus operandi of the Newcastle CBCT team is consistent with the guidelines of the NSF (Standard 7.54-6; DOH, 2001) and Audit Commission ('Forget me not' 2002), concerning the input of a specialist multi-disciplinary outreach team into care home settings.

The present article provides an overview of the impact of this team. It is relevant to note that there is limited evaluation of the impact of the work of community teams into care homes, with relatively few exceptions

(Bullock, 2002; Stevenson *et al.*, 2006). Thus the aim of the present study was to evaluate the work of the CBCT using the Neuropsychiatric Inventory with Caregiver Distress scale (NPI-D) in order to monitor the effectiveness of the service.

Method

Participants

The audit examines the outcome data of two specialist nurses and an assistant psychologist between September, 2005–2006. The data represents all completed NPI-Ds (pre- and post-pairings) obtained by each member of the team after they had received formal training in the use of the assessment scale. The members completed training at different times, and thus the NPI-Ds used in this analysis are taken from the point at which each member completed this training. For one member of the team this data represents six months of his caseload.

For each resident who was referred to the CBCT, a member of staff in the home who knew the resident well, was asked to complete an NPI-D pre- and post-treatment. All staff were senior carers (general/mental health nurses, management) who were involved in the care of the resident. For various reasons, as specified in Table 1, post NPI-D's were not completed for every resident. Such cases were excluded from the statistical analysis. The study employed a repeated measures design.

Table 1: NPI and Carer distress scores for cases discharged by the CBCT.

	Main Challenging Behaviour	Pre NPI (frequency x severity)	Pre NPI Carer Distress	Post NPI (frequency x severity)	Post NPI Carer Distress
1	Aggression	56	6	0	0
2	Disinhibition	8	3	0	0
3	Aggression	44	18	2	0
4	Disinhibition	10	3	4	0
5	Agitation	61	24	5	0
6	Disinhibition	11	11	5	6
7	Agitation	8	1	6	0
8	Aggression	26	3	6	0
9	Aggression	50	21	6	2
10	Sex. disinhibition	37	3	7	3
11	Aggression	13	1	8	0
12	Sex. disinhibition	29	6	8	2
13	Aggression	20	8	8	3
14	Aberrant motor behaviour	6	1	8	3
15	Shouting	22	11	9	3
16	Irritability/aggression	57	21	10	5
17	Anxiety	38	19	10	5
18	Aggression	21	11	11	1
19	Aggression	11	8	12	2
20	Anxiety	25	14	12	3
21	Anxiety	28	12	13	4
22	Aggression	14	6	14	5
23	Aggression	36	10	14	8
24	Anxiety	67	24	15	3
25	Apathy	30	18	15	4
26	Agitation	47	16	15	10
27	Aggression	27	4	18	2
28	Aggression	34	13	20	4
29	Absconding	68	18	21	7
30	Anxiety	24	13	23	10
31	Aggression	30	6	24	6
32	Aggression	56	18	29	1
33	Sex. disinhibition	50	14	30	10
34	Aggression	101	27	33	5
35	Anxiety	64	21	40	17
36	Aggression	11	5	16	6
37	Agitation	75	25	32	0
38	Aggression	44	10	15	5
39	Aggression	8	4	7	2

	Main Challenging Behaviour	Pre NPI (frequency x severity)	Pre NPI Carer Distress	Post NPI (frequency x severity)	Post NPI Carer Distress
	Means (and standard deviations)	35.05 (22.43)	11.72 (7.60)	13.61 (9.51)	3.77 (3.65)
				Reason for no post NPI	
40	Aggression	44	12	Admitted to Inpatient Unit	
41	Aggression	36	19	Admitted to Inpatient Unit	
42	Non-compliance	39	16	Physical deterioration/died	
43	Aggression	47	20	Physical deterioration/died	
44	Shouting	44	17	Physical deterioration/died	
45	Non-compliance	34	13	Spontaneously resolved	
46	Non-compliance	Re-referral*		Admitted to Inpatient Unit	
47	Aggression	Re-referral		Moved to another care setting	
48	Aggression	Re-referral		Moved to another care setting	
49	Aggression	Re-referral		Moved to another care setting	

*Owing to an administrative oversight, the re-referrals did not get an initial NPI assessment during the time period specified.

Materials

Neuropsychiatric inventory with caregiver distress scale (Cummings *et al.*, 1994): The NPI-D measures both the frequency and severity of problematic behaviours and the emotional/psychological distress of caregivers in relation to 12 neuropsychiatric symptoms. For each of the 12 symptoms, a behaviour score is obtained by multiplying the frequency (1–4) by the perceived severity of the behaviour (1–3). A total behaviour score is achieved by adding the individual behaviour scores of each symptom (maximum score=144). The distress caused to caregivers

for each symptom is also scored (0–5), and then totalled (maximum score=60).

Procedure

The three members of the CBCT received referrals from Old Age Psychiatrists of residents displaying ‘challenging behaviours’ in care settings. If a referral was deemed appropriate, the case was allocated to a member of the team according to caseload capacity. On an initial visit to the care setting, an NPI-D was completed with a senior member of staff. The routine procedure of the CBCT is outlined below:

Time	Activity
Week 1	Referral accepted.
	Assessment phase, details obtained from staff, family, GP and medical notes.
Week 4–6	Formulation session with staff in home (sometimes repeated 3 to 4 times to obtain widespread participation), and intervention developed with staff.
	Formulation formalised and summarised on A4 sheet of paper, and checked-out with staff. Intervention sheets attached.
	Intervention supported and monitored.
Week 14	Discharge.

On discharge, a repeat NPI-D was conducted, with the same member of care staff who conducted the original assessment to control for inter-rater reliability (James, McClintok, Reichelt *et al.*, in press).

Results

Paired sample T-tests revealed a significant difference in the pre-intervention and post-intervention behavioural scores, $t(38)=7.03$, $p<.001$. The post-intervention behavioural scores (mean 13.61, s.d. 9.51) were significantly lower than the pre-intervention behavioural scores (mean 35.05, s.d. 22.43). There was a significant difference between the pre-intervention and post-intervention scores for caregiver distress, $t(38)=6.64$, $p<.001$. The post-intervention distress scores (mean 3.77, s.d. 3.65) were significantly lower than the pre-intervention distress scores (mean 11.72, s.d. 7.60).

Discussion

The results revealed that there was a significant reduction in the pre- and post-NPI-D scores in terms of frequency and severity of behaviour, and caregiver distress. Additionally, during the periods specified above only three residents (6.1 per cent) were admitted to hospital and three (6.1 per cent) was relocated to another care setting. Jointly, these findings suggest that the CBCT's approach is an effective method of reducing both challenging behaviour and staff distress. Of note, two of the residents' behaviours (4.3 per cent) resolved spontaneously, without receiving any intervention.

In terms of transfers and hospital admissions, although one cannot be certain of the numbers of residents who would have been relocated, it is likely that a number of these complex cases would have been admitted, due to high initial NPI scores for a number

of the residents (see Table 1). Such a finding is important both in terms of maintaining the well-being of residents by maintaining familiarity/continuity of environment, and potential cost savings to the Older People's Service. Indeed, a recent review of the cost of admitting a resident from care into a hospital setting estimated the sum to be £75K per annum; the average length of stay was found to be four months (Scott, 2006).

Whilst these findings reveal a positive impact of the CBCT, it is important to acknowledge that many factors may have contributed to the results. Hence, the next step in the evaluation of the service is to conduct a controlled study, comparing the CBCT with standard treatment protocols.

Conclusion

Despite evident flaws in the design of this clinical audit, the findings suggest that the formulation led approach used by the CBCT, which is wholly consistent with the recent NICE (2006) guidelines, shows promise. More specifically the results tentatively suggest this bio-psychosocial service benefits residents and care staff, and is also cost effective. These findings have implications at both a local and national level with respect to the treatment of residents presenting with highly complex needs.

Correspondence

All authors are members of:
Newcastle Challenging Behaviour
Community Team,
Castleside Unit,
Newcastle General Hospital,
Northumberland,
Tyne and Wear NHS Trust,
NE4 6BE.
E-mail: ianjamesncht@yahoo.com)

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E-mail: ann.scott@homefirst.n-i.nhs.uk
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An investigation into carer experiences of a Memory Clinic service: Satisfaction and identified needs

Joanna Coyle

Joanna's name is now: Dr Joanna Clair.

Symbolic Interactionism

Stéphane Duckett

IN TWO RECENT publications, (*PSIGE Newsletter 99*, Spring, 2007), I showed how ageism can creep into our work as therapists. The issue is, essentially, our tacitly endorsing our clients' beliefs that they are the authors of their own misery when in point of fact, it is the wider societies discrimination of older adults that confirms a loss of self-hood. This form of 'benign ageism' to me seems the ultimate betrayal, since it comes in the guise of help. The difficulty for us is that Freud's legacy casts a long shadow and we as a consequence have difficulty thinking in any other mode but intra-psychically. One way we can protect against this is to ensure that our formulations are 'ecological', that is that they encapsulate the wider social context within which to understand the presenting problem. There are two theoretical models, one drawn from sociology and one from developmental psychology that I believe can, when combined, help ensure that we remain ecologically minded in considering our clients problems.

Symbolic Interactionism

At its core, Symbolic Interactionism has two fundamental principles. The first is that we are symbolising creatures. That is our world only exists by virtue of the fact that we impute meaning, principally through language, thus all things come into relief for us. This symbolising applies equally to imputing meaning to ourselves. Thus, the second principle is that we are reflexive: the meaning that we impute to an object by virtue of its functionality, we understand equally applies to ourselves. In other words, we see ourselves as others see us. The importance of this is that it creates an 'I' and a 'me'. 'I' is my experience of myself from moment to moment; 'me' is as I define myself through my reflection in others. Self is comprised of both the 'I' and the 'me'.

Socio-ecological context

The above is embedded in a social ecology. Bronfenbrenner (1979) dissected this into four components: micro, meso, exo and macro-systemic.

1. *Micro-systemic* refers to the immediate day-to-day relationships that fill our lives, such as with colleagues, spouses, friends and various professionals.
2. *Meso-systemic* refers to relationships that parties involved with the subject may quite independently have between themselves, such as a doctor on a ward may have to a consultant colleague from another speciality in relation to a particular patient.
3. *Exo-systemic* refers to the wider social context within which an individual exists, which may be a hospital, a work place, home or community.
4. *Macro-systemic* refers the wider cultural environment, such as that which distinguishes us as a nation, or racial or religious group, for instance.

These components can be mapped out diagrammatically. However, what is perhaps more important is the fact that this ecology is reflected in us all (just as Stanley Milgram's distorted topologies found their curious representations in his subjects.) This internalised ecological map is distorted because of attributional forces, our state of mind, and our personal experience. It is layered over time. I would argue that many of the problems faced by our clients are a product of a conflict between the ecological context they occupy and the internal ecological map, which may be grossly at odds with that context.

Each dimension of our ecological context reflects back to us who we are seen to be. This may match the me that has come to be formed at various points of my existence or it may not. Quite often our 'me' is crystallised at a point in our lives when we felt ourselves to be most relevant to our world. The slide to irrelevance and disenfranchisement can sometimes be so gradual that we are unaware that our 'me' has changed and a rude awakening may on occasion await us. Faced with this insight there is much that we can work with with our clients, but perhaps our first duty is to do no harm, that is tacitly being party to what Maggie Kuhn (cited in Hessel, 1997) termed 'the Detroit syndrome': the built in obsolescence of humanity.

Correspondence

Dr Stéphane Duckett

Chartered Clinical Psychologist,
Royal Free Hospital,
London.

E-mail: Stephane.duckett@royalfree.nhs.uk

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'Budding Flowers': The GATE-ways programme for people with dementia

Margaret Muir

It was like watching buds become flowers!'

AFTER CONCLUDING my videotape presentation and discussion at the recent 2007 PSIGE Conference Seminar on psychotherapy for people living with dementia, a member of the audience made the above comment. The metaphor of a 'bud opening' to its full potential and beauty, indicated to me that a difficult and long journey had been worthwhile. It also validated my belief that we can connect with and make life better for people living with dementia.

The conference presentation enabled me to share with others a 'glimpse' of the data collected for my current PhD research. These data included the above-mentioned videotape 'Some days are brighter', which portrays a group of women participating in Gestalt Art Therapy Experiential-ways (GATE-ways) to recovery and discovery programme. My second presentation at the conference included data comparing GATE-ways with a different programme also used during the research, Gestalt Awareness in Movement Exercises (GAMEs; Muir, 2006), of Gestalt-based exercises for people with dementia. In this paper, I provide a brief overview of what motivated my work, the Gestalt Approach, conceptualising dementia as trauma and the preliminary study findings.

Why embark on such a journey?

I am asked frequently why I undertook my PhD and why I used the above methods. My approach has developed from mine and my husband Bill's background as psychologists with Gestalt training and our experiences over the past 37 years of having six family with conditions that have led to neurological

degeneration. Five of these have been our siblings. However, the most significant person was our son. Following a massive meningo-encephalitis viral infection at 11 months of age, he experienced nearly eight years of neural degeneration. Bill, our daughter Suzanne, and I wanted to transform some of the painful experiences we had endured during our son's illness into something 'tangible' that would help others in similar situations. Currently a significant number of people experience neurological impairment and degeneration and their family caregiver/s travel with them on that difficult journey.

After long discussions we decided that if I adapted programmes I had developed over time perhaps we could make 'a difference' for the better. I then enrolled in a PhD (Medicine) at the University of Newcastle (Australia). What I wanted to do was reduce levels of anxiety and/or depression together with improving engagement, physical abilities, social interaction and well-being for people living with a neurological impairment. The family proviso (remember my husband is a psychologist) was the programme I developed needed to be valid and reliable as well as effective.

The Gestalt approach

The use of a Gestalt approach is suggested as an appropriate style of psychotherapy for older people and those with dementia:

Frequently resigned and self-critical, the elderly can benefit from a humanistic, growth-centred non-psychopathological approach ... the Gestalt therapist can work with body, mood image and thought; with a disabled client he or she can emphasise that faculty least impaired. The Gestalt emphasis on responsibility

counteracts the common, demeaning dependency of old age and fosters self-awareness, physical well-being, energy and motivation, and a sense of integrity.'

(Greene, 1980)

The emphasis in Gestalt is on awareness. Awareness can be considered as comprising three zones (Stevens 1971). These include awareness of the outside world. We gain such awareness through our senses. Describing awareness of actual sensory contact with objects and events in the present involves 'What I now actually see, hear smell, taste or touch. Awareness of our inside world relates to our lived experience – our inner being – muscular tensions and movements together with feelings, emotions, discomfort or well-being. The third zone is fantasy activity such as imagining, interpreting, guessing, or remembering the past. Gestalt also emphasises awareness about the need to focus on what is meaningful for our sense of 'self' (Oldham, Key & Starak, 1978; Perls, 1969; Stevens, 1975).

Gestalt tools and process

My PhD clinical project involved the use of two Gestalt approaches with people living with dementia in residential care. One being Gestalt Art Therapy, which extends Gestalt therapy by using psychotherapeutic multi-modal techniques including fantasies, imagery and memories, various art media, and movement (Rhyne, 1973; Rubin, 1998; Steven, 1971) to assist these people to communicate through 'visual languaging' (Rhyne, 1973). The approach involved the use of several forms of art material such as meringue, uncooked rice, pencils, acrylic inks, textiles, and papers. To encourage self-expression, participants in the study were asked to choose how they wanted to use the art materials – what they wanted to communicate, describe or create.

The other approach used, GAMES, also involves extending Gestalt therapy as a developmental exercise programme that focuses primarily on 'the inner awareness zone' and once more degrees of fantasy activity. The

latter is encouraged when the participant needs to plan the suggested movements. For example, during the research our first session started with moving the muscles of the face, gradually extending over the duration of the programme, to provide opportunities to activate all the muscles in the body with the final goal, to stand safely and independently.

In both GATE-ways and GAMES arm movements in conjunction with controlled breathing were an integral part of each session. This activity was increased both in duration and frequency at each session. This component of the approach involves 'the second, inner awareness zone' together with some input from 'the awareness of fantasy activity with the facilitator saying 'Now imagine that your breathing is like gentle waves on the shore, and each wave slowly washes some tension out of your body ...' (Stevens, 1971, p.38).

Person-centred approach and the context of dementia as trauma

From the perspective of a psychotherapist and considering my life experiences, I considered there was value using a Gestalt approach in the context that neurological impairment represented a form of trauma. The concept of linking trauma and trauma recovery with dementia (Muir, 2004) is relatively new but clearly resonates with the views of Judith Herman in 'Trauma and recovery': '... The common denominator of trauma is a feeling of intense fear, helplessness, loss of control, and threat of annihilation.' (Herman, 1992). These same terrifying feelings often haunt people living with dementia.

In the same way as providing person-centred care for people living with dementia, the core of recovery from trauma requires meeting basic and essential psychological needs: safety, trust, mastery and control, self-esteem and intimacy (Rosenbloom, 1999). The person-centred approach of both Gestalt and trauma recovery are in line with Kitwood's (1997) work in this area

and in particular, his diagrammatic description of the essential psychological needs of people living with dementia by using a flower with each petal named accordingly. The petals describe occupation, inclusion, intimacy, attachment, and comfort. In the centre of the flower Kitwood placed the word 'love'.

Kitwood (1997, pp.90–92) proposed specific ways caregivers could meet these essential needs for people living with dementia. He described approaches such as recognition; negotiation; collaboration; play; 'timalation' (which he used to represent sensory stimulation); celebration and relaxation. These, together with validation, holding, and facilitating he saw as 'more distinctly psychotherapeutic'. A further two types of interactions proposed, are those of creativity and giving, where the person with dementia takes the leading role. Above all, as not only Kitwood but many others agree is the notion of life as 'fun'.

Because of the appropriateness to the aims of the study, I decided to 'weave' Kitwood's philosophy of caring for people living with dementia into the 'fabric' of the project. That is, two programmes for GATEways Muir (2003, pp.159–165) and GAMES (Muir, 2006) were developed consistent with Kitwood's philosophy of person-centred care and recommended staff approaches.

Participants and barriers

The research participants were older women who lived in secured units of a large regional residential care facility. Their average age was 82 years and a number of these women were quite frail. They all had a confirmed diagnosis of dementia. For the study to be statistically significant a minimum of 48 participants was required and fortunately I was able to gather data for 51 women. This meant conducting over 30 programmes involving 130 women. In addition to the usual research obstacles, sadly several residents became terminally ill, while a series of influenza epidemics provided a significant barrier to the research process. With the

latter problem there were occasions where quarantine was needed and programmes cancelled.

Assessments, tools and a snapshot of analysis of findings

Quantitative and qualitative evaluations of the programmes were detailed, using multiple tools for pre-, during- and post-programme assessments of the participants' progress and well-being. Measurement domains included cognition, depression, activities of daily living and other key areas of function and emotion. Each assessment used in such a way as to be consistent with Kitwood's language and philosophy of person-centred care.

Two key assessment tools were the revised Pool Activity Level (PAL; Pool, 1999) and Dementia Care Mapping (DCM: BDG, 1997). The PAL outcome sheets utilised during the programme were completed at the end of each session. Scoring involved recording each person's level of Engagement; Physical Abilities; Social Interaction and Well-being and manipulating these scores to provide a 'Total Score'. The quantitative data from this tool is in the process of statistical analysis but examples of several significant improvements in total scores are shown in Table 1 (overleaf).

DCM was conducted by accredited DCM staff with the participant groups over several sessions. DCM is a developmental evaluation tool which provides both qualitative and quantitative data. It is a method used to identify the most relevant behaviour in which the person is engaged from a variety of Behaviour Category Codes (BCCs) together with a score indicating levels of Well or Ill-being (WIB) during five-minute observational time-frames. BCCs represent positive behaviours (being involved in an exercise groups='J') as well as those behaviours considered potentially as contributors to ill-being ('C'=being cool and withdrawn). WIB scores may range from -5 to +5.

The following graphical representations of two participants enables you to see the

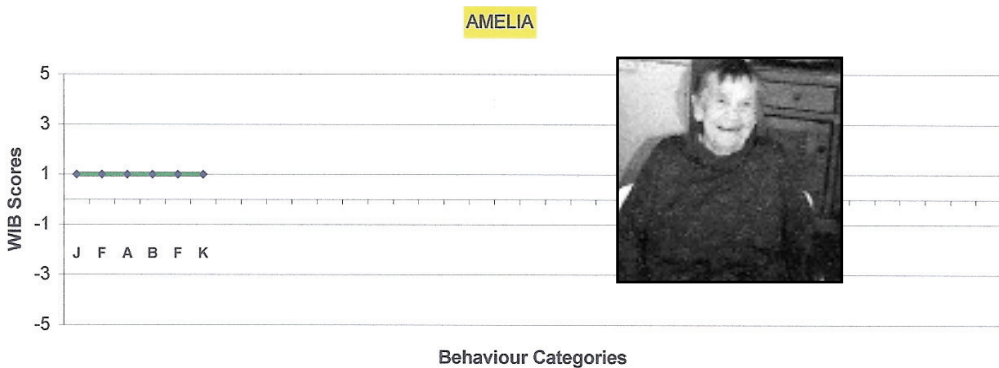
Table 1: Changed Scores Revised Pool Activity Level: Sessions 1–12.

GATE-ways	Session 1	Session 12
Alice	17	54
Molly	80	110
GAMES	Session 1	Session 12
Alison	-5	46
Edna	38	110

changes in their behaviours – BCCs, and increases in their WIB scores – feelings – for longer periods between the first and the last session. Consent has been provided for the

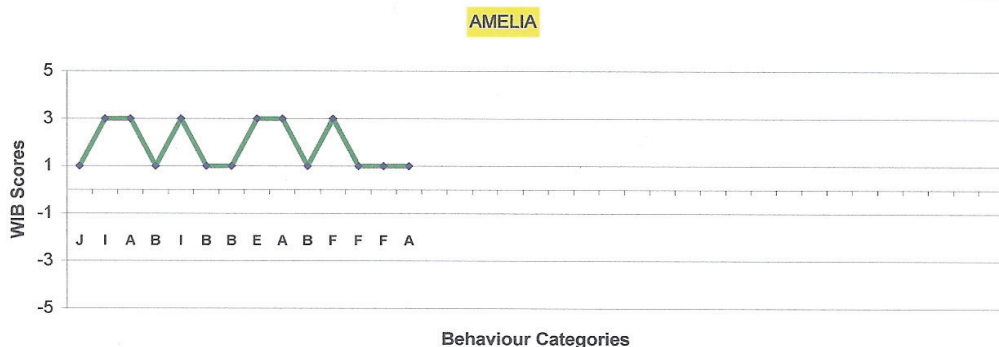
use of these residents’ photographs in publications. The first graphical representation below depicts results from Session 1 – WIB score of +1 (=coping) being the norm.

Figure 1. The GATE-ways participant with the lowest WIB Score and BCC at baseline.



being) in Session 12.

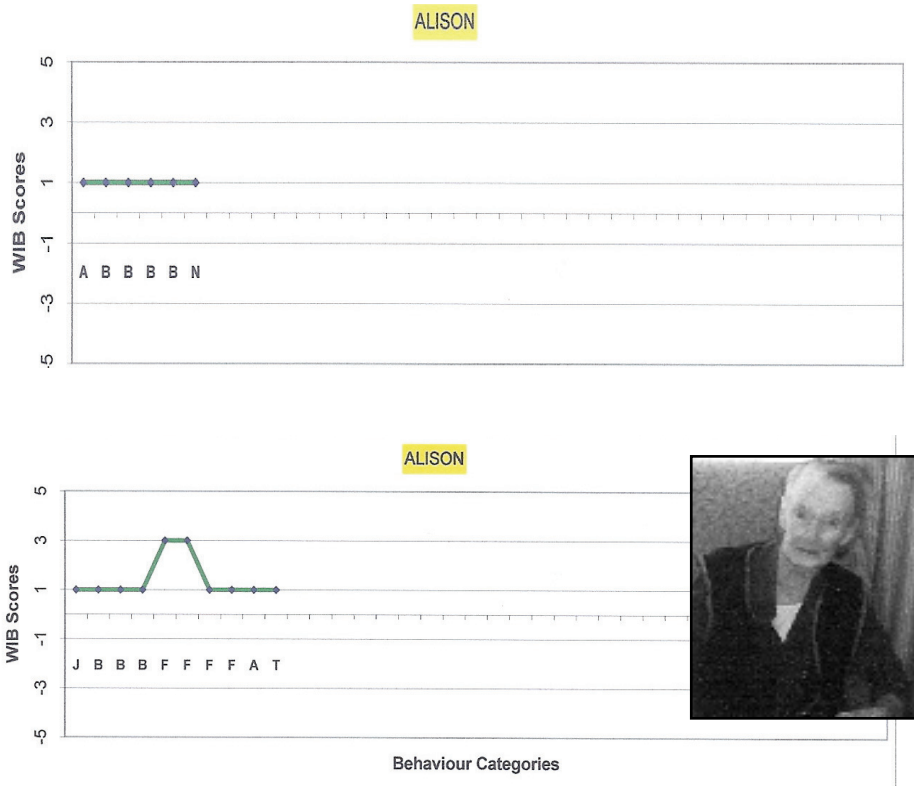
The results below reflect WIB improvement to a level of +3 (=considerable well-



In Session 12, new BCCs include 'I' representing activities using intellectual skills and 'E' – engaging in an expressive or creative activity. As explained, these are snapshots. They do not represent equal time

frames, however, they do give us an indication of how well-being can be enhanced through the psychotherapeutic and person-centred use of art.

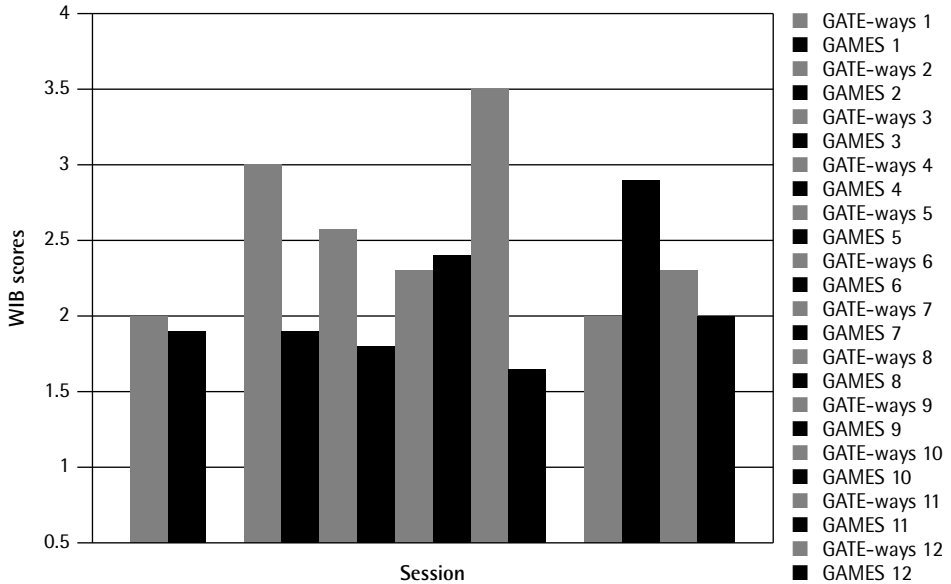
Figure 2. Comparison with the GAMEs participant with the lowest WIB score and BCC at baseline.



Above BCCs: 'N'=sleep; 'B'=passive involvement; 'F'=eating and drinking. 'A'=interacting. Alison slept not only through Session 1 but also Sessions 2, 3 and 4 before she began to participate as shown in the photo, when she 'wakes up'! Changes in the two representative examples shown

above are consistent with other participants who were observed using DCM. Data suggest that the GATE-ways (art) programme provided opportunity for a more varied BCC for a greater duration and usually higher WIB scores.

Figure 3: Comparison of WIB score for GATE-ways and GAMES.



DCM was conducted on a seven occasions. Both groups started from a similar baseline and both groups improved. This result is consistent with the qualitative feedback given by staff and as shown in the video

The vignettes of the six participants shown in the video validate the results above as represented in the following example;

Lillian, a competent artist who had before the programme shown no interest in drawing, was able to draw a lovely sketch of the documentary maker. She also assertively declined to draw on the last session as it was not what she wanted to do that day!

It would appear Lillian was ‘motivated’ quite strongly in the Gestalt awareness zone of ‘expression about what was meaningful to her’ at that point in time in her life!

Molly warmly remembers that as a child at night she sat on her father’s lap in his rocking chair. Molly teases the facilitator that ‘I could make a better rocking chair than you!’ Molly’s mood of joyful remembrance changes to deep

sorrow, as she remembers that her father’s comfort is no long available to her. Although supported by the facilitator it was, Lillian, who comforts her by saying ‘We will all meet again’.

Conclusion

I observed residents using particular types of fabrics or material to describe memories that were and remained meaningful to them. Creating images using different art mediums which also related to memories absorbed and consumed sessions as did humour, laughter, joy and a sense of meaningful relationship with each other and with me. These sentient and wise women shared their loves, lives and losses. I owe them a great deal. Now, I must continue my journey of analysis and publication in a way which honours and continues to help them and all those other people with a neurological impairment and their caregivers who travel with them.

For your interest

Following the above finding and in consultation with the Activity Officers the two programmes are now integrated into Gestalt Art Therapy and Exercise-ways to recovery over five weeks. This has made the programme more diverse, time- and cost-effective. To date the approach has been further trialed during 2007 in six units located within a number of different facilities. Further training sessions for the implementation of new GATE-ways in other parts of Australia is scheduled for 2008. If you would like more information about the GATE-ways programme please contact Margaret Muir.

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Correspondence

Margaret Muir

1400 Leggetts Drive,
Brunkerville,
New South Wales 2323,
Australia.
E-mail: margaret.muir@bigpond.com.au

Experiences of offering EMDR to older people with PTSD in Coventry

Sally Robbins, Amanda Clarke & Iris Kay

This paper explains how the current Eye Movement Desensitisation and Reprocessing (EMDR) service for older people in Coventry meets our overall service aims and presents a summary of the qualitative feedback provided by our clients who have benefited from it. There appears to be limited research on the effectiveness of EMDR specifically with older people with PTSD. We hope that this service evaluation can contribute to this area.

EYE MOVEMENT DESENSITISATION AND REPROCESSING (EMDR) is an integrated therapy developed by Francine Shapiro in the 1980s. The therapy includes techniques of cognitive behavioural therapy, psychoeducation and psychotherapy, as well as the lesser known, and EMDR specific, bi-lateral stimulation techniques. In bi-lateral stimulation the EMDR therapist leads the client through a safe recall of a traumatic memory, whilst simultaneously asking them to focus on an external stimulus, often the therapist's finger, causing the clients eyes to move laterally. Whilst it is not totally clear how this particular EMDR technique works, proponents advocate that this combination allows the trauma to be re-processed physiologically and psychologically. This has led to a reduction and sometimes elimination of, emotional distress. For further reading please see Shapiro, 1989a & b.

Background

About five years ago our colleagues in other sections of Psychological Services in Coventry were beginning to use EMDR and to share their experiences with us. In the Neuropsychology Specialty, colleagues trained in EMDR, and were reporting successful outcomes with people who were traumatised following accidents and head injuries. Colleagues working with people aged under 65 were seeing a number of traumatised refugees, who at that stage had been

settled in Coventry long enough to seek psychological help, and using EMDR with good results. Therefore, when a lady was referred from the general hospital to our department in 2004, showing signs of PTSD following a violent burglary in her own bedroom, it seemed timely to experiment with providing an EMDR service for her. Those first sessions of EMDR with an older person, provided by Iris Kay, were so successful that the service has continued for older people in Coventry who have similar difficulties ever since.

Service aims

Overall, our service aims to provide as much high quality psychological service as possible for the people of Coventry, delivered in the easiest and most convenient way possible. This can be summarised in the following four points:

- Cheap as possible;
- Quick access;
- Fast and relatively easy for people;
- Effective.

It is not common to be able to point to part of our service where we seem to have achieved all these goals, however, albeit in a small way, over the course of 12 referrals, this EMDR service appears to have achieved it.

We make no apology for putting 'cheap as possible' in this list, after all this means we can treat more people with the resources available and do more useful work. The current costings of the EMDR service bills

give a mean cost of £168, ranging from £120 to £225. Our EMDR service is quickly accessed; Iris Kay, our third author, is able to offer flexible appointments including evenings and weekends. In addition, EMDR treatment appears fast, which reduces the possibility of a lengthy waiting list. Typically in our service EMDR has good measurable outcomes within four to five sessions. Most of those referred have not needed to come back to mainstream psychology again, despite having some symptoms before the EMDR treatment which were not obviously trauma-based.

Clinical guidance

Since our early experiences of working with EMDR therapy, the NICE guidelines on PTSD (2005) have included EMDR as one of two recommended ‘trauma focused psychological treatments’.

‘All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]).’ *The management of PTSD in adults and children in primary and secondary care*, NICE (2005).

Although NICE (2005) cite research literature to support the guidelines, a scan of the publications revealed just one study with older people in the title. Therefore, we felt we could contribute to the literature and add experiences of receiving EMDR for PTSD, from an older person’s perspective.

Participant information and methodology

The qualitative methodology used to evaluate the service was an interview schedule. Of the 12 clients who had received the EMDR service, eight were invited to participate, four were deemed not appropriate. Seven agreed to participate and were sent information regarding the study, including a consent form. Interviews took place after all of their EMDR treatment had finished. All participants had received EMDR in the previous 18 months. Participants were asked to evaluate the service they had received and what impact it had on their symptoms. Interviews were recorded, transcribed and analysed using a thematic analysis.

The demography of the participants is shown in Table 1.

The origin of trauma for which the participants were referred is shown in Table 2.

The interview schedule was divided into three areas. Firstly participants’ evaluation of their presenting symptoms, secondly the EMDR service they received and thirdly their reflections on any change post EMDR.

Table 1: Participants.

Male	4
Female	3
Average age	74
Age range	72–85 years
Average number of sessions	8
Number of sessions range	4-12

Table 2: Origin of trauma.

Car accident	2
Physical assault	2
Medical procedure	2
Fall	1

Results and discussion

Interview area 1

Participants' evaluation of their presenting symptoms are presented in Table 3.

Table 3.

Participant 1	Anxiety, panic attacks, isolation.
Participant 2	Anxiety, panic attacks, depression, exhaustion, vivid memories.
Participant 3	Depression, feeling of helplessness, increased procrastination.
Participant 4	Fear of being alone, anxiety.
Participant 5	Flashbacks, insomnia, anxiety, loss of appetite.
Participant 6	Flashbacks, insomnia, anxiety, anger, frustration.
Participant 7	Anxiety, panic attacks.

'I would just stand there in a shop doorway and panic, I had to get home as quick as I could ... an ordeal' (Participant 1).

'Frightened to go out ... would make myself go and then be shattered on return' (Participant 2).

'Shaken up and generally depressed' (Participant 3).

'Really low and a fear of being on my own' (Participant 4).

'In my flashbacks I could see the car coming towards me' (Participant 5).

'You resent the fact that it's happened ... an horrendous experience and I was told I was lucky to get out of it – it changed my life' (Participant 6).

'The fear sets in as you try to control yourself and not make a spectacle of yourself' (Participant 7).

Prior to beginning EMDR, six out of seven participants had found their GP supportive.

'I think the GP could see how wound up I was about it, more than I could I suppose' (Participant 3).

Four out of seven had received other psychological therapies which they felt had not significantly reduced their symptoms. Five out of seven had already tried psychiatric medication for their symptoms. None had experienced significant psychiatric/psychological problems prior to the trauma, except one participant who had received support to come off tranquilisers.

Attitudes to beginning EMDR were open minded overall though two out of seven participants, on hearing about it were sceptical.

'It sounded really strange and I thought to myself, how can this possibly help, it seemed so bizarre really' (Participant 2).

'Didn't think that would work, really pleased when it did' (Participant 1).

Interview area 2

Participants were asked about the EMDR intervention itself. When their experiences of EMDR were analysed, five themes emerged:

- Information;
- Relaxation;
- EMDR Techniques – Bi-lateral Stimulation;
- Counselling;
- Therapeutic relationship.

Information

All seven participants told us that the first EMDR session was a helpful flip chart exercise, where information about the neuro-physiological responses to trauma were explained. A brief formulation of the symptoms was developed by the therapist and client. Three out of seven participants had kept their flip charts and offered to show them to the interviewer, providing some indication of their value. One participant described the flip chart work as:

‘Quite brilliant, I was able to identify with the theory of it all’ (Participant 6).

Relaxation

All of the participants described the moments immediately before the specific EMDR techniques of bilateral stimulation began, as ‘relaxation’ by all of the participants; as ‘soothing’ as a ‘safe haven’. In fact, they referred to the collaborative creation of a ‘safe place’ by the therapist and client which allowed them to leave the traumatic memory if it became too distressing.

EMDR techniques – Bi-lateral Stimulation

Four out of seven participants remembered the specific EMDR techniques of bi-lateral stimulation, e.g. finger following, tapping knees. Evaluations of the techniques by those same participants were characterised by bemusement and mystery – yet an appreciation of their effectiveness.

‘How or why or the way it works? I’ve no idea’ (Participant 4).

‘Sit close, watch my finger, tapped my knees? – Strange’ (Participant 5).

‘Don’t think Iris knows how it works to be honest’ (Participant 2).

Participant 2 described the first time the therapist administered the bi-lateral stimulation:

‘You just follow her finger and imagine you are going through it all again, it’s difficult to keep following the fingers and remembering the scene, to keep your mind focused, but afterwards you definitely feel as if its done something. I said to Iris, I feel such a relief as if I’ve let something go. it’s very hard to describe, its amazing as if a load as been lifted’

Three out of seven participants did not mention any bi-lateral stimulation techniques, though each had received them according to the clinical notes. Instead those three each describe something else:

‘I knew I was there, but I wasn’t aware of anything going on around me – that’s how I felt – no idea what she was saying to me’ (Participant 5).

‘She is doing more than relaxation’ (Participant 4).

All Participants described their trauma as either ‘fading’ or ‘behind them’ as a result of the EMDR sessions. Each was participant was clear that they still have the traumatic memories, just that they can cope with them better.

‘The memory gradually faded – before it was really vivid and would come to me really easily-it kind of just fades into the distance, don’t ask me how it works I really don’t know’ (Participant 2).

'I have a general feeling of relief, it's happened and that's it, it's behind me' (Participant 6).

'I started to sleep again, eat, I'd come home [after each session] and sleep for an hour, flash backs got less and less and the car got further away' (Participant 5).

Counselling

The EMDR therapist is a trained psycho-therapist; the participants each made comments around this.

'Someone who understood the way I was and how I felt was the first step' (Participant 3).

'Took me through talking about lots of things, other distress came out, don't know why I ended up talking about these things, cried a lot – realise now it was trauma in back of my mind' (Participant 2).

Therapeutic relationship

All participants said they liked the therapist, a crucial factor in the success of any therapy.

'Felt comfortable from the first' (Participant 1).

'Got on well with her – absolutely' (Participant 2).

'Reassuring, felt like she really cared what happened to me' (Participant 2).

Interview area 3

Participants were asked about how they were coping now, having received the EMDR service, and whether it had made a difference to their original symptoms.

Overall, participants talked clearly of the usefulness of the EMDR session; they were all clear that it helped, although they did not understand how the bi-lateral stimulation worked specifically. All participants said they would recommend it to others.

'By the time I was finished with her I was a new woman and I've been like that since I went to her' (Participant 4).

'By the end, after six weeks, I felt great, she was marvellous, what ever she was doing' (Participant 5).

'Not as bad as I was, let's be honest – she gave me a boost' (Participant 7).

'Iris more or less pulled me round, Strange thing [trauma] that happens to you, you read about it, felt easier with myself after the sessions' (Participant 3).

Participants 1 and 6 said it helped them get 'back to normal'. All noticed a reduction in their original symptoms and all were clear that the memory of the trauma remains, but not the accompanying level of distress.

'[The] flashbacks got less and less and the car got further away' (Participant 5).

Three out of seven participants use the word 'relief' when describing how they felt after sessions. Two out of seven participants used the phrase 'Like a steel brick/load had been taken off my shoulders.'

Table 4 summarises the participants' self-evaluation following the EMDR service.

Table 4.

Participant 1	'Better', confidence increased, still panic but not as severe.
Participant 2	Anxiety and depression reduced, able to go out again.
Participant 3	Less depressed, more hopeful, less angry.
Participant 4	Much better, happy to be on own, less anxious and depressed.
Participant 5	Less frequent flashbacks, appetite, sleep, 'normality returns'!
Participant 6	No flashbacks just memory, positive, able to put it behind me.
Participant 7	Able to cope in anxiety provoking situations and not panic.

'At the end of each session I could walk up the road and feel strong, my heart wasn't banging ... I was proud of myself (Participant 1).

'Tremendous relief. Certainly think she helped me a lot' (Participant 2).

In addition to the qualitative evidence, other outcome measures, including Clinical Outcomes for Routine Evaluation (Core System Group 1988) and the Hospital Anxiety and Depression Scale (Zigmond and Snaith 1983), have also been used to assess effectiveness with individual patients. We are still in the process of collating this quantitative data.

Conclusion

EMDR therapy has become an established part of the service offered to older people in Coventry. This study supports the NICE guidelines (2005) which promotes EMDR as effective in the treatment of PTSD. It appears to meet our service aims of being relatively cheap, quick to access, fast (though the mean number of sessions was higher for this particular group of participants), and relatively easy for people, as stated by the participants themselves.

'There was nothing you could put your finger on but a general smoothing out; having the sessions and feeling the relief' (Participant 3)

It is not possible, on the basis of this evaluation, to divide EMDR therapy into individual techniques and conclude that one aspect, for example, bi-lateral stimulation, is more effective than another. EMDR therapy is an integrated therapy which contains elements of Cognitive Behavioural Therapy and Psychoeducation. Iris Kay is a psychotherapist and, therefore, brings elements of this training to the EMDR sessions, in addition to those from the EMDR training programme which she completed.

However, in terms of the effectiveness of an EMDR approach, and on the basis of this evaluation, all of the above elements integrated together seem to account for the successful outcomes for these participants in Coventry. We support the clinical impression that older people seem to benefit from this approach and that they find it effective, useful and value it.

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The authors

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Amanda Clarke, Assistant Psychologist, Coventry and Warwickshire Partnership Trust.

Iris Kay, Psychotherapist and EMDR Therapist, Coventry and Warwickshire Partnership Trust.

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See and hear the real me – not just dementia

Glynice Smith

THE DIAGNOSIS OF dementia in my mother was devastating. What followed was a sharp learning curve and lifestyle adjustments as the condition worsened. The National Service Framework for Older People (NSF) and Single Assessment Process (SAP) place the needs and desires of the individual at the heart of care. This talk compared and contrasted the theory with patient/carer experience. It illustrated the psychological needs of someone with dementia and their family; highlighting the importance of person-centred, pre- and post-registration dementia care training for all who care for older people. More is understood about this terminal disease and the opportunities to improve well being and quality of life abound. Personal experience led to a dramatic career change and my commitment to ensure other vulnerable older people and their families did not suffer as we had. Working together, we can overcome the challenges and create positive outcomes for service users and providers alike.

A diagnosis of vascular dementia

My mourning began when we were told my mother had vascular dementia. She deteriorated in slow, painful stages over five years, until her death in 2005. It is wrong to assume all sufferers of this terminal disease are in the final stages, where they cannot communicate or care for themselves. My mother gradually became forgetful and confused, and then walked with a frame, needing help with personal care. The close relationship we shared for almost 50 years never wavered and words were often unnecessary.

Adjustments were made as our world became small and friends slipped away. I took a part-time job, juggling finances and

two homes. Those who understood dementia saw my mother as a unique, warm, friendly and humorous little lady – the rest just saw an awkward person.

Obtaining the right information and help when needed

It took months to obtain an initial care needs assessment and medication supervision. A five-year fight began against bureaucracy, poor quality service and indifference. The situation would have been unsustainable without staff from the local Alzheimer's Society. They prepared me for the future; giving unlimited, practical and emotional support. Most carers battle to obtain accurate, appropriate and timely information and services – when and where they are needed. Many older people are close to collapse or contemplate suicide through the strain of trying to cope.

NSF Standard 2. Person-centred care

The Department of Health website states 'The way to achieve person-centred care is by listening to the views of users and carers about the services they need and want and this is strongly promoted within the NSF.'

My mother's GP always addressed her directly; aware I wrote it all down. We worked together to maintain her health. He respected and supported both of us. Forgetting my birthday distressed my mother so I bought huge, flattering cards. She read the words, chuckled and signed in full agreement. It was difficult to hide my pain in what had always been an open and honest relationship. Delivering person-centred dementia care isn't easy. It requires specialist skills and patience. Local care providers and I worked well together but when they did not listen or

pass on facts, it took hours to repeat phone calls. My mothers' daily care workers coped with many crises. She felt they were her friends and they looked after both of us.

NSF Standards 4 and 7.

General hospital care and mental health in older people

I always felt ignored in Accident and Emergency, as I anxiously tried to tell them information about my mother's history and dementia that she could not convey herself. On admission, other patients told me that food and medication were left by my mother's bedside untouched. A nurse, on being asked about two falls, replied 'Your mother refuses to ring the bell when she needs to go to the bathroom.' It is unjust to label someone with dementia as 'difficult' without understanding their behaviour. Any complaints I made were dismissed as misunderstanding.

The NSF and SAP state the needs and desires of the person being assessed must lie at the heart of the process. This did not happen in the general hospital. Despite a prior, formal diagnosis of dementia, health and social care staff insisted on labelling my mother as 'confused' throughout an assessment for residential care. The social worker was alarmed when she asked 'If you made a meal, what would you make?' – my mother thought she made the nightdress she was wearing. It was a reasonable response for her. I found her in tears because she did not understand why she was being 'interrogated'. I could have explained in words she understood and her distress could have been avoided. The 'spiritual, social and relationship needs and lifestyle choices' section was blank on all paperwork that I saw.

Requests for a comprehensive, individual care needs assessment, GP involvement and life history were refused. Staff criticised my insistence on a single, en-suite room within a setting registered for dementia care.

The assessment should have been conducted by specialist staff to ensure the person being assessed and their family were

not terrified by the experience. Whilst on the ward my mother fell and broke her hip. She was transferred to another hospital where she described the staff, quite accurately, as 'much more humane'. The doctor on the orthopaedic ward repeatedly asked my views on resuscitation, without explanation, over a two-week period. I could hardly eat or sleep because of it. My mother contracted C Difficile and died. Neither bug Diff nor dementia was on the death certificate.

Partners in care

Just before she died I told my mother I would spend the rest of my life speaking up for other vulnerable older people and carers. I started by contributing toward teaching sessions for doctors learning psychiatry. Our story changed attitudes. One doctor tried a different approach with a lady who had complained about every ward. Her daughter had schizophrenia. He called and said he had information that might help her. She was so grateful. In working together, recognising individual needs, everyone benefits.

A recent Reminiscence and Dementia course, led by Lyndsay Royan, at the Age Exchange in Blackheath, inspired me to run reminiscence groups. This approach can help people with dementia recall the past and reveal reasonable explanations for apparently difficult behaviour. It's a fantastic opportunity to improve the daily quality of life of older people on their own terms and to unite families and care providers.

In conclusion

Dementia does not discriminate. It could affect any of us. According to the Dementia UK report from the Alzheimer's Society (2007), by 2025 it is estimated one million people in the UK will have it and it costs the UK over £17bn a year. The National Audit Office report, Improving Services and Support for People with Dementia, 2007, claimed one-third to one-half of people with dementia never obtain a formal diagnosis. It is the second biggest killer in this country

and the Government must act now to place it higher up its own agenda.

There are good policies in place but not all providers comply with them. Pre- and post-registration dementia care training and support must be compulsory to ensure older people receive the standard of care they deserve. We must also give good practice a much higher profile.

One of the few times I let go in five years was during the formal diagnosis of dementia I requested for my mother. The professional team included a psychologist. We were both safe and relaxed with them. People with dementia and their families badly need psychology specialists like the delegates at the PSIGE conference. I look forward to working together to see the real person inside each older person, not just the dementia.

Correspondence

Glynice Smith

Public Speaker for Older People & Carers,
4 Chester House,
Prospect Road,
New Barnet,
Herts EN5 5BW.
Tel: 07779 788521
E-mail: GlyniceS@aol.com



Exploring family functioning post-stroke

Camilla F. Dyer

CEREBROVASCULAR ACCIDENT, or stroke, is the leading cause of disability and the third most common cause of death worldwide (Warlow, 1998). Although stroke can affect people of any age, the majority of people who have a stroke are over the age of 65 (Chief Medical Office (CMO), 2002; Westcott, 2000). As with other types of chronic illness, stroke impacts on the individuals themselves and can also have consequences for family members, particularly in cases where residual effects are apparent.

Although people aged 65 and above are more likely to suffer stroke than other age groups, the consequences of stroke on older people and their families have not received extensive attention. Previous studies assessing family functioning post stroke do not differentiate between younger people and older people who experience stroke.

In this study stroke patients (aged 65 and above) and family members were compared to healthy older adults and family members. One-hundred-and-twelve people took part in the study in total; 56 people in each of two groups: 28 individuals who had experienced a stroke within the last five years were recruited from local health and voluntary services within the Highland region of Scotland, and 28 older adults, who had never had a stroke, were recruited from local community groups. Each Older adult participant nominated a family member to also take part in the research, hence two groups of 28 pairs.

In addition to a demographic questionnaire, all participants completed the Family Assessment Device (Epstein, Baldwin & Bishop, 1983) the World Health Organisation Quality of Life Short Measure (WHOQOLBref) (The WHOQOL Group, 1998), the Significant Others Scale (Power, Champion & Aris, 1988) and the Hospital

Anxiety and Depression Scale (Zigmond & Snaith, 1983).

The main result was that, in families where an older person had a stroke, the stroke did not negatively impact on family functioning. Group comparisons revealed that there were no differences between the stroke and control groups on measures of family functioning, perceived social support and mood. However, older people who had had a stroke reported a lower perceived quality of life than older people who had not had a stroke.

Results of the study were interpreted as suggesting a cohort finding with regards to adjustment to life post stroke. Perhaps stroke is an expected consequence of ageing, in accord with the developmental sequence highlighted in both individual and family life cycles. However, rather than the expectation of physical ill health leading to negative outcomes for patients and their family members, it may be that expecting ill health with advancing age is a valuable coping mechanism for dealing with the illnesses and losses that people are faced with in later life. The study focused on comparing groups of people and does not aim to minimise the distress that some individuals experience as a result of a family member having a stroke. The results of the study do however suggest that, on the whole, older people may cope better than younger people with the effects of stroke. This finding that older people may show strength and resilience in coping with physical illness is both an interesting and a positive one.

Correspondence

Camilla F. Dyer

Trainee Clinical Psychologist (4th year),
NHS Highland/University of Edinburgh.
E-mail: Camilla.Dyer@hpct.scot.nhs.uk

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The St. Andrew's Sexual Behaviour Assessment (SASBA): Development of a standardised recording instrument for the measurement and assessment of challenging sexual behaviour in people with progressive and acquired neurological impairment

Caroline Knight, Chrissie Johnson, Nick Alderman,
Sharon Green, Louise Birkett-Swan & Graeme Yorston

INAPPROPRIATE SEXUAL BEHAVIOUR (ISB) as behavioural sequelae of neurological impairment is often overlooked in comparison to other challenging behaviours such as agitation and aggression, yet the impact on patients and carers can be equally significant and pervasive. Limited published research, inconsistencies in terminology and lack of standardised measurement tools for ISB limit the degree to which such behaviour can be objectively and consistently identified, reported on, and managed within and between services. Other crucial factors include the stigma experienced by staff, the perceived intent of such behaviours and concerns over 'labelling', all of which potentially limits confidence and openness in discussion within teams (Johnson, Knight & Alderman, 2006).

The research undertaken proposes a new ISB scale, the St. Andrew's Sexual Behaviour Assessment based on the Overt Aggression Scale – Modified for Neurorehabilitation (OAS-MNR: Alderman, Knight & Morgan, 1997). The SASBA allows continuous observations of ISB to be recorded against sixteen defined behavioural categories of increasing severity, divided up into four main themes (verbal comments, non contact with others, exposure and touching others) developed

with reference to relevant literature (Johnson, Knight & Alderman, 2006). The scale also incorporates antecedents and interventions/responses to behaviour.

The aim of the scale was to provide detailed consistent descriptions of behaviour, which clinical teams could then utilise to create a formulation/function analysis regarding intent, rather than relying on observer interpretation. This clear differentiation between 'what' behaviours are observed and 'why' they potentially took place, addresses issues of individual subjectivity and some of the perceived concerns expressed by staff.

The research was undertaken in a number of stages. The statistical properties of the scale were obtained using written descriptions of ISB generated by clinicians. The validity and reliability of the SASBA for use within clinical in-patient environments was found to be similar for two groups of individuals with neurological impairment (Progressive Neurological Conditions and Acquired Brain Injury). Results indicate strong construct and content validity, and good inter-rater reliability. Staff involved in the research also gave a high positive rating in relation to the clinical acceptability of such a scale.

The scale alone cannot address some of the broader context issues in relation to ISB such as the culture of services. However, when implemented in conjunction with staff training, there are a number a positive clinical uses of the scale. This includes providing vital information for formulations/functional analyses, guiding and evaluating interventions, evidence for resource allocation, audit and creating change and openness through a common language.

Correspondence

**Dr. Caroline Knight, Chrissie Johnson,
Prof. Nick Alderman, Dr Sharon Green,
Dr Louise Birkett-Swan &
Dr Graeme Yorston**
St. Andrew's Healthcare,
Billing Road,
Northampton NN1 5DG.

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Keeping older adults safe: What happens when things go wrong?

Sarah Head & Ally Taft

How do you learn from serious untoward incidents and cases of neglect in both the statutory and residential sector? This article looks at situations, which arose in two care settings in Birmingham and how psychologists can be involved in recognising cultures that might foster assaults on and neglect of patients being cared for by staff. The importance of taking action in such cases is also highlighted.

The stories

Avonside Older Adult Mental Health Assessment Unit

Background

Mrs B was a patient at the Avonside Unit, an older adults mental health assessment unit within the Birmingham and Solihull Mental Health Trust, from 2 August, 1999, to 27 October, 1999. In November, 1999, Mrs B, aged 64 alleged that a member of staff, Mr X, had sexually assaulted her during her admission. The allegation was made to a consultant psychiatrist, who found her account consistent and confirmed that at the time of his interviews her mental state was stable and she had recently recovered from a relapse of her long standing mental health problems. Mrs B informed the consultant that a nurse had entered the toilet and sprayed her around her genitals and inner thighs with a detergent spray cleaner. The same nurse had also made inappropriate sexual comments, such as asking whether Mrs B 'felt sexy'. On one occasion, on her responding no, Mr X protested that she would do and forced her to drink a 'brown-coloured liquid'. Mrs B remembers waking after this feeling awful and having a black eye. Mrs B died on 4 January, 2003, and Mrs B's daughter remained convinced that her mother was raped or assaulted on this occasion.

Mrs D suffered from severe depression and had self harmed on numerous occasions throughout her life. She was an intermittent in-patient from 1998 to 2001. Mrs D was found dead in a shallow bath in June 2001 soon after nurse X returned to work on the unit. The Coroner returned an open verdict. The family were very concerned because they had never been offered the opportunity to talk with the staff who found Mrs C. To take a bath was not something Mrs C did and they did not know whether she had tried to self harm again or whether there had been a tragic accident, or, indeed, something more sinister.

Mrs E was a patient at the Avonside Unit, from 5 July, 2002, to 6 August, 2002. On 6 August, 2002, having only shortly before been informed that she had an inoperable brain tumour, Mrs E, aged 73, reported that a member of staff had raped her in her room. Staff did not call the police nor take steps to secure the crime scene, until the arrival of Mrs E's sons some eight hours later. Criminal proceedings took place against the nurse, Mr X, but not before Mrs E's sad death. In part due to various failures on the Trust's part, Mr X was acquitted. He was later dismissed by the Trust following disciplinary proceedings and was finally struck off by the Nursing and Midwifery Council in 2006.

Mr C was an in-patient in Avonside during 1991. His family came forward following the call for the Public Enquiry and complained about the poor care he received in the unit. They also described Mr C's nervousness and fear of a particular staff member. Although the Review Panel could not identify any particular instances of physical assault of Mr C, they did note in the Review findings that: *'The Inquiry Team is sure that the staff member in question, who is linked with the two sexual assault cases, was disciplined over this period for his 'unacceptable manner in dealing with patients.'*

Inquiry

Following complaints raised by families of relatives involved in a total of four serious untoward events, an independent inquiry was established, leading to the publication of a report, *The Avonside Review – report of the Independent Inquiry Team – April, 2004*. In summary, the inquiry highlighted the following generic failures:

- a. the financial investment in older care adult services suffered in consequence of re-direction of funds in other areas which had an impact on staffing levels, human resources support and training;
- b. the adoption of a medical, rather than therapeutic, treatment model;
- c. a lack of clinical audits and failure to implement standard procedures;
- d. a poor working relationship between the Ward Manager at Avonside and the Clinical Services Manager
- e. in relation to adult older services, a failure to draw upon issues highlighted in a report from the Commission for Health Improvements ('CHI') in 2001 which included a lack of effective governance monitoring.

Furthermore, the Inquiry found that there was a lack of learning from the experience of adverse incidents and a lack of audit.

The Inquiry Team found that in consequence of these failures the Avonside Unit was a *'very depressing unit'* for both staff and patients: the décor and layout was

depressing; there were poor facilities; minimal therapeutic treatments practices; lack of stimulation; and the general hygiene and odour of the unit was *'totally unacceptable'*.

Additionally, and most significantly, in 1999 an allegation of serious sexual assault was made against Mr X, a member of staff. At a disciplinary hearing he was completely cleared of the allegation and thus permitted to return to working on the ward. The Inquiry Team found however that the case against Mr X was poorly prepared and that *'the Trust had failed in its duty ... for allowing this individual to return.'* The report concluded that had an effective investigation procedure been followed it was more likely than not that Mr X would have been dismissed for gross misconduct.

The Trust has implemented significant ongoing changes to improve the older adults mental health services and has taken steps to ensure Mr X will be prevented from working in other hospitals, although there is nothing anyone can do to stop him being employed as an unqualified carer in a private residential setting.

Maypole Nursing Home

Mr F died unexpectedly on 7 September, 2002, just 10 days after being admitted to the Maypole Nursing Home in August, 2002. He suffered from both Alzheimer's disease and Parkinson's disease, but was considered fit and well upon his admission to the Nursing Home.

As part of the investigations into the civil claim against the Maypole Nursing Home, there was a supportive medico-legal report concerning Mr F's care and treatment at the Maypole Nursing Home. The report concluded that following his admission to the home Mr F received excessive sedation and appeared to have received inappropriate nursing care in a 'bucket chair' (used as a restraint) which would have made him more susceptible to pneumonia. There was also poor record keeping and a failure to consult the family about Mr F's final illness. The report also highlighted that the certifi-

cation of Mr F's death due to bronchopneumonia by Dr Y had insufficient evidence to support this conclusion.

Mr F's death was not reported to the authorities and neither a post-mortem nor an inquest was held.

On 21 January, 2005, the family called for their father's death to be included in the Birmingham Coroner's investigations into the suspicious deaths of 16 other elderly residents at the Maypole Nursing Home. In light of the very serious allegations reported in the media surrounding the number of unexplained sudden deaths at the Maypole Nursing Home, the Birmingham Coroner was urged to look into Mr F's death as part of his ongoing investigations with the police.

A number of other agencies were involved in the investigation of the Maypole Nursing Home.

The National Care Standards Commission

The National Care Standards Commission carried out an investigation and finally produced a report dated 26 February, 2003, criticising the management of the Maypole Nursing Home. The report did not address individual problems, however, but looked at the management of the home in general.

Amongst a number of failings, it was reported there were poor standards of care, insufficient staffing, dirty equipment and hazardous storage, no interaction between staff and residents, cramped living conditions, excessive use of restraint with significant medication, no awareness of nutritional needs and a significant number of accidents, some of which could be considered under Adult Protection procedures.

Birmingham and Black Country Strategic Health Authority (SHA)

During further enquiries it came to light that the Birmingham and Black Country Strategic Health Authority (SHA) also carried out an investigation. The scope of the report was limited in that it did not attempt to provide a detailed account of events at the Nursing Home or the circum-

stances of the deaths of those patients who died there or shortly after admission to the home. The purpose of the report was to provide an overview of the strategic issues and broader policy considerations from the need for several statutory bodies to carry out a complex series of separate and inter-agency investigations. Mr F's family were not involved in this investigation. Despite requests, there was considerable delay with a copy of this report being provided and it could not be located on the internet.

GMC

There was also a GMC investigation into the practice of Dr Y and his wife, Dr Z, who ran the home and also administered medical care to the residents. The enquiry commenced on 12 September, 2004, and was completed on 20 January, 2006, when both doctors were removed from the medical register.

Mr F's daughter, Mrs G gave oral evidence at the GMC hearing on 14 September, 2004. Unfortunately, questions were not raised concerning the excessive dose of medication given to Mr F and the use of the bucket chair or the death certificate in Mr F's case. The issues covered related to the general state of the nursing home and nutrition. Mrs G considered that the GMC had not addressed the main issues of concern.

UKCC

It is believed that the UKCC are investigating the practice of the nursing home manager who was working at the Maypole Nursing Home when Mr F was a resident. There is no further information in this regard.

Inquest

On 4 January, 2006, the Birmingham Coroner announced he would not be conducting an inquest into the nursing home deaths. He stated in a press release that he found no evidence which would justify the holding of an inquest touching some or all of the 13 deaths reported to him. He stated there was reason to believe the

home was not well run, but the deficiencies were matters which should be dealt with by the authorities who are responsible for the control of nursing and residential homes and the authorities responsible for the professional behaviour of doctors and nurses.

The coroner's decision is not supported by Mr F's family. In his case there is clear evidence of medical wrong doing which would warrant an inquest into the cause of death and the conditions at the Maypole Nursing Home were unacceptable. The scope of enquiry of the other agencies is thought to be insufficient to deal with this matter and that, in the absence of an inquest, a public enquiry would be justified in such circumstances.

Judicial review proceedings have begun by Mr F's family requesting the Coroner's decision not to hold an inquest in this case to be overturned. This will be heard in the High Court in October, 2007.

Recognising a culture where abuse and neglect may occur

The Avonside Review used a form of Root Cause Analysis to investigate the culture of the unit. Their findings highlighted several areas which could be relevant to any institution caring for older adults. These are issues which should be looked for when visiting or working in any ward, unit, residential or nursing home.

The seven factors which indicate a culture where abuse may occur are:

1. Isolation;
2. Under-staffing and lack of training;
3. A 'closed' group of staff;
4. Lack of patient-centred care;
5. Lack of research or audit;
6. Lack of awareness about risk management;
7. Financial stress.

The unit is insular and isolated

The person in charge may be very controlling and not allow staff to act without prior permission. They may have been promoted

beyond their capabilities and do not feel secure in what they are doing. They do not welcome 'outsiders' either professional or lay. There is an unhealthy close relationship between the person in charge and the visiting medical staff, so the doctors do not encourage outside investigation or investigations of untoward incidents.

The unit is consistently understaffed and training is lacking

There is a high turnover of staff with a reliance on agency nurses/support staff. Staff are not appropriately trained and are not allowed to go on external training courses. No internal training is provided including updates to practice and policy. Staff who put themselves through external training are not allowed to implement their knowledge and skills. Patient records are inadequately maintained. The number of staff who make records in patient notes is restricted. Health care assistants, students and visiting therapists are not encouraged to make notes in patient records.

Staff are a closed group

Staff form cliques and people who don't 'fit in' leave soon after appointment. Staff do not feel able to report inappropriate levels of care by colleagues. Staff are actively discouraged from 'grassing' on colleagues who perform inappropriately. Staff who report neglect or abuse are victimised by their peers.

'Patient-centred care' is not the ethos of the unit

Patients are not seen as individuals with rich lives and histories. Relatives, friends and carers are not welcomed into the unit and are not encouraged to participate in care management or planning. Staff do not routinely inform relatives immediately when a patient has been injured or hurt, either through accident or deliberate action. Staff do not answer relatives' or carers' questions in a useful or meaningful way. There is no external user and carer involvement in the unit.

Research, risk management and financial stress

Staff do not take part in any kind of research or clinical audit. They are not aware of risk management and do not actively engage in assessing risk. The unit may be under financial stress, with managers refusing to fund appropriate staffing levels, or failing to respond when extra staff are required to meet a safe level of care. Managers may claw back unspent budget to bail out other units within the organisation.

What to do if you discover a patient/client has been abused.

Follow the unit Serious Untoward Incident Policy if there is one.

Remember the area is now a 'crime scene',

- Check someone has called the police. If not, do it yourself. (*The police should be informed of the incident as soon as possible after the event. If several hours or days elapse before the police can gather forensic evidence, vital evidence will be lost which might harm a successful investigation and/or prosecution.*)
- Make sure the patient's clothes and bed linen have not been changed, removed and/or washed. The police will need to examine them for forensic evidence.
- Make sure the room in which the incident happened has been sealed for forensic examination. **It should not be cleaned.**
- Do not touch anything until the police have been.
- Ask the ward/Home manager if they have contacted the people they need to contact. This includes relatives. (*It is not enough to call another manager and just tell them what has happened.*)
- Make sure someone stays with the patient and explains what will happen next.
- If the alleged abuser is a member of the ward/home staff, make sure no one talks to them until after the police have interviewed them. They **should not** be contacted and told not to come into work.

- If the alleged abuser is another patient, they should be kept in a closed environment with a member of staff with them at all times. They should not be allowed to wash or change their clothes until after the police have been and taken whatever they need for forensic examination.

What to do if you have concerns about a patient/client

Your concerns should be reported to the appropriate body as soon as possible and certainly within 12 hours of first noticing the concerns. It is important for trainees, Assistant Psychologists and newly qualified clinical psychologists to alert and discuss any concerns with their supervisor or head of service immediately except in the event of a serious incident where the agreed service procedure should be followed.

If you work for the NHS or Local Authority, you should follow the multi-agency guidelines for the protection of vulnerable adults (POVA).

If the patient/client is a resident of a care home you should contact the local Social Care and Health Social Work Team responsible for vulnerable adults and the Commission for Social Care and Inspection. If they are resident in a nursing home or private health facility, you should contact the Health Care Commission as well as your local appropriate social work team.

If you are acting in a private capacity or as a member of the public you should contact:

- the local Social Care and Health Children and Families Team if the client/patient is under 18;
- the local Social Care and Health Social Work Team responsible for the vulnerable adult.

Making changes

It is hard to identify a culture where abuse may occur. It can be even more difficult to identify resources and procedures which can influence such a culture to change. Psychologists can play a key role in facilitating

change. Although their primary concern is to their clients – the patients/residents, they can also be seen as a team member of the indigenous group of professional carers. In addition, they can offer informal professional advice and support to staff members during difficult times such as bereavements on the unit.

One of the overwhelming criticisms of the Avonside and Maypole establishments was the lack of stimulation and activities for people living there. Psychologists can work with OT and physiotherapy colleagues to identify appropriate and meaningful activities which may offer a small degree of respite for harried nursing staff. They can also liaise with and champion the introduction of user and carer representatives within the unit to ensure their input is seen as a vital and integral part of patient-centred care.

Conclusion

Keeping older adults safe is the responsibility of everyone involved in their care at any level. Psychologists have a unique opportunity to be able to identify a culture where abuse or neglect may occur because the nature of involvement means that they are both part of and yet often outside of the team providing the majority of care to patients.

If abuse or neglect is either suspected or becomes a major concern, then steps should be taken to ensure the investigative bodies are contacted within hours, not within days. Role playing scenarios can help to give confidence to individuals who might otherwise not feel able to take appropriate action.

The older adults intimately involved in the case studies used here are no longer with us. We owe it to their memory to ensure what happened to them does not happen elsewhere.

Correspondence

Sarah Head

Public and Voluntary Sector Liaison
Manager, Irwin Mitchell Solicitors.
Member, Avonside Review Panel.

Ally Taft

Associate Solicitor, Irwin Mitchell Solicitors.

Useful contacts

Commission for Social Care and Inspection

Tel: 0845 015 012; 0191 233 3323

Textphone: 0845 015 2255; 0191 233 3588

E-mail: enquiries@csci.gsi.gov.uk

Website: www.csci.org.uk/

Addresses for national and regional offices can be found on the website which also has an online feedback form.

Healthcare Commission

Freepost

LON15399

London EC1B 1QW.

Tel: Helpline 0845 601 3012

E-mail:

feedback@healthcarecommission.org.uk

Website:

[www.healthcarecommission.org.uk/
homepage.cfm](http://www.healthcarecommission.org.uk/homepage.cfm)

Action on Elder Abuse

Astral House

1268 London Road

Norbury

London SW16 4ER.

Helpline:

UK: 0808 808 8141; ROI: 1800 940 010

Tel: 020 8765 7000; Fax: 020 8679 4074

E-mail: enquiries@elderabuse.org.uk

Website: www.elderabuse.org.uk/

Ann Craft Trust

The Ann Craft Trust is a UK-based organisation working with staff in the statutory, independent and voluntary sectors to protect people with learning disabilities who may be at risk from abuse. They also provide advice and information to parents and carers who may have concerns about someone that they are supporting.

The Ann Craft Trust
Centre for Social Work
University of Nottingham
University Park
Nottingham NG7 2RD.
Tel: 0115 9515400; Fax: 0115 9515232
E-mail: ann-craft-trust@nottingham.ac.uk

PAVA (Practitioner Alliance Against Abuse of Vulnerable Adults)

PAVA
PO Box 127
Ryde PO33 9AE.
E-mail: siteenquiry@pavauk.org.uk
Website:
www.pavauk.org.uk//home/home.php

WITNESS against abuse by health and care workers

32–36 Loman Street
London SE1 0EE,
Helpline 08454 500 300
E-mail: info@witnessagainstabuse.org.uk
Admin Tel: 020 7922 7800
Website: www.popan.org.uk/index.htm
WITNESS (formerly POPAN) runs a helpline, a support and advocacy service, provides training and develops new policy approaches to the prevention of abuse.

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Annual Conference reports from Bursary recipients

THIS YEAR THE Bursary scheme was extended beyond Assistants and trainees to include newly qualified clinical psychologists and others experiencing difficulty obtaining funding to attend the PSIGE annual conference. All bursary recipients are required to submit a brief report reflecting their experience of the conference. A selection of these reports is published here but due to the increased number of bursary recipients it has not been possible to publish them all.

The following people also submitted bursary reports:

Sarah Beech, Julia Bird, Kate Court, Emma Harris, Michael Jubb, Julia Little, Monique Maroney, Gemma Murphy, Nazareen Nisajida, Lena Palmer, Neil Ralph, Kathryn Sams, Meer Shah and Jessica Zetteler.

... A different kind of workshop

Louise Barnard, Sheffield Care Trust.

Have you ever walked into an academic workshop with colourful posters on the walls, relaxing music playing in the background, tranquil photos being projected onto the whiteboard and a variety of fun activities to play with on the tables including magnetic drawing boards, pots of bubbles, cuddly toys and paints. If not, then you've probably never been to a workshop by Kate Allan and John Killick. Their workshop, *Creating Joy and Hope: People with Dementia and the Arts – A Positive Psychology Perspective*, was very much an experiential workshop whereby they practiced what they preached. It served as a basic introduction to positive psychology.

Positive psychology focuses on what makes life worth living (Seligman, 2004, 2005). Flow is an important aspect of positive psychology and it was this very concept that the facilitators of this workshop tried to engender in the delegates. Flow occurs when we become absorbed in an enjoyable activity to such an extent that our sense of time is distorted and our sense of self is diminished. Flow is intrinsically rewarding and motivating. The activities that lead to flow are unique to each individual.

The facilitators emphasised that non-verbal means of communication take on a new importance with people with dementia and often become more important than verbal communication. A critical message of the workshop was that creative and artistic activity play important roles in communication, self-esteem and quality of life and, as such, we should be using them not only to try to engage people with dementia (and others) but also to try to broaden their thought-action repertoires (Frederickson, 2005) and improve their well-being.

I found this to be an extremely thought-provoking and useful workshop. In my mind it has validated some of my current practices and helped me to reframe them under the auspices of positive psychology.

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Thoughts from a PSIGE Conference presenter

Nathalie Garbutt, Leeds Partnerships NHS Foundation Trust.

This has been the first year that I've had the opportunity to attend the Annual Conference. Needless to say, when it was suggested to me that as a newly-qualified Clinical Psychologist I had 'a responsibility to share the findings from my thesis' with my peers a few thoughts entered my mind. Firstly, after spending two good years of my life fretting, sweating and getting increasingly hateful thoughts about my thesis I had hoped that I would get away with never having to lay eyes on it again. Secondly, public speaking has never been a strong point and presenting to a group of PSIGE members about dementia care issues was more than a little anxiety-provoking. When, however, it was also put to me that it would be 'character building' and if nothing else 'would look good on my CV' I eventually conceded. Consequently, this report represents the thoughts of a reluctant presenter who, on reflection, can honestly say it was a positive experience and would recommend it to Trainee Clinical Psychologists and newly-qualified people alike. Here then are a few pointers for anyone thinking of presenting at PSIGE for the first time:

Prior to the conference:

1. *Picking up the thesis again* – essentially the point to make here is that it's really not that bad so do it sooner rather than later. I attempted to make the process feel clinically relevant to my current work by meeting with the team where I recruited participants to feed back the research findings and discuss clinical implications for their team. Getting a new angle on the research 'post-thesis' was helpful for generating new enthusiasm.

2. *Preparing the presentation* – This is also best done sooner rather than later and where possible give it a test drive with your target audience. I presented a longer version of my presentation at my local PSIGE meeting which was invaluable for getting feedback about my presentation style, what people found interesting, unclear, wanted to know more about, etc. I then could easily edit it for the conference. I was also told that people generally value a handout – this is true.

At the conference:

3. *The day before* – For those of a nervous disposition like myself, try to take in as much information from other presentations or seminars as possible on this day as the other days will prove less fruitful in this respect. This will be due to sudden waves of either anxiety or nausea (see point 5) prior to and the day after your presentation respectively.

4. *The night before* – The reputation that PSIGE conference attendees have for 'letting their hair down' is well known in local circles. For presenters this can represent something of a challenge during the evening's festivities depending on your constitution and will power. In short, a certain level of restraint is advisable the night before your presentation.

5. *The night after* – Do reverse of point 4.

6. *The day after* – You'll feel less guilty if you heeded the advice in point 3 though I cannot promise you will feel less unwell. You may, however, like myself, think you would be ready to do it again next year.

What did I get from the PSIGE Conference?

Ama Everatt

This was my first PSIGE conference and I believe it reflected wonderfully the diversity of interests within PSIGE. There was a large variety of topics, a balanced mixture of research, clinical and service development issues and all of these were presented with great enthusiasm. The atmosphere was friendly and relaxed and I was heartened to see how much everyone I met evidently enjoys working with older adults.

I am a second-year trainee on the University of Edinburgh/NHS Scotland D. Clin. Psychol. Course doing the flexible training route, specialising in older adults. Flexible training differs from the typical three-year route in that the trainee is attached to a specific speciality and works part time in this service whilst doing the regular training the other half of the week. I am thus completing my training over five years, doing training and placements two-and-a-half days per week and working in an older adult service the other half of the week. On qualifying I will, therefore, have the equivalent of two years experience in an older adult service in addition to my clinical training, hopefully standing me in good stead to continue working in this field.

Attendance at the PSIGE conference has been valuable for both my work component and clinical training. In my work component I am involved in developing the service offered to the Medicine of Old Age so I found the stream on physical health particularly useful. I have been considering a specialist placement in CAT so was delighted to hear how this is being used with the older adult population. I attended the conference hoping to get ideas for my research thesis. As well as many research ideas I also had the opportunity to reflect on my clinical work, to think about further service development and, seeing the passion of others for their work, to feel enthused about my future work in this area.

The Nottingham conference

John Killick

My take on the Nottingham conference is probably rather different from that of other delegates/presenters. I am not a psychologist (though I am a member of PSIGE) but a writer, and a poet at that! So presentations/workshops of the more medical persuasion don't hold a lot of appeal for me. I'm interested in psychosocial approaches in general, and communication and creativity in relation to people with dementia in particular, and hoped to find these with a place on the programme.

I must confess at the outset that these subjects were indeed in evidence, partly because of the three contributions from myself and my colleague Kate Allan! But there were also Dawn Brooker's analysis of the Enriched Opportunities programme, an initiative of which I was already aware, and

which certainly utilised the creative resources of staff and residents in the Extracare Housing programme. There were also two presentations on narrative therapy, a really important area for development I believe, given by Joanne Smith and Julie Barber, and Philip Anderson. In addition there were two sessions by Margaret Muir from Australia; she described an innovative activities programme for those with dementia, which she has designed.

I would like to pay tribute to PSIGE members. I have rarely encountered a more enthusiastic, open-minded, friendly group of people in my travels around the conference circuit here and abroad, and I thank the Committee for giving me the opportunity to participate.

PSIGE 2007 – Compassion, Lies and ‘Coronation Street’

Andrew Roberts

Arriving at Jubilee Campus didn't deliver the street parties and bunting that the name suggests (to someone of my age at least!), but there was undoubtedly a celebratory mood in the air. The usually careworn features of the older adult clinical psychologist seemed to fade over the course of a hugely enjoyable three days – to be replaced with a slightly guilty (shamed?) hung-over expression in many of the 'hardcore' delegates. Others, separated from their families dried their eyes and looked forward to a good night's sleep at last.

The first day was spent in the company of Paul Gilbert (and many others) exploring the issues of shame, self-criticism and the resulting safety behaviours. There was a beautifully concise account of the underlying models in his approach, drawing from various therapies, evolutionary psychology and neuroscience. This is what people really mean when they use the word integrative. It is tempting to try and provide some sort of summary here, but that would fail to do justice to the speaker or the content. I can only recommend that you attend a similar workshop if you can. The last part of this day was spent in a variety of meditative exercises and many people (myself included) emerged from the session feeling warm, relaxed and compassionate – at least until I encountered Nottingham's rush-hour traffic!

The second and third days were spent shuttling between streams in order to attend an incredibly diverse range of talks, including: enhanced opportunities for people with dementia; revisions to the CBT model of 'fear of falling'; relationship centred care; and social exclusion and developing older people's networks. I want to devote particular attention to two presentations coming from Newcastle and Northumberland. Ruth Elvish and Ian James' provocatively-titled talk on the use of lying in dementia care – this was a brave and thoughtful (and thought-provoking) presentation, which also made good use of 'Coronation Street' clips! Their other presentation focused on the setting up of a challenging behaviour team. The formulation approach was presented as an alternative to the 'therapist intuition' which often predominates in this area, and persuasively argued for the necessity in systematically involving care home staff in generating both the formulation, but also the interventions which derive from it. Although the work is focused around very complex cases the structure that this approach provides seems to be containing for all of the staff concerned.

So, it was full of energy, inspiration and fried food that I left Nottingham. I think I was also suffering with Post Ceilidh Fatigue Syndrome (PCFS), and also slightly traumatised by witnessing the full majesty of the Boddington Bounce! It was a great conference, in a good location, well organised, and with a great range of speakers. Next year's conference will have to aim high to match this.

Thanks PSIGE!

Stacey Robson

Thanks to a PSIGE bursary I was fortunate enough to attend all three days of the PSIGE conference held at Nottingham University. As a third-year trainee currently working in an Older Adult Psychology and Therapies Service, this conference gave me an opportunity to consider some of the pertinent issues relevant to working with older people enabling me to broaden my knowledge and clinical skills with a client group that I hope to work with post-qualification. The 'Caring and coping with loss in dementia service' workshop run by Charlotte Piney and Lisa Heller was both informative and inspiring, allowing me to learn about an evidence-based psychosocial intervention for informal carers of people with dementia. The workshop enabled me to think about the practicalities of setting up a group within my own practice as well as develop an awareness of the importance of meeting the emotional needs of this often neglected population.

Louise Bergin and Stephanie Anaya ran a useful and interesting workshop on 'Assessing the mental health of black and minority ethnic older people'. This workshop focused on some of the main issues and challenges that arise when carrying out neuropsychological assessments with interpreters. As I have not worked directly with interpreters during my training, it was very interesting to hear about some of the shared experiences and difficulties the group had faced when working with a client with whom they did not have a shared language. It increased my awareness of the extent to which our practice is based on our own cultural assumptions and allowed me to think about the implications this has on neuropsychological assessments. In addition, the role plays were extremely valuable for exploring ideas of good (and bad) practice and preparing me for working with interpreters in the future.

The papers and seminars presented at the conference were divided into four streams, with the freedom to move between each one throughout the day. This enabled me to attend a range of talks on therapeutic models, dementia care, and service development issues. For example, the presentation on 'attending to neglect' used a cognitive analytic framework to explore the roots of the detached and seemingly not-needy presentation of some of the older clients we see. It discussed the important contributions made by attachment theory, social history and ageism in a client group where needs of care and dependency become increasingly salient. Ian James presented an interesting seminar on setting up a challenging behaviour outreach team which enabled me to reflect on my own practice and develop a useful framework for working directly with carers and staff at residential and nursing homes. Finally, Oonagh Koppel presented a qualitative research study that explored the experiences of individuals with memory difficulties who are yet to receive a diagnosis. This research highlighted the importance of giving a voice to the uncertainty people feel prior to a diagnosis and recommended that, for clients who wish to know, the diagnosis is fed back in a clear and accessible way, free from the complex terminology often used in assessments of dementia.

Overall, the PSIGE conference was a thoroughly enjoyable and informative event that highlighted just a snapshot of some of the valuable research and contributions being made by psychologists working with older adults. It has further increased my enthusiasm for working with this client group when I qualify and I would like to thank PSIGE for providing me with the opportunity to attend an inspiring three days.

A day's break at the Conference

Jane Bell

Thanks to a PSIGE bursary I was able to take a much needed break from my thesis and attend the annual conference for a day. I chose to attend the Wednesday because I wanted to have the experience of presenting my research at the poster presentation session and I also wanted to attend the day of workshops.

I chose to attend the 'Caring and coping with loss in dementia: A support package for informal carers for people with dementia' workshop. I thought the work that Lisa Heller and Charlotte Piney described was an inspiration; a multidisciplinary project based on a sound evidence base. I found it interesting to consider how crucial the role of the observer appeared to be, to both the carers and the facilitators. It seemed to be this group structure that enabled the carers to share difficult feelings and the facilitators to carry out such intense work. This workshop gave me some useful things to consider when working with carers generally; I think this came from being able to consider in more depth some of the issues that this group enables carers to share.

The other workshop I attended (assessing the mental health of black and minority ethnic older people) was equally thought-provoking. It was surprising to hear the same story from psychologists working in diverse, multicultural cities; that 'we just do not see people from black and minority ethnic backgrounds'. This issue plus the role-plays with interpreters made for an interesting, practical session.

Finally, I would like to say that I enjoyed presenting my poster in such a supportive environment. I would like to thank PSIGE for presenting me with a prize for my poster; it was a lovely way to end my conference experience.

Now I see why the PSIGE conference is so special

Samantha Hull, Assistant Psychologist, Surrey NHS Primary Care Trust

Following the PSIGE conference, I attempted to reflect upon my experience before writing this report. However, a natural reflection period overlapped with a second conference the following week at the World Congress of Behavioural and Cognitive Therapists (WCBCT) in Barcelona, Spain. The WCBCT attracted well over 3000 delegates from 70 countries for 39 invited addresses, 51 open papers, 182 symposiums and 890 posters. Of these, I found only seven posters and two symposiums related directly to older people. Having been inspired with the 'PSIGE mentality' (Woods, 2005), I found this lack of coverage astonishing to say the least. This altered my interpretation of the importance of the PSIGE conference and highlighted the amount of work that is still needed to ensure older people are treated equally. This issue is of particular importance as it is proposed older people services merge with those for younger people.

At the PSIGE conference, I truly valued being amongst clinicians who shared a passion for the client group and wanted to make a positive difference for older people. Overall I found the conference programme to be comprehensive, interesting and engaging, and the event provided a valuable opportunity to network.

Alongside Prof. Germaine Greer and Michelle Lee from Age Concern, the highlight of my conference experience was attending Dr Laidlaw's full-day workshop on 'CBT with older people'. The workshop provided a good introduction and overview to this empirically supported treatment, highlighting the importance of measurement, agenda setting, collaborative work, specific therapeutic techniques and the use of homework tasks. The inclusion of video clips was helpful to illustrate clinical application and provided a neat forum for group discussions. Dr Laidlaw also highlighted three important therapeutic issues (cohort beliefs, different developmental lifespan and

comorbid conditions), which may require consideration when using CBT with older people. I anticipate these principles being immensely helpful as I commence training in clinical psychology.

The opportunity to present some of the work I am currently undertaking with Dr Ian Kneebone on a revised cognitive-behavioural model for fear of falling (Hull & Kneebone, 2007), was also valuable. The presentation was well received and clearly sparked ongoing interest as indicated by the e-mails I have received, including one from a physiotherapist who attended the conference. I would recommend anyone conducting research with older people to consider presenting at PSIGE: it is rewarding and enjoyable to be a part of the conference.

In terms of peer support, the conference provided a good opportunity to meet like-minded assistant psychologists and current trainees. It was helpful to lunch with two assistants from the Newcastle area who also gave oral presentations. Not only were we able to share tips and hints about effective public speaking, but also discussed the joy and relief of gaining places on training courses. I feel that others in a similar position would benefit from these encounters and would suggest an informal lunch targeting assistants and trainees is considered for the next conference programme. On a similar note, it may also be advantageous to have a trainee/assistant representative on the PSIGE national committee to represent the views of these sections of the membership.

Finally, if I had one tip for future conference delegates, it would be to attend the AGM. Alongside the more formal issues of annual budget reports and electing new members, it is an invaluable occasion to hear about the policies (and politics), which are currently influencing PSIGE, the DCP and the British Psychological Society.

Thank you to the PSIGE committee for my bursary and for the opportunity to present our research. I look forward to York 2008!

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Older adult psychologists – what a friendly bunch!

Marrian Durran, Assistant Psychologist, St. Andrew's Healthcare, Northampton.

This year was my first PSIGE conference and my roles at the Jubilee campus were three-fold. Firstly I was there as a delegate, secondly as a half-day conference steward, and lastly as a presenter. I found that this gave me the opportunity to appreciate the conference on many levels. Whilst fulfilling my role as a steward I managed to tie myself in knots over which talks to attend, and whilst I was very inspired by the presentations I did attend as a delegate (especially the 'sensecam', communication in advanced dementia, and Amy Wood-Mitchell's medication prescribing), there are always other talks that one would wish to attend if we could be in two places at one time! Although a little nervous before I presented my own paper I found the experience of speaking at a conference very valuable and I look forward to doing further research and presenting at events in future.

Whilst I reflect on the conference I am forced to recline in my chair and breathe in – I have never been so well fed at a conference, so a big thanks to the caterers and especially to the inspired person who decided to put deep-fried prawns on the lunch menu twice! It was a humbling experience to be back in 'halls,' I had thought that over-learned behaviours might force me to revert to some of my previous undergrad habits. However, I am delighted to advise that the exciting array of available seminars and presentations meant that I didn't have a single afternoon nap, and that none of the wine I consumed originated from a buy one get one free deal at Iceland – how times change!

In all seriousness, my heartfelt thanks go out to the PSIGE bursary team whose kind contribution allowed my attendance at the conference. I found the experience wholly worthwhile and already, after just one day back at work have found myself rather excitedly telling MDT colleagues about the fascinating research that is going on in the world of older adults. Thanks also to fellow delegates – what a friendly bunch older adult psychologists are (but we won't mention the dancing!)

A three-day conference, plenty of cheesecake and a steel band to boot!

Kerry Parkinson, Assistant Psychologist, St. Andrew's Healthcare, Northampton.

Thanks to a PSIGE bursary, I was able to attend the full annual conference. As this was my first conference experience, I was unsure as to what to expect. Nevertheless, it exceeded all my hopes in providing a forum in which to attend some very interesting, thought-provoking and enthusiastic seminars and workshops, put faces to the names of psychologists whose work I have become familiar with, and eat to my hearts content!! All in all, the conference provided a fantastic opportunity to hear up-to-date research and findings in the realm of older adult psychology, and offered the chance to reflect upon my own clinical experiences.

I particularly enjoyed the seminar on the use of lying in dementia care (Ruth Elvish & Ian James). I thought that the issues discussed in this session really gave food for thought, and that the seminar really did evoke strong feelings within the group. Even better, as a 'Coronation Street' fan, it allowed me to see the great Mike Baldwin return from the dead! Ken Laidlaw's workshop on the use of CBT with older adults made me appreciate further the factors that may influence an older individual's motivation to change, such as previous life events and life-transitions. I also enjoyed attending the seminars which gave findings about therapies that could be readily implemented to dementia services but proved very beneficial to the well-being of it's participants, for instance Margaret Muir's 'Join us for Art and Exercise'.

The great British weather prevailed, and scuppered the plans to have lakeside drinks and a garden BBQ. However, the steel drum band ensured that 'summer vibes' were ever-present in the student bar. The conference was well organised, and the delegates were well-catered for (to say the least!). I left on Friday afternoon, numerous pounds heavier – surely this could only be attributed to the well-stocked conference pack and handouts rather than my consumption of wine and cheesecake?

An overseas perspective ...

Claudia Miranda, PhD Student, University College London.

As a clinical psychologist from Chile and also a PhD student at University College London, I decided to attend to the PSIGE conference not only because I wanted to present my research, but also due to my work with older people in Chile. I would like to go back to my country and share all the experience and knowledge I have gained here in England. Ageing is a topic which is being studied just recently by psychologists in South America, so I consider that my participation at the PSIGE conference was very valuable.

In general, I was very pleased with the diversity of topics covered during the conference. I attended to a workshop and some presentations focused on psychotherapy for older people. All of them refreshed and increased my knowledge about different psychotherapeutic approaches in working with the elderly. I also decided to attend to some talks regarding to dementia. For example, it was very interesting to learn about how to approach deaf people with dementia or how it is possible to communicate with people with severe dementia. The posters presented were a good contribution to the conference and it was interesting to have the opportunity to ask questions about their contents to the posters' authors.

The venue was a big asset. Even though the weather was not the best, it was pleasant to walk around the lake during the evening. I have to congratulate the organisers not only on the contents of the conference, but also on all the recreational activities prepared, particularly the dancing at the Gala Dinner!

In summary, I must say that, after working only on my research for about three years, attending the conference made me realise how much I miss my clinical work and how valuable is the work of a clinical psychologist to meet some of the needs of older people. I really liked to share experiences with other psychologists and I will certainly make the most of it when I return to Chile.

Finally I would like to thank the PSIGE Bursary Fund and to Professor Orrell at the Department of Mental Health Sciences at UCL for funding my participation at the conference.

A trainee's view ...

Amy Langman-Levy, Trainee Clinical Psychologist, Oxford Doctoral Course in Clinical Psychology.

En route to the PSIGE annual conference I carefully considered what I was hoping to gather from my time attending the conference. Firstly, I was eager to present a poster of my thesis research exploring experiences of depression in later life. It was heartening to find others who shared the view that it is of importance to develop a greater understanding of how older people themselves conceptualise and experience depression. Many agreed that giving greater consideration to the impact of cohort beliefs and the impact of stigma around mental health illness would be helpful in improving identification and treatment for depression in later life. Secondly, as a soon-to-be qualified clinical psychologist I was keen to ascertain a clearer idea of the specialist skills that those working with older people value. Having witnessed the local merging of adult and older adult mental health services, and the resulting controversy and reluctance (from both sides) I was eager to understand the specialist skills put into practice by psycho-

logists working with an older adult population. Furthermore, having been persuaded throughout training about the virtues of core competencies and flexible skills, it was at the forefront of my mind how this equated with having to pick to work in a particular specialism, commonly dictated by age-related needs. The comprehensive work-streams of the conference demonstrated the wide and varied roles of psychologists working with older people, and highlighted the range of different approaches within the specialism itself. Furthermore, attending Paul Gilbert's compelling workshop on 'Understanding and Treating Shame Compassionately: An Evolutionary Approach', it became apparent that there are a number of issues which remain highly important across the lifespan. It struck me that such an approach which emphasises the impact of shame and self-criticism, and highlights the importance of an empathic therapeutic relationship is of great relevance to all people, irrespective of age.



RESEARCH PRIZE

PSIGE is delighted to announce a Research Prize. Trainees who completed a research thesis relevant to the psychological needs of older people and who graduated in 2005, 2006 or this year, in 2007, may apply.

The prize will be registration at the PSIGE Conference in York, 2–4 July, 2008, an opportunity to present your research at the conference, plus assistance with travel expenses (prize value £500).

Please submit a report (max. 3000 words), describing your research study. This report should be in the form of a research paper (introduction, methods, results and discussion).

Please give the following information:

- Name of applicant;
- Title;
- Supervisor(s);
- Training Programme;
- Year of Graduation.

Submit by e-mail to aja3@st-andrews.ac.uk@soton.ac.uk by 5 January, 2008.

Entries will be shortlisted by Sarah Dexter-Smith, Sinclair Lough and Arlene Astell and a final entry chosen at the National Committee Meeting in February, 2008.

We are hoping to make this an annual prize, funding permitting.

Geographical Group Convenors

as at 18 May, 2007

EAST ANGLIA

Kathryn Sams

Chatterton House, Goodwins Road, King's Lynn, Norfolk PE30 5PD.

Tel: 01553 815117; Fax: 01553 815181;

E-mail: Kathryn.sams@westnorfolk-pct.nhs.uk

Cath Burley

Older People's Mental Health Services, The Bungalow, Gables Drive,
Peterborough District Hospital, Thorpe Road, Peterborough PE3 6DA.

Tel: 01733 318186; Fax: 01733 318180; E-mail: cath.burley@cambsmh.nhs.uk

or

E-mail: Samantha.wilson@cambsmh.nhs.uk

ESSEX & HERTS

Sara Banks

Department of Psychology and Psychotherapy, Derwent Centre, Princess Alexandra Hospital,
Hamstel Road, Harlow, Essex CM20 1QX.

Tel: 01279 827276; Fax: 01279 827282; E-mail: Sara.Banks@nemhpt.nhs.uk

NORTHERN

Louisa Shirley

Psychological Services Directorate, Northumberland Locality, St. George's Hospital,
Morpeth, Northumberland NE61 2NE.

Tel: 01670 501747; E-mail: louisa.shirley@nmht.nhs.uk

NORTH THAMES

Geraint Price

Older Adults Psychology, Chamberlain House, St. Charles Hospital, London W10 6DZ.

Tel: 020 8206 7140; E-mail: geraint.price@nhs.net

NORTH WALES

Fiona Sanders

Glan Traeth Day Hospital, Royal Alexandra Hospital, Marine Drive, Rhyl,
North Wales LL18 3EA.

Tel: 01745 443384; Fax: 01745 330250; E-mail: Fiona.Sanders@cd-tr.wales.nhs.uk

NORTH WESTERN

Sylvia Dillon

Senior Clinical Tutor – Older People, Clinical Psychology, Community and Behavioural Sciences, University of Liverpool, The Whelan Building, The Quadrangle, Brownlow Hill, Liverpool L69 3GB.
Tel: 0151 794 5534; E-mail: s.c.dillon@liverpool.ac.uk

Polly Kaiser (from Summer, 2007)
E-mail: pollykaiser@f2s.com

NORTHERN IRELAND

Brenda Carney-Gallagher

Consultant Clinical Psychologist, Department of Elderly Medicine, Lagan Valley Hospital, Hillsborough Road, Lisburn, Northern Ireland.
Tel: 028 906 69475 (Home); 028 926 65141 x 2639 (Work); E-mail: mandbgall@aol.com

OXFORD

Candy Stone

West Oxfordshire Community Mental Health Teams, Older Peoples' Services, Nuffield Health Centre, Welch Way, Witney, Oxon OX28 6JQ.
Tel: 01993 202100; E-mail: candy.stone@obmh.nhs.uk

SCOTLAND

Liz Baikie

Consultant Clinical Psychologist, Royal Victoria Hospital, 13 Craigleith Road, Edinburgh EH4 2DN.
Tel: 0131 537 5096/7; Fax: 0131 537 5141/0; E-mail: elizabeth.baikie@luht.scot.nhs.uk

SOUTH THAMES

Elizabeth Field

Temple Ward, St. Martin's Hospital, Canterbury CT1 1TD.
Tel: 01227 812340; E-mail: Elizabeth.Field@ekentmht.nhs.uk

Helen Foster

Coleman House, Brookfield Avenue, Dover, Kent CT16 2AH.
Tel: 01304 216671; E-mail: Helen.Foster@ekentmht.nhs.uk

SOUTH WALES

Sarah Morgan

Resource Centre, Tonna Hospital, Neath SA11 3LX.
Tel: 01639 862869
E-mail: Sarah.Morgan@bromor-tr.wales.nhs.uk
E-mail: psychology.tonna@bromor-tr.wales.nhs.uk

SOUTH WESTERN

Philippa Wilson

Poplar Unit, The Coppice, Callington Road Hospital, Brislington, Bristol BS4 5BJ.
Tel: 0117 9195800; Fax: 0117 9195809; E-mail: Philippa.Wilson@awp.nhs.uk

P.F. Joyce

Templer House CMHT, Newton Abbot Hospital, 62–64 East Street, Newton Abbot,
Devon TQ12 4PT.
Tel: 01626 362179; E-mail: pf.joyce@nhs.net

TRENT

Rhona Nicol (Convenor)

West Leics CMHT, Hynca Lodge, Tudor Road, Hinckley, Leicestershire LE10 0EW.
Tel: 01455 443600; Fax: 01455 443636; E-mail: rhona.nicol@leicspart.nhs.uk

Catherine Edwards (Secretary)

11/12 Keresford Close, Off Broadway, Barnsley S70 6RS.
E-mail: catherine.edwards@barnsleypct.nhs.uk

WESSEX

Paul Whitby

CMHT, 2nd Floor, Bewley House, Marshfield Road, Chippenham SN15 1JW.
Tel: 01249 707987; E-mail: paul.whitby@awp.nhs.uk

WEST MIDLANDS

Ian James

Head of Psychology Specialty for Older People, Bloxwich Hospital, Reeves Street,
Walsall WS3 2JJ.
Tel: 01922 775402 (Secretary); 01922 775404 (Direct); E-mail: Ian.James@walsall.nhs.uk

YORKSHIRE/HUMBERSIDE

Michael Jubb

Clinical Psychologist, Leeds Older People's Psychology and Therapies Service,
The Mount, 44, Hyde Terrace, Leeds LS2 9LN.
Tel: 0113 30 55587; Fax: 0113 30 55659; E-mail: Michael.Jubb@leedsmh.nhs.uk

PSIGE Committee 2006/2007

CHAIR

Steve Boddington

Felix Post Unit, Maudsley Hospital, Denmark Hill, London SE5 8AZ.

Tel: 020 7919 2832; Fax: 020 7919 2109; E-mail: steve.boddington@slam.nhs.uk

VICE-CHAIR

Sinclair Lough

Psychology Service, North Dorset PCT, 10 Cornwall Road, Dorchester, Dorset DT1 1RT.

Tel: 01305 266011; Fax: 01305 266720; E-mail: Sinclair.lough@northdorset-pct.nhs.uk

HONORARY SECRETARY

Don Brechin

17 Blenheim Terrace, Leeds LS9 9HN.

Tel: 0113 343 1949; Fax: 0113 343 1961; E-mail: Donald.brechin@leedsmh.nhs.uk

TREASURER/MEMBERSHIP SECRETARY

Alice Campbell Reay

Dept. of Older Adult Psychology, Lea Hurst Day Unit, Walton Hospital, Whitecotes Lane, Chesterfield S40 3HW.

Tel: 01246 515576; E-mail: alice.reay@chesterfieldpct.nhs.uk

MEDIA OFFICER

Chris Allen

The John Hampden Unit, Stoke Mandeville Hospital, Mandeville Road, Aylesbury, Buckinghamshire HP21 8AL.

Tel: 01296 565016; Fax: 01296 399791; Mobile: 07766 763245; E-mail: chris.allen@bmh.nhs.uk

NEWSLETTER EDITOR

Arlene Astell

E-mail: aja3@st-andrews.ac.uk

GEOGRAPHICAL GROUPS LIAISON AND WEBSITE CO-ORDINATOR

Patrick McGuinness

Psychological Therapies Service, Morland Lodge, 4 Morland Road, Croydon CR0 6NA.

Tel: 020 8663 8137; E-mail: Patrick.mcguinness@slam.nhs.uk

CHAIR OF TRAINING SUB-COMMITTEE

Catherine Dooley

Barnes Hospital, South Worple Way, London SW14 8SU.

Tel: 020 8878 4981 ext. 8327; Fax: 020 8876 5471; E-mail: catherine.dooley@swlstg-tr.nhs.uk

SCOTLAND REPRESENTATIVE

Liz Baikie

Department of Clinical Psychology, Royal Victoria Hospital, 13 Craighleith Road,
Edinburgh EH4 2DN.

Tel: 0131 537 5096/5097; Fax: 0131 537 5141; E-mail: elizabeth.baikie@luht.scot.nhs.uk

WALES REPRESENTATIVE

Janice Rees

Ty Dafydd Day Hospital, Ystrad Mynach Hospital, Ystrad Mynach, Gwent CF82 7XU.

Tel: 014438 11457; E-mail: Janice.Rees@gwent.wales.nhs.uk

COMMITTEE MEMBER

Polly Kaiser

312–314 Oldham Road, Royton, Oldham.

Tel: 0161 909 8200; E-mail: pollykaiser@f2s.com

COMMITTEE MEMBER

Cath Burley

The Bungalow, Gables Drive, Peterborough District Hospital, Thorpe Road,
Peterborough PE3 6DA.

Tel: 01733 318186; Fax: 01733 318180; E-mail: cath.burley@cambsmh.nhs.uk

COMMITTEE MEMBER

Sarah Dexter-Smith

Older Adult Inpatient Services, Wells Villa, St Luke's Hospital, Marton Road,
Middlesbrough, TS4 3AF.

Tel: 01642 516135; Fax: 01642 852822; E-mail: Sarah.Dexter-Smith@tney.northy.nhs.uk

CO-OPTED MEMBER (NATIONAL COUNCIL OF AGEING)

Lindsay Royan

The Petersfield Centre, Petersfield Avenue, Harold Hill, Essex RM3 9PB.

Tel: 01708 796476; Mobile: 07958 699871; E-mail: lindsay.royan@haverinpct.nhs.uk

CO-OPTED MEMBER (DCP FINANCE COMMITTEE)

Nicky Bradbury

Psychology Services, Harry Walton House, 97 Church Lane, Aston,
Birmingham B6 5UG.

Tel: 0121 685 6420; Fax: 0121 685 6421; E-mail: nicola.bradbury@bsmht.nhs.uk

Notes for Contributors

Articles

Contributions in the form of short articles on any aspect of psychological theory or practice with older people are always welcome. As the *Newsletter* aims to cover a broad, cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication.

Articles should be submitted three months before publication (i.e. October for the January issue, January for the April issue, April for the July issue, and July for the October issue).

Research Updates

The *Newsletter* is particularly keen to publish contributions concerning ongoing research. These can reflect any stage in the research process, e.g. ideas for discussion or early stage results, which are not ready for formal publication. Try to keep them below 500 words.

The Editorial Board reserves the right to make minor changes to any submissions. Where major editing is necessary, the authors will be informed. All contributions must be typed.

Images

The *Newsletter* is published in black-and-white. It is not advisable to send complicated, colour diagrams. If you are unsure, try printing the image or photo out on a mono laser printer to check for clarity.

Please send original image files (.tif, .jpg, .eps or the like), not simply a Word document with the pictures imported into it, as these do not print properly.

Submission Procedure

Please submit articles as a Word file via e-mail to aja3@st-andrews.ac.uk
Language should be inherently respectful to older people and consistent with the British Psychological Society's guidelines. Formatting should be consistent with the Society's guidelines.

When submitting articles please send the following information:

- Full name;
- Affiliation (title, place of work);
- Contact details (should you be willing to be contacted by the membership);
- Acknowledgements (as appropriate).

Finally, if you are reporting research, please indicate whether or not Ethics Committee approval was awarded, and by which Ethics Committee, or whether the work was carried out as an audit/service evaluation project.

Letters to the Editor

The Editor welcomes correspondence which combines brevity with rational argument. Letters may be edited if more than 250 words in length.

All contributions should be sent to: aja3@st-andrews.ac.uk

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St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel 0116 254 9568 Fax 0116 247 0787 E-mail mail@bps.org.uk www.bps.org.uk

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