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.

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PSIGE is the Faculty for Old Age Psychology (British Psychological Society, Division of Clinical Psychology).
Letter from the Chair
Sinclair Lough

Since my last letter the National PSIGE Committee has held our annual Strategy meeting. This took place in late September and was very ably summarised by our Geographical Group Liaison Officer, Patrick McGuinness, in a letter to all Geographical Group Convenors in late October. I therefore will not reiterate all the information that Patrick has provided and just pick up on a couple of salient developments.

Dominating our thoughts as a Committee has been the DCP/BPS relationship with PSIGE. This is a ghost I hope to lay to rest before I stand down as Chair next summer. Prior to our November Committee meeting I met again with Jenny Taylor, DCP Chair, and felt thoroughly reassured that it is well within PSIGE’s best interests to remain within the DCP.

Annjanette Wells from the Society attended the last hour of our November meeting and it is clear that she has shared our concerns re Society administration problems and has/is taking steps to address them. We as a Committee, therefore, feel confident in starting the transfer of our membership database. We are still a bit wary regarding trusting them with our finances! More on these issues later this year.

Regarding our financial situation, it is becoming clear that funds are running down and we are trying to look to the long term as to how to best manage finances. Foremost in our thoughts are continued provision of CPD. In order to do this we need to reduce Committee costs and we’re working on that. We also wonder whether an electronic version of the Newsletter would be acceptable to the membership. This would provide a considerable saving in printing and posting. I know those of us who have been around for awhile hold the glossy hard copy dear, but maybe it’s time to move on. Please let me have your views on this.

There will be significant changes to the Committee membership at next summer’s AGM. Our media person, Chris Allen, will be standing down as will Patrick. Therefore, two major vacancies alongside the current Treasurer vacancy. There will also be at least one Ordinary vacancy. I urge all of you to consider applying for these posts. OK it’s a bit of extra work, but I can assure you it adds an exciting new dimension to your everyday work.

At our September meeting it was strange for me that Steve Boddington, Catherine Dooley and Jane Hawkins weren’t there as they are no longer Committee members having been constant features in all my seven years on the Committee. I thank all of them warmly for all they have done over the years for PSIGE.

By the time you read this it will be 2009 so breaking with Scottish tradition a very Happy New Year from 2008! Look forward to seeing you all in Wales in July.

Sinclair Lough
Letter from the Editor
Arlene Astell

IT IS MY GREAT PLEASURE to welcome you to the latest issue of the PSIGE Newsletter brought to you by the Yorkshire and Humberside Geographical Group. The guest editors, Chris Clarke, Esme Moniz-Cook and Michael Jubb, have pulled together a varied and stimulating set of papers from across the region that demonstrate the range and breadth of clinical and research endeavour taking place. As usual there is a mix of contributions from recent recruits to work with older people including Assistant Psychologists and trainees through to more seasoned campaigners updating us on their latest work. I hope that you enjoy reading these papers as much as I have and will join me in thanking Chris, Esme and Michael for pulling this together in the wake of hosting the very successful and enjoyable Annual Conference in York in July.

Turning to the 2009 Conference I would draw your attention to the PSIGE Research Competition, which is running once again. The competition is to open to trainees who qualified in the last three years, i.e. 2006, 2007 or 2008. The winner’s expenses will be paid up to £500 to attend the Annual Conference in Swansea in July where they will present their research. In addition, the winning article will be published in the Conference issue of the Newsletter. I would strongly encourage all trainees to enter the competition as this presents the ideal opportunity to disseminate your doctoral research to your peers and gain experience of conference presenting and publication in a friendly and supportive environment. I would also ask all supervisors to encourage current and recent trainees to submit their work in recognition of the wealth of doctoral research taking place each year.

And finally, something to occupy you during coffee breaks and journeys between clinics – coming up with a new name for the Newsletter. The PSIGE Committee would like to change the name of the Newsletter in recognition of the quality and range of research contributions that are consistently being received for publication. You are therefore invited to submit suggestions (as many as you wish) to me before 1 March, 2009, for a new name. The only constraint is that we are not permitted to use the word ‘Journal’ in the title. Otherwise, let your imagination roam!

Happy New Year

Arlene Astell

THE DEEP AQUARIUM, HULL
Guest Editorial

The Yorkshire and Humberside PSIGE Group – Joined Up

Chris Clarke, Esme Moniz-Cook & Michael Jubb

The Yorkshire and Humberside PSIGE covers a large and diverse geographical area that includes six English counties and the largest NHS region in England. The area is one of contrasts, encompassing large expanses of beautiful countryside (Yorkshire Dales, North York Moors, East Yorkshire Wolds) and coastline as well as densely populated cities and towns, including Leeds, Bradford, Wakefield, York and Hull. Levels of cultural diversity and deprivation also vary broadly in this region.

We are a well-established and growing group of around 40 members and, despite the geographical size of the area, we are connected by an enthusiasm for linking clinical practice with research and policy. We have quarterly meetings that are routinely well attended and involve annual day-long CPD workshops. We have not held major training events this year as our minds have been firmly focused on the preparations for the PSIGE Annual Conference, which took place the University of York in July, 2008. The theme of the conference, Extending the Boundaries, was timely given the challenges that many of us in the NHS have to address. We are proud to have hosted this well attended conference and hope that for many it was an opportunity to learn from each other and find new ways to embrace change in working clinically with older people.

PSIGE in Yorkshire and Humberside has the advantage of contributing to two clinical psychology training courses (Hull/York and Leeds) which also have input from PSIGE members in relation to the development of curricula and learning as well as supporting doctoral research projects. One of these (Emma (Radbourne) Wolverson’s work on Hope and Dementia) was presented at the 18th Alzheimer’s Europe Conference in Oslo, received a pleasing review by Mary Marshall (see Journal of Dementia Care 16(4) July/August, 2008, p.16). As a group we have also benefited this autumn from an increase in the number of newly qualified psychologists able to find posts in old age clinical psychology departments across the region.

Academia, training and research are alive and well in our region. The Bradford Dementia Group and the Institute of Rehabilitation at Hull are two resources of international repute, both clinical psychology courses (Leeds and Hull/York) have old age specialists as core staff, there are two active neurosciences research centres at York and Hull Universities and the Psychology Departments at Hull, York and Leeds Universities have particular strengths in aspects of neuropsychology that are of interest to clinical psychologists. In this edition we are pleased to include a contribution on Memory and ageing from a first-person perspective from Chris Moulin at Leeds University. Many practising clinicians are also involved in a broad and impressive range of clinical and research activity. Members have been involved in the implementation of IAPT services (see the report by Clare Hilton) and the development of psychological therapies for older people, the development and evaluation of psychosocial interventions in memory clinics and the development of formulation-based psychological care within in-patient settings. The development of community networks to improve social inclusion has been another notable area of work (see Wilkinson et al.).
Other members are active in large-scale research activity of international note, including research into memory and ageing, reminiscence therapy and the development of web-based training and support packages for carers of people with dementia. Our PSIGE website carries full information of our membership and recent activity. We have tried to reflect the richness of the work of PSIGE members within the articles that comprise this edition of the newsletter. However, the readership should be aware that many of our members have been suffering from ‘post-conference fatigue’ which made it hard for us to gather the full range of innovation and activity that we would have liked. We hope that you nonetheless enjoy this edition of the Newsletter, which we have structured in line with our identity as clinical psychologists as follows: Embracing Research, Policy into Practice, and Clinical Practice.

No description of the Yorkshire and Humberside PSIGE group would be complete without a mention of Dave Wallace, a long-time and active contributor to PSIGE. Dave retired from his clinical post earlier this year and we wish him all the very best in his future exploits.

Dr Chris Clarke
North Yorkshire and York PCT & University of Hull.

Professor Esme Moniz-Cook
Institute of Rehabilitation, University of Hull & Humber Mental Health Teaching NHS Trust.

Dr Michael Jubb
Yorkshire & Humberside PSIGE Convenor, Leeds Older People’s Psychology & Therapies Service.
IN THIS PAPER, we illustrate a few contemporary themes in the cognitive neuropsychology of memory as applied to healthy and memory impaired older adults. We outline some work carried out by our group in Leeds and argue that to continue to better understand and remediate memory, we must increasingly take a first-person, individualistic approach. Some of the ideas elucidated will resonate with existing clinical practice, and in other cases, the research community offers new insights. We conclude with a brief manifesto of the principles of researching subjective experience.

The state of the art: First person approaches

Four key developments in the cognitive neuropsychology of memory can help explain the shift to researching memory from a first person perspective.

Transgressing the ‘doctrine of concordance’

Memory researchers (and clinicians) use methods inherited from behaviourists. The dominant ‘measure’ is objective performance on a memory test. Early memory tests tended to use word pairs, measuring the ability to form associations*. As the field developed, researchers used lists and stories, but the emphasis remained firmly on the direct observation of tasks that were objectively verifiable. If someone remembers the word apple from a list, it is possible to check whether it was presented earlier. It is, therefore, possible to index a person’s abilities against a yardstick of their earlier – controlled – experience. Tulving (1989) described this prevailing use of objective-based measures of memory as the ‘doctrine of concordance’ whereby behaviour, cognition and experience are assumed to be one; if you measure one, you get an approximation of the others. This is very convenient for clinicians and psychometricians; it will always be more pragmatic to give someone a word list and score it out of 10, than it is to ask about subjective experiences of remembering. However, consider that a participant divulges a vivid memory of the time their mother had an ulcer on her eye and came back from the hospital with an eye patch. The conditions surrounding encoding of this event are uncontrolled, and difficult to verify, short of interviewing family members. Nonetheless, this material may be of importance to the person remembering it and could offer insights into the memory processes active whilst encoding and retrieving it. This form of autobiographical memory exemplifies contemporary ‘first-person’ memory research.

Tulving (1989) classified different memory systems on the basis of subjective experience, rather than content. He characterized episodic memory as ‘autonoetic’ (self-knowing). In contrast, semantic memory, often described as memory for facts, is ‘noetic’ (just knowing). Anoetic memory – memory without awareness – is implicit, or procedural memory. According to Tulving (1989), an episodic memory

*Note that not all early research takes this form, e.g. Ebbinghaus’s self-tests on nonsense materials, and Bartlett’s prose recall.
includes an awareness of its origin, a feeling of pastness, and a conscious evaluation of itself. It is an evocative, first-person experience akin to mental time travel and is the form of remembering involved in recalling childhood events, but not necessarily in reproducing the item apple on a word list. Many researchers converge on the idea that this form of memory is impaired in both healthy aging (relative to younger people) and Alzheimer’s disease (relative to age-matched controls).

We also draw on the introspective approach advocated by Gennaro and colleagues (2006) who propose that there are seen and unseen contributions to our understanding of behaviour. Some of this concerns beliefs, attitudes and memory. Let us suggest that someone has a specific ‘umbrella-related’ memory deficit. Cognitive neuropsychology (at least as a research entity) might be thought of as assessing the ability to remember umbrellas (as compared to remembering raincoats) and factors such as permeability of the umbrella, frequency of rainfall, and when in childhood one first used an umbrella. We believe that a Bio-Psycho-Social model should be at the heart of Cognitive Neuropsychology when it comes to researching memory. At the core of researching umbrella-specific memory impairments we should be asking about what it feels like to be wet, what the person feels about rain, and collate some narratives of forgotten and remembered umbrellas.

The neuropsychological case as ‘snowflake’

Most of our neuropsychological knowledge about memory comes from case studies of individuals with brain damage. The complexity of the relationship between brain and behaviour in cognitive neuropsychology has led to the description, ‘each patient may be as unique as a snowflake’ (e.g. Caramazza & Coltheart, 2006). A specific clean-cut amnesia without other cognitive difficulties is extremely rare and it is likely that self-hood is affected by any cognitive impairment, either directly or as a response to the sudden challenge to one’s abilities, independence and so on. Adult development is gradual, diffuse, ever-changing, and memory loss disrupts a range of cognitive abilities which impinge on social functioning and personality.

In brief, our ability to extrapolate from single cases who are as varied as snowflakes requires us to have theories and approaches which can take subjective experiences at face value and incorporate these into a scientific framework. Researchers must think widely about subjective experience and use these additional insights in explaining the behaviour of patients, a point we shall illustrate below by briefly reviewing our work on a very peculiar subjective experience, that of déjà vécu.

What is memory for? Adaptive and functionalist accounts

Cognition is the process by which we have personal views, thoughts and experiences. It clearly defines our social interactions and our understanding of the world. Recollection and mental time travel give humans a unique opportunity to experience and reexperience personal thoughts and to reflect on prior experience. If you simply knew about your honeymoon, but did not remember it, you could not form the same relationship with your past, or reflect upon prior events and outcomes that defined your later self.

Arguably, we should take more account of what memory is for, and therefore pay more attention to what comes to mind, rather than how much comes to mind. Conway (2005) proposed ‘a key feature of the approach taken to memory … is that cognition is driven by goals: memory is motivated.’ What is retained in the mind of an individual is a personal history of that self. To study the self, one should look at the contents of what is remembered. Arguably, the investigation of the purpose of memory requires an individual account – we take this view in our work on ‘I am …’ statements reviewed below.
Person-centred approaches to rehabilitation

Rehabilitation has been defined as ‘a process whereby people who are disabled by injury or disease work together with professional staff, relatives and members of the wider community to achieve their optimum physical, psychological, social and vocational well-being’ (McLellan, 1991). The memory performance of healthy older adults and people with Alzheimer’s disease can be improved using standard memory manipulations, such as semantic relatedness, repetition and encouraging deep levels of processing (e.g. Moulin, 2002). But merely improving people’s memory is not rehabilitation. Rehabilitation must consider selfhood and quality of life. In fact, cognitive neuropsychology is rather advanced in this regard. For instance, Clare et al. (2002) offered person-centred rehabilitation by asking of patients what they would like to improve, and then focused on individual regimes to accomplish this (e.g. learning the names of the people at the golf club). Personally meaningful activities such as knitting have also been used to pinpoint rehabilitation goals for the individual (Adam et al., 2000).

Some examples from our group

Memory awareness

At the centre of the first-person approach is awareness. Contemporary approaches ask participants to reflect on their experience (see Souchay, 2007). In cognitive neuropsychological terms this is ‘metacognition’, literally knowing what you know. Our research suggests that depending on the types of question asked or the materials used, people with Alzheimer’s disease are more or less aware of their abilities. Where awareness fails, it appears to be due to an inability to remember that one has a memory problem. People with Alzheimer’s disease do have a reflective faculty to consider their memory function online, but they fail to update their self-concept. That is, their memory deficit is such that they forget that they forget.

One manifestation of this unawareness-as-memory deficit theory relates to the feeling of knowing (FOK). The FOK is a first-person experience of knowing something whilst being temporarily unable to retrieve it. Usually, one’s FOKs are accurate and informed, for example one can accurately gauge whether one will later recognise something that is currently not accessible. People with Alzheimer’s disease and healthy older adults have impaired FOK, that is their judgements are less predictive of their later performance.

We suggest that at the centre of this metacognitive problem is a memory deficit. Older adults and indeed people with Alzheimer’s disease have an FOK deficit only for episodic materials. Their FOK on general knowledge tests are unimpaired. Moreover, we find that the ability to accurately predict performance in an FOK task is related to memory ability. Older adults’ memory is often insufficient to produce reliable cues on which to gauge their performance (Souchay et al., 2007). Thus even where there is a prima-facie deficit in awareness, on closer examination it appears to be due to the material on which that information is based.

Cognitive feelings

The FOK is a cognitive feeling. Our notion of cognitive feelings is driven by an adaptive stance. That is cognitive feelings operate to interpret and constrain cognitive processes. Another commonly experienced cognitive feeling is the tip of the tongue (TOT) state. This is where we know we know a word, but momentarily cannot access it. The TOT is a state which drives us to consider using another word, to search harder for the word that we want, or to ask someone else to help resolve the situation.

Our research into cognitive feelings is exemplified by work we have undertaken with people who have inappropriate cognitive feelings, for example patient AKP (Moulin et al., 2005). Normally, cognitive feelings operate in harmony with the goals of processing: when we are retrieving information from memory it feels like a memory. However, such feelings can be disturbed by...
neurocognitive dysfunction. Without a cognitive neuropsychology that aims to validate and examine subjective research, it would be impossible to take this research forward.

AKP was an 80-year-old gentleman who initially presented to his GP with frequent sensations of déjà vu. This sensation was so permanent and persuasive that we termed it déjà vécu, meaning ‘already lived’. AKP constantly confused the present moment for the recollection of one previously experienced. His erroneous cognitive feelings were so compelling that he was unwilling to engage in activities such as watching television and reading the newspaper, as he felt he had already carried them out. Recollective confabulation is a critical feature of this condition. Since recollection is associated with the retrieval of contextual information and experiences at study, patients such as AKP also generate high levels of incorrect contextual information for items that in fact, they have not encountered before. AKP made such reports spontaneously, for instance, confabulating secret early morning trips to the newsagents to read the newspaper as it was unloaded from the lorry whilst his wife was asleep in bed, to justify his feeling that he had read the paper before.

In our group we are now looking at rehabilitation of this false cognitive feeling. It appears that carers and clients are reassured to know that their intensely subjective experiences are in fact a memory error and, though rare, are experienced by others. However, we feel that such cases are under-reported, possibly because people are unhappy reporting such strange sensations to clinicians, but also because psychologists have been too focussed on assessing objective performance.

**Autobiographical memory**

A final theme from our laboratory is autobiographical memory. We have been interested in this perspective in terms of memory deficits and personally significant or striking events. For example, demonstrating that people with Alzheimer’s disease have unimpaired memories for events such as those of 11 September, 2001 (Thompson et al., 2005). We have also begun to map out the cognitive deficits associated with conditions like Parkinson’s disease with recourse to memories of one’s own life (e.g. Smith et al., under review).

Increasingly, our research within autobiographical memory focuses on demonstrating the links between the self and memory, demonstrating for instance, that memories of our own life centre on periods of self-formation (Rathbone et al., in press). In this work people generate their own cues for memory tests and report back to us their memories. First we collate information about a participant’s self, asking them to complete ‘I am …’ statements. We can then use these ‘self-images’, such as *I am a father*, to cue autobiographical memories. This approach has shown that across the lifespan, memories agglomerate around important times of self-formation, and we are now beginning to apply the paradigm to older people with memory impairment and depression.

**Conclusions:**

**A return to introspectionism?**

How should we measure subjective experience, and be confident that we are reflecting true internal processes, and not the idiosyncrasies of a few select participants? We think there are four general principles that underpin research on subjective experience.

1. **Subjective evaluations should relate to actual performance.** If someone feels that something has been very well learned, then their performance for that item should be better than their performance for something they feel they have not learned well. The fact that people can predict how well they will perform or how well they have performed, suggests that their subjective reports are indicative of some level of access to mental operations.
2. **Subjective evaluations should relate to objective characteristics of stimuli.** Different types of materials produce different levels of performance. One such difference is between high frequency words (such as ‘computer’) and low frequency words (such as ‘roulette’). These produce different levels of memory performance, but reassuringly, they generate markedly different reports of subjective experience as well.

3. **Participants should be able to justify their responses.** This is possibly the simplest approach (e.g. Gardiner, 2001). People’s justification of responses should relate to their experience, and the way that they have responded to a test. We regularly collect such justifications from our participants, and they can effortlessly discriminate between feelings such as, ‘It’s vague – I think I saw it before’ and ‘I made an association with Polka dot. It’s a Polish word, it means woman.’ It is particularly persuasive if people spontaneously justify their experience, or draw parallels between what you have produced in the laboratory and what they feel in daily life.

4. **There should be converging evidence from neuroimaging.** If these are truly verifiable subjective processes, it should be possible to ‘see’ them using neuroimaging. This is one area where an objective approach (neuroimaging) can validate a more introspective one (phenomenology). Consider Rubin’s vase, the famous ambiguous figure which can either be seen as two faces, or a vase. Andrews et al. (2002) demonstrated that different areas of the brain were activated when seeing this as a face or a vase. Participants’ subjective reports mapped onto activation within their brain. The same has been demonstrated for memory where the responses of different brain regions dissociate according to phenomenology. How subjective experience manifests in the brain is one of the frontiers of neuroscience.

As a final note, we would hope that the stories of older adults’ memory experiences are not just seen on an individual level, but can be built up to direct and inform whole research programmes. For this reason we run open-days and focus groups to make sure our research targets the right topics.

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References


Hope – is it a relevant concept for dementia research?

Emma (Radbourne) Wloverson, Chris Clarke & Esme Moniz-Cook

CONSTRUCTS such as hope, resilience and optimism in adaptation to chronic health conditions, therapeutic change and in enhancing quality of life are emerging as important areas of enquiry in health care research. Positive psychology – the scientific study of human strengths – emphasises the value of helping people with disabilities to maintain and build on their strengths, rather than solely focusing on or compensating for losses and deficits. However, to date there has been little application of positive psychology to dementia-related research and practice (but see Stirling, PSIGE Newsletter, 105). This paper considers one important construct within the sphere of positive psychology – hope – and examines its relevance to dementia research. We begin by considering what hope is, before looking at why this construct might seem, on the face of it, incongruent with the study of dementia. Finally, we summarise the results of a qualitative study of hope in dementia.

What is Hope?

Although the study of hope is not new, no consensus currently exists regarding its definition. Examination of social science literature in PsychINFO and CINAHL databases (from 1969 to 2006) reveals 18 definitions and 13 standardised measures of hope, with hope being conceptualised variously as a cognition, an emotion, an intra-personal process, an inter-personal process, a personality trait, a spiritual or transcendent process and a coping mechanism. What is clear is that hope is a multidimensional construct as is seen in definitions which although often overlapping, have several key attributes as follows:

- Hope involves looking forward to a better future (e.g. Obayuwana & Carter, 1982).
- Hope is activated in stressful and uncertain life-situations, such as chronic and terminal illness (e.g. Fryback, 1991).
- Hopes relate to ‘target’ life domains that are valued and important to the person (e.g. Averill, Catlin & Chon, 1990).
- Hope can refer to specific, defined and measurable goals (e.g. Dufault & Martocchio, 1985).
- Hope can refer to the more generalised desire for life to be ‘worth living’ (e.g. Farran et al., 1995).
- Hope is an energising motivator that propels people toward action (e.g. Snyder et al., 1991).
- Hope depends on relationships with others and occurs between people (e.g. Miller, 1986).

Furthermore, definitions of hope overlap in certain ways, suggesting that it has several key attributes:

1. Hope involves looking forward to a better future (e.g. Obayuwana & Carter, 1982).
2. Hope is activated in stressful and uncertain life-situations, such as chronic and terminal illness (e.g. Fryback, 1991).
3. Hopes relate to ‘target’ life domains that are valued and important to the person (e.g. Averill, Catlin & Chon, 1990).
4. Hope can refer to specific, defined and measurable goals (e.g. Dufault & Martocchio, 1985).
5. Hope can refer to the more generalised desire for life to be ‘worth living’ (e.g. Farran et al., 1995).
6. Hope is an energising motivator that propels people toward action (e.g. Snyder et al., 1991).
7. Hope depends on relationships with others and occurs between people (e.g. Miller, 1986).

Whilst hope has been considered a trait or disposition (Snyder et al., 1991), its content and meaning may change across the lifespan (Cutcliffe & Grant, 2001). Older people may also have different ways of maintaining and regaining hope when ‘challenged’ by barriers associated with the ageing process (see Herth, 1995). For older people without dementia, hope has been defined as ‘a multi-dimensional dynamic life force characterised by a confident yet uncertain expectation of achieving a desired future goal which, to the hoping person, is realistically possible and personally significant’ (Dufault & Martocchio, 1985, p.380).

In its application hope is seen as a valuble personal resource that is important in
times of trial and suffering (Miller, 1986). Hope has consistently been linked with adjustment to chronic health conditions. It has been associated with adjustment and coping in severe arthritis (Laird, 1991); cancer (Magaletta & Oliver, 1999); schizophrenia (Lovejoy, 1984) and AIDS (Moon & Snyder, 2000). Research has demonstrated that people with greater levels of hope make better use of illness-related information, show greater adherence to medical regimes (Moon et al., 2001) and demonstrate improved coping and problem solving (Snyder et al., 2000) when compared with those lower in hope. Significantly, it also seems that people with greater levels of hope are more able to find benefits and meaning within their illness experience (Linley & Joseph, 2004). Consequently, in some areas of health care such as oncology, research has focussed on psychological interventions that are both hope-engendering and hope-maintaining (Herth, 1990).

Dementia: Daring to Hope?
On the face of it, the concepts of ‘hope’ and ‘dementia’ may appear incongruent. Hope has been described as ‘an anticipation of a future that is good and based upon mutuality, a sense of personal competence, coping ability and psychological well being, purpose and meaning in life’ (Miller, 1986, p.6). It can, therefore, be difficult to reconcile this sense of a positive future orientation with the view of a predictably progressively deteriorating and inevitable course of dementia. Indeed hope in dementia, can be seen as misplaced or even ‘false’. Conversely, research on the role of hope in other chronic illnesses suggests that people can in fact be positive and hopeful about their future even in the face of an apparently hopeless situation. Studies document evidence for the existence of hope in people who have other incurable illnesses (Herth 1990; Hinds & Martin, 1988; Nowotny, 1989). Herth (1990) noted that the degree of hope in patients with cancer actually increases, as signs of disease progression become evident.

It is fair to note that dementia presents some unique challenges to the understanding of hope that set it apart from other chronic health conditions, since it is defined as a progressive deterioration in cognition and behaviour. However, this will depend on the conceptualisation that is adopted for the construct of hope itself. Current dominant models of hope are based largely within a cognitive-motivational framework. For example one of the more popular models of hope (Snyder et al., 1991) purports that hope is a cognitive-set that is based on a reciprocally derived sense of successful agency (goal-directed determination) and associated pathways (plans to meet goals). If hope is, therefore, conceptualised solely as a cognitive, goal-orientated process, it follows that the cognitive losses associated with dementia, may obstruct the experience of hope in people with dementia. However, in one of the few studies on hope and cognitive impairment, Cutcliffe and Grant (2001) contend that the nature of hope is changed rather than entirely compromised in these circumstances. They suggest that cognitive impairments may preclude people from utilizing internal hope-fostering strategies (such as devising and revising goals), but that relationships and interpersonal factors therefore become more salient in engendering a sense of hope for people with cognitive impairments. This study drew from the observations of nursing and care staff rather than those of people living with dementia and therefore provides limited insight into the experience of hope in dementia. However, an important finding is that the experience of hope is present in people with cognitive impairments but is moderated by interpersonal contexts, which can vary across social environmental settings.

Another dominant conceptualisation of hope emphasises that ‘real’ hope is based on a realistic appraisal of one’s current situation and future (e.g. Dufault & Martocchio, 1985; Herth, 1989; Stanley, 1978). The notion that specific hopes are grounded in real world evidence and a clear-headed appraisal of
one’s aims, resources and limitations is thought to be one important factor that sets hope apart from broader positive constructs associated with the literature on coping strategies, such as wishing and optimism. In dementia, this conceptualisation is complicated by the debate on awareness. One assumption is that it is not possible to experience hope in dementia due to low awareness and/or that high awareness must be linked with hopelessness. Low subjective awareness of impairments among people with dementia can be common and might represent a biologically-driven process that corresponds to illness severity. However, levels of awareness may also vary according to the inferences drawn about a person’s level of awareness which are subject to a complex psychological and social context (Clare et al., 2005). For example, apparent lack of awareness might often represent an avoidant coping strategy aimed at preserving identity in the face of declining ability (see Clare, 2003). The relationship between hope and awareness awaits further empirical inquiry but like awareness, it may be that hope in some cases is preserved but obscured in dementia. Irrespective of constructs of awareness in dementia, an understanding of hope may be within the social and interpersonal context of enquiry (e.g. Cutcliffe & Grant, 2001; Millar, 1986) and accounts that emphasise the generalized – as opposed to the specified – quality (Farran et al., 1995) of the experience of hope in people with dementia.

A third perspective that contributes to the apparent incongruence of hope and dementia rests within societal constructions about dementia, old age and dependency. Often prevailing assumptions and media representations surrounding dementia and old age can engender fear (Moniz-Cook et al., 2006) and strengthen associations with despair and hopelessness, rather than with hope. Stigma and prejudice are known suppressants of hope in whole groups (Snyder, 2002). For example, individuals with AIDS have been found to have significantly lower levels of hope than those with other chronic or life threatening illnesses (Herth, 1990). If, as we have noted previously, hope in dementia becomes salient within an interpersonal context, then the prevailing social discourse that is associated with stigma and hopelessness will need to be counteracted (Vernooij-Dassen et al., 2005), in order to achieve a better understanding of the capacity for hope in people with dementia. In current dementia care services the barriers to the experience of ‘realistic hope’ are all too evident. For example, information about the condition is often held back from people with dementia (Bamford et al., 2004) when deception reflects an obstacle to hope that may be overcome through information, education and an honest alliance that acknowledges difficulties and barriers (Snyder, 2002).

**Preliminary evidence for hope in dementia**

Despite the aforementioned challenges, accounts of living positively with dementia are emerging (Bryden, 2002; Cahill, et al., 2004), thus expanding the arena for enquiry into hope in dementia. The late Tom Kitwood (1997) recognised that a sense of hope was central to the well-being of people with dementia, describing it as one of four ‘global sentient states’. It could be that psychosocial interventions aimed at improving or maintaining quality of life in dementia could be enhanced through better understanding of how some individuals maintain hopefulness in the face of the disease. Therefore, information on what people with dementia hope for and how people maintain and foster their hopes has the potential for improving dementia care services.

A qualitative study of the subjective experiences of hope in 10 older people living with early-stage dementia, was conducted in a memory clinic where all participants and their families had in the past, received an early intervention programme which included information provision within an
honest therapeutic alliance (see Moniz-Cook et al., 2009). Since little is known about hope in older people with dementia, an exploratory study was designed to understand how individuals with early stage dementia construe the concept of hope in the light of their knowledge of having dementia. Semi-structured interviews were used to explore participants' hopes, specifically looking at their individual meaning, the sources, and the potential barriers to and facilitators of hope in this clinical group. Interviews were analysed using Interpretative Phenomenological Analysis (IPA).

The results of this qualitative study suggested that hope is both present and vital in the lives of people with early-stage dementia. They described hope as a process that is embedded within their developmental histories, where hopeful thinking styles and views of the world are first fostered in childhood. Primary sources of the ability to hope were usually parents – often fathers – who acted as effective role models for hope. This notion of ‘learned hope’ thus appeared to be well-preserved in old age, despite the knowledge of having a dementia. Participants described hope as the belief that there was ‘something better’ and in addition, hope acted as a facilitator to encourage them to ‘keep going’. A hopeful attitude enabled participants to view the difficulties that they encountered (these were usually associated with ageing and dementia) as challenges. Thus for this group, hope was not described as a passive experience, but an active process towards personal growth in dementia.

A second important finding was that participants’ hopes were framed within a realistic appraisal of hope-hindering life experiences that were encountered as a consequence of the effects of ageing and memory loss on personal resources. All 10 participants demonstrated a clear understanding and awareness of the changes that they had experienced due to dementia and each were able to outline a number of associated barriers to hope. Some of these were personal, such as feelings of growing dependency, but many represented contextual barriers related to feelings of loss of role, loss of respect, and increasing isolation. Here an important theme was that hope for them reflected more than wishful thinking or naive optimism. Participants’ current hopes were both grounded and legitimate: they were centred on keeping healthy; staying connected with others; and continuing to engage in their coping behaviours. ‘Realistic hope’ appeared to be achieved through a balance of the sense of learned hopefulness with an awareness of the reality of current dementia-related challenges. This in turn reflected a process that resulted in feelings of contentment and resolution.

Conclusions
In this paper we have examined why the discipline of positive psychology has yet to impact on research in dementia care. We have focussed on the apparent incongruence between one construct (i.e. hope) and dementia, as a means of understanding how positive psychology can influence research in dementia. An exploratory study of hope in dementia has demonstrated that hope may be relevant to a person’s experiences and that people with dementia have the capacity to make rich contributions to research that examines positive aspects of their personal experiences. As research in dementia care turns towards exploring ways in which the quality of life of people with dementia can be enhanced, we suggest that constructs from the discipline of positive psychology may be applied to an understanding of well-being in dementia. In addition to hope other such constructs that may be relevant to dementia care research include that of humour, joy, courage, love and resilience. Participants in the present study have outlined the barriers to hope that face many older people living with dementia. Future clinical research should now explore the utility of hope-fostering strategies to support individuals to maintain their quality of life.
This study was conducted by the first author towards the qualification of the Doctoral in Clinical Psychology at the University of Hull (2008) supervised by both co-authors.

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Hope – is it a relevant concept for dementia research?


PSIGE RESEARCH PRIZE 2009

PSIGE is delighted to announce the call for submissions for the PSIGE RESEARCH PRIZE 2009. Trainees who completed a research thesis relevant to the psychological needs of older people and who graduated in 2006, 2007 or 2008 may apply.

* * * * *

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* * * * *

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-and.ac.uk by 15 March, 2009.

* * * * *

Entries will be short listed by Sarah Dexter-Smith, Don Brechin and Arlene Astell and a final entry chosen at the National Committee Meeting in April, 2009.
Focus: Research Networks

This article summarises a workshop presented at the 2008 PSIGE Conference on research networks. The session was chaired by Esme Moniz-Cook and included contributions on the UK and European opportunities for psychologists to engage in research.

Introductory note
Esme Moniz-Cook

Locally members of Yorkshire and Humberside PSIGE were awarded a NIHR Programme Grant in 2007. We have also secured extra research support from DeNDRoN, one of seven Clinical Research Networks established to develop and strengthen NHS infrastructure to support the delivery of clinical research in the UK. DeNDRoN is the specialist UK network for Dementias & Neurodegenerative Diseases and has been approached to support an extension of one of our trials in Sheffield. We are hoping that a Clinical Psychologist Team will receive extra resources from DeNDRoN to support clinical psychology research.

INTERDEM, a multi-professional pan-European network focusing on early intervention in dementia developed in the region in 1999 and is hosted in Hull. Clinical and academic PSIGE members across the country contribute to this group. INTERDEM recently published Early Psychosocial Interventions in Dementia: Evidence-Based Practice. This is a collection of articles on early intervention practice starting with a stepped approach to early interventions in a memory clinic, followed by contributions (many from clinical psychologists from the UK) on diagnostic disclosure programmes, enhancing cognitive support, providing psychological and emotional support and developing evidence-based psychosocial intervention services to maintain people and their families at home.

In the following section Bob Woods describes the opportunities for clinical psychologists to use the clinical networks that are developing in the NHS in contributing to high quality research. This is followed by Myrra Vernooij-Dassen’s outline of the organisation and activity of INTERDEM.

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Reference
Applied old age research programmes and networks in the UK: An overview

Bob Woods

More research is needed’ is the refrain at the conclusion of every DClinPsy thesis and every research paper, but what is the current state of research in the domain of clinical psychology and ageing in the UK? We clinical psychologists make much of our training in research skills and our commitment to ‘evidence-based practice’, but are we living up to our potential and do our research findings have any influence on services for older people in the UK?

It must be said that there are some very encouraging signs, with a number of high profile projects in the field of ageing and dementia led by clinical psychologists, with a good number of major publications arising from them. Two of these studies have even led to papers in the venerated British Medical Journal. Jane Fossey and Ian James were key members of the team which showed that a psychosocial approach could reduce the use of anti-psychotics in care homes (Fossey et al., 2006) and Georgina Charlesworth led a large project evaluating the effects of offering carers of people with dementia a befriender (Charlesworth et al., 2008).

Clinical psychologists working with older people have also enjoyed some success with the recently established NIHR Programme Grants Scheme (only available in England), which offers research teams up to £2 million over five years for research which will have an effect on health care in the short- to medium-term. To date, four have been awarded to projects with a specific focus on dementia and/or older people mental health projects. One of these is the CHALLENGE DEMCARE programme in Hull, led by Esme Moniz-Cook. Another, SHIELD, although led by a psychiatrist, has a high level of clinical psychology input.

Announcing the first tranche of awards in June, 2007, then Health Minister Rosie Winterton said: ‘This significant new research funding stream, which will be worth up to £75 million each year when fully established, provides a marvellous opportunity for the NHS to carry out research that will lead to improved health care or better health care delivery in the near future. Programme Grants for Applied Research are prestigious awards supporting teams of leading researchers, from the NHS and academia working together, who have already demonstrated an impressive track-record of achievement in applied health research.’

However, this is certainly not a time to rest on our laurels. As a member of the Guideline Development Group working on the NICE-SCIE Guideline on the management of dementia (2006), it was difficult to identify evidence-based recommendations on psychological interventions, and most of the recommendations that made it into the final document were classed as ‘expert’ opinion. Hopefully, their very presence therein will be useful, but in this evidence-based world, the paucity of evidence does make it difficult to raise the priority accorded to psychological aspects of care for older people.

If there are gaps in the knowledge base around dementia and care-giving, there are, of course, great chasms relating to other areas of clinical psychology with older people. Often, this is simply because research studies on psychological interventions have excluded older people, showing quite explicit ageism at times. There are some significant oases in this desert – areas of excellent work on, for example, CBT and

Focus: Research Networks
depression in older people, recovery from stroke, etc., but many gaps remain especially in the context of multiple areas of difficulty, the bread and butter of clinical psychology for older people.

There has never been a better time for clinical psychologists working with older people to become involved in research and to shape the research agenda. Dementia and stroke are currently major government priorities, and this is reflected in priorities for research funders. For example, the most recent call from the NIHR Health Technology Assessment Programme for clinical trials prioritised exactly these areas, and ageing is a priority area for all Research Councils. In a letter to The Times newspaper, dated 17 June, 2008, under the banner ‘Dementia research needs more funding’, Prof. Simon Lovestone and 11 others asserted dramatically that ‘The NHS will not survive the next 20 years without further funding for dementia studies.’ Two days later the National Dementia Strategy was launched for consultation by the Department of Health in England, including ‘Recommendation 14: A clear picture of research evidence and needs’ to be addressed through the convening of a ‘research summit’, with the Department of Health to generate a strategic review identifying strengths to build on and gaps in the evidence base, leading to a collaborative programme of dementia research into prevention, cause, cure and care. If psychologists do not engage fully in this process, we should not be surprised if most emphasis is given to biomedical studies.

Over the last few years a number of research networks have developed in the UK, which have perhaps been viewed with some suspicion by psychologists working with older people. However, I would argue that they represent an opportunity rather than a threat. In England, a number of thematic research networks have been established, now under the NIHR umbrella, with slightly different arrangements in the devolved nations. In England, relevant networks include DeNDRoN (Dementias & Neurodegenerative Diseases), the Stroke Research Network and the Mental Health Research Network. In Wales, NEURODEM Cymru covers the same disease areas as DeNDRoN (the dementias, Parkinson’s, Huntington’s and Motor Neurone Disease) and we also have an Older People and Ageing Research Network and a Mental Health Research Network. In Scotland, there is now a research network dedicated to the dementias.

DeNDRoN’s ‘vision’ is ‘to provide all patients with a dementia or neurodegenerative disease with the opportunity to participate in high quality clinical research’. Its objectives include increased collaboration between all stakeholders to ensure the development of a greater quantity of high quality research; the development of an infrastructure in the NHS capable of supporting the delivery of this research; and an increase in awareness of the importance and value of clinical research. In England, an elaborate infrastructure has indeed been established including seven Local Research Networks, covering around 50 per cent of the country, with other targeted resources to address gaps for the rarer conditions. It also links with the Comprehensive Research Networks.

What support is this infrastructure able to offer? Assistance is provided in the set up of studies, including local research governance approvals; in screening and recruiting patients to participate in specific research projects; in providing access to trained research staff to deliver studies; in collecting, collating and submitting quality research data; in supporting central coordination and performance management of specific projects; in promoting the active involvement of patients and the public in research; and in developing the capacity and skills of the research workforce through appropriate training and education. In practice, this can be translated into ‘whatever is needed to make research happen …’

A view often expressed is that the Clinical Research Networks have only been set up to support drug trials in the NHS funded by the pharmaceutical industry. It is certainly the
case that the huge investment in networks was prompted by concerns that drug companies would stop investing in the UK, but in reality trials funded by the industry form only around a quarter of studies being supported. Most studies are non-commercial, and to meet the criteria of the UKCRN portfolio and automatically be eligible to receive support they should be the result of national competition, from recognised funders and have been subject to peer review. They do not have to be Randomised Controlled Trials – other ‘well-designed studies’ are also welcomed and the portfolio includes qualitative and observational studies. Studies funded by the drug companies are only accepted following a rigorous review and adoption process.

In Wales, the NEURODEM Cymru portfolio of studies eligible for support includes a range of funders, with just 29 per cent being funded by the pharmaceutical industry. One-in-nine involve social care, and a similar proportion involves evaluations of psychosocial interventions. Only a quarter are randomised controlled trials, and a quarter of studies in Wales are genetic studies. Although researchers were sceptical at first, there is now clear consensus that the input of Clinical Studies Officers, who can assist with recruitment, etc., has made a real difference to projects meeting their targets.

The research networks have, as might be expected, involvement of service users, carers and practitioners high on their agendas, with the Mental Health Research network in England having shown how this can be done successfully. In Wales, for NEURODEM, this aspect is led by the Alzheimer’s Society, drawing in other members of the Neurological Alliance and building on their QRD programme. Users, carers and practitioners are involved in developing research ideas, through membership of Research Development Groups, and are involved in implementing research findings, e.g. through DSDC Wales, conferences, the practitioner magazine Signpost, etc.

Limitations of the network approach as implemented can be identified. There is, of course, an ever-present risk of a large bureaucracy being created, drawing money away from actual research activity. It is vital that the 80+ new research support staff in DeNDRoN, for example, make a real difference to research success. Large, externally-funded studies are given priority and there is a need to protect the possibility of smaller-scale developmental work. Carrying out a definite RCT before the intervention is fully developed is a waste of resources and effort, and there is a great need to continue creatively to develop interventions. There is no obvious niche for PhD studies or indeed for the many excellent DClinPsy studies in this field. The whole range of levels of research needs to be included, if there is to be a genuine increase in research capacity.

In conclusion, psychologists working with older people have an unprecedented opportunity to engage in these research networks and to ensure that the psychological dimension of research is not overlooked. Further details of networks can be obtained as follows:

- DeNDRoN contact details: www.dendron.org.uk
- NEURODEM contact details: www.neurodem.org.uk

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What is the value of pan-European Research Networks?
Myrra Vernooij-Dassen on behalf of the INTERDEM group

Scientific collaboration is not self-evident at a European level, but it is possible to stimulate collaboration through research grants, for example, from the European Commission. This allows applied researchers to meet together and work on projects, thus cementing the knowledge base and expertise of a scientific European collaboration. European frameworks in the mid-1990s and associated initiatives such as the European Alzheimer’s Programme on Actions in favour of persons with dementia, achieved both collaboration and baseline scoping exercises between researchers and practitioners in dementia across Europe. Warner et al. (2002) summarised studies that came out of the 5th Framework R&D Programme as it related to policy and practice in dementia and outlined the many gaps in ‘Best Practice’ across Europe. Funded research projects are time-limited and other avenues to enhance scientific endeavour in the absence of funding is needed. Networks offer the opportunity for continuity in collaboration.

There are a number of dementia-specific European networks such as the North Sea group, the European Alzheimer’s Disease Consortium (EADC) and the Early and timely INTERvention in DEMentia group (INTERDEM). The North Sea Group in its early stages arose out of the Dementia Services Development Centres (DSDCs) and the Bradford Dementia Group in the UK and arranged annual or bi-annual meetings. The EADC developed with initial support from the European Commission and has a particular focus on bio-medical research. INTERDEM developed on completion of a European Commission funded research project. The objective and value of these research networks in Europe is the exchange and dissemination of existing knowledge and the synthesis of new knowledge. The INTERDEM network has a particular focus on psychosocial research in dementia – an area of particular interest for psychologists working in dementia care. This paper will therefore describe the development of INTERDEM and a pan-European clinical
research programme, in order to outline how network-based collaboration can add value to dissemination, practice developments and new research.

INTERDEM is an example of where collaboration extended beyond the activity that researchers were originally funded for. In 1999, a multi-professional group of researchers who had contributed to the international literature on early detection and psychosocial intervention in dementia from the UK, Ireland, Netherlands, Spain and Italy gathered at the University of Hull, supported by co-funding from the Commission (File no. SOC 97 201452 05- F03). Collaboration was maintained through self-financed annual meetings in Spain (2000), the Netherlands (2001), Italy (2004) and France (2006). Annual meetings have also been arranged in parallel with the Alzheimer’s Europe annual conference starting at Maastricht (2002), Prague (2003), Ireland (2005), Portugal (2007) and Oslo (2008). At these, INTERDEM members arranged symposia to meet, share and develop new research as well as use the Alzheimer’s Europe conference for dissemination of completed research.

The INTERDEM group consists of a network of psychosocial researchers and practitioners including psychologists, medical sociologists, nurses, occupational therapists, social workers, geriatricians, general practitioners and psychiatrists. The group includes 16 European countries, 87 members and 63 centres as well as collaborators from China and the US. The aims of the INTERDEM group are to develop and carry out pan-European psychosocial research and person-centred practice in dementia, by: (a) placing people with dementia and their supporters at the centre of European research and practice and actively involving them in developing these activities; and (b) actively disseminating research to enhance practice, policy and the quality of life of people with dementia and their supporters, across Europe. At its inception there were relatively few internationally accepted evidence-based psychosocial therapies for people with dementia and their families and what existed came from outside Europe. The underpinning rationale for INTERDEM was that Europe, with its diverse cultural and societal identities, provided a natural arena for research. Despite the complexity that dementia may bring to policy and practice, collaboration across countries could investigate how people with dementia and their families could be positively supported to enhance their well being.

The group has worked with and without funding from the European Commission. Examples of ‘volunteer’ projects that have contributed to the body of knowledge in dementia care include an update on the knowledge base for primary care physicians (Woods et al., 2003); Special issues in peer-reviewed journals on early psychosocial intervention (Aging & Mental Health, 7(1), 2003) and psychosocial interventions in primary care (Dementia: International Journal of Social Research and Practice 5(3), 2006); harmonisation of outcome measures (Moniz-Cook et al., 2008) and a book summarising evidence-based early psychosocial interventions in Europe (Moniz-Cook & Manthorpe, 2009). Results from the European Commission funded DIADEM project indicated that in eight European countries stigma in ageing and dementia was a major obstacle in dementia care, accompanied by a sense that there is little to offer. It was also found that dementia care services varied widely across Europe and that dementia-related stigma was less prominent in countries with developed health services (De Lepeleire et al., 2008; Iliffe et al., 2005; Vernooij-Dassen et al., 2005). However, even in countries with many facilities, practitioners felt they had little to offer. The conclusion of the European Commission funded AWARE project was that people with dementia can have intact awareness and for them psychosocial intervention might help in preventing the development of comorbid affective problems (Clare et al., 2005; Verhey et al., 2004).
Collaborative project awarded to Alzheimer's Europe – EuroCoDe – INTERDEM has evaluated psychosocial aspects of available guidelines on dementia care across Europe and is now developing quality indicators for psychosocial interventions at a pan-European level.

There is clearly an added value of European collaboration within a research network. First experts are easily available and can thus facilitate easy access to information in many states as has been the case in the current EuroCoDe project. This can, therefore, stimulate initiatives to address high-level research problems such as the harmonisation of outcomes and overviews of existing interventions (see Moniz-Cook et al., 2008; Moniz-Cook & Manthorpe, 2009). Secondly, it offers a forum for exchange of new insights on challenging areas of enquiry (see Clare et al., 2005; Verhey et al., 2004). Third, there can be greater and more intensive collaboration between pan-European researchers since they are not obstructed by the competition that can occur at a national level. Mature networks may also foster within-nation collaboration as is seen in the UK where INTERDEM members (Esme Moniz-Cook, Bob Woods, Martin Orrell, Georgina Charlesworth, Aimee Spector, Steve Iliffe and Jill Manthorpe) were awarded three NIHR Programme Grants of £2 million each over five years for psychosocial dementia care research and the NIHR-HTA awarded to Bob Woods with INTERDEM members – Martin Orrell, Esme Moniz-Cook and John Keady – approximately £1.2 million for an eight-centre reminescence therapy trial. Finally and perhaps of greatest importance, European collaboration provides the opportunity to make comparisons between states and to learn from cultural differences between countries (see, for example, De Lepeleire et al., 2008; Iliffe et al., 2005; Vernooij-Dassen et al., 2005).

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The East Riding of Yorkshire Improving Access to Psychological Therapies Pathfinder Project – Struggles in relation to the inclusion of older people

Clare Hilton

This article is based on a paper presented with Vanessa Russell, Head of Psychological Services East Riding of Yorkshire, at the National BPS-PSIGE Conference, University of York, 2–4 July, 2008.

In 2007, the Secretary of State for Health announced substantial additional investments in the Improving Access to Psychological Therapies (IAPT) programme on a national scale. In the first year this programme was rolled out through 10 ‘pathfinder’ project sites which, collectively, aimed to find out how stepped-care services could best meet the needs of the whole population. The initiative was intended to expand the models of care piloted in Newham and Doncaster, where the focus was on working-age adults (IAPT pathfinders – achievements and challenges, 2008).

Primary Care Trusts (PCTs) across England were invited to express interest in joining the IAPT programme as a pathfinder site. By July, 2007, 10 PCTs, one in each Strategic Health Authority (SHA) in England, had been chosen to receive funding. The pathfinder sites were asked to identify a special interest group (SIG) within their local population from older people, children and young adults, offenders, new mothers, black and minority ethnic communities and people with long-term conditions. The aim, alongside the delivery of core services, was to identify benefits and address specific barriers around improving access to psychological therapies for the target groups. Each pathfinder site received £200,000 to develop a defined care pathway and service specification that included their chosen SIG. Outcomes were monitored for each individual using a prescribed minimum data set.

The aim of this article is to share our experience to date of IAPT in relation to older people in our area. It is not to go into detail about the design and implementation of the IAPT programme. In doing so we would like to communicate some of the barriers we have encountered in including older people, possible explanations for these, and our planned way forward.

Pathfinder Project Group – aims and development

In the East Riding of Yorkshire a project group was formed and made an application to be one of the pathfinder sites – older people and people with long-term health conditions were chosen as special interest groups. The project group at application included; a Commissioning Manager, Head of East Riding Adult Psychological Services, a Service User Representative, a Relate Centre Manager, a Senior Nurse (Older People), a Clinical Psychologist (Older People – the author) and a representative from MIND. Our broad objectives for the first year were to increase service capacity at steps 2 and 3, reduce waiting times and improve training for primary care staff in the recognition and treatment of anxiety and depression. The IAPT application limited the number of GP surgeries involved in the project due to restrictions of funding and data collection. We were successful in the joint application and became one of the pathfinder sites. The regional IAPT Lead then joined the project.
group and later a Project Manager and Vocational Support Worker were appointed and joined the project group. The project was pressured in terms of deadlines in the first few months and, therefore, energies were concentrated on identifying GP surgeries and employing three Graduate Mental Health Workers (GMHWs). Once in post the GMHWs received low intensity worker training. The project group met monthly to highlight any problems/barriers in the project and to develop ways of addressing these. For example, it became evident that training around recognition of mental health difficulties, particular for older people, would be helpful generally for people working in primary care and a training programme was developed to address this.

IAPT Project – Older People in the East Riding of Yorkshire
There are an estimated 100,000 older people (defined as over the age of 65 years) living in the East Riding of Yorkshire. According to Boddington (2006) this would indicate that approximately, at any one time:
1. 9000 to 11,750 will have depression; 3000 will be severely depressed (Baldwin, 1996)
2. 9000 will have anxiety-related disorders (Lindesay, 2002)
3. 1100 will have psychosis-related disorders (Livingstone & Hinchcliffe, 1993)
4. 5500 will have dementia
5. 4000 will be living with the consequence of a stroke (Wolfe et al., 1996) of whom up to 2000 will be experiencing mood disorders and 1400 will need to adjust to living with permanent cognitive difficulties.

As is evident, there is potentially a huge need for mental health services and interventions for older people within the East Riding. Locally, it has been acknowledged that current services are not adequate at recognising and responding to functional mental health difficulties and providing accessible psychological therapy for older people, particularly at the mild-moderate levels of severity. Our pathfinder group has a keen interest in including older people to try to go some way toward improving current services for them, particularly at step levels 2 and 3 in primary care.

The project has now been in place for 12 months and we have data in relation to access for this period. Unfortunately the data collected has shown that less than three per cent of people going through the IAPT programme were older people. We have interpreted this as a clear indication that older people have not been adequately attended to by the project up to this point. This low figure is particularly interesting because we know that primary care services are the first line of contact for older people with mental health difficulties and that older people consult almost twice as often as other age groups (Craig & Mindell, 2007). Twenty-two per cent of older people will have attended their GP surgery within the last two weeks and 40 per cent of those will have mental health difficulties.

We therefore recognise that, although we felt we had originally communicated to primary care services that older people were part of the project, barriers seemed to have emerged in relation to older people being able to access the service. The need for us to consider the nature and origins of these barriers has become readily apparent.

Potential barriers
Nationally speaking, a number of issues have been identified that can go some way to accounting for the disparity between apparent need and the uptake of psychological therapies in primary care by older people. In 2006, a joint report from the Healthcare Commission, Audit Commission and Commission for Social Care Inspection identified deep-rooted cultural attitudes to ageing in local and public services, especially in relation to mental health. It is very possible that indirect ageism acts as a barrier to the timely recognition of mental health problems such as depression, which in older
people can be seen as a consequence of ‘normal ageing’. In addition, GPs and other primary care professionals may inadvertently prevent older people accessing psychological therapies services because time constraints lead to the under-recognition of psychological problems. Alternatively, they may detect symptoms but fail to recognise the utility of psychological therapies (IAPT positive practice guide, 2008).

Locally, when looking at the data collected and anecdotal reports, it was felt that the above barriers did go someway to explaining low number of referrals into the IAPT project. An additional consideration is that the interplay between psychological, physical and social factors is fundamental to working with older people in fact, comorbidity of physical and psychological problems is the rule rather than the exception for older people. Therefore, a keen awareness and knowledge of their respective contributions and interactions is required, indicating the need for an enhanced skills set when working with older people with mental health problems (Minshull, 2007). Otherwise mental health difficulties may get obscured or ‘missed’ in favour of medical and social interventions. This is interesting when considering that only two per cent of primary care mental health workers have received appropriate mental health training and training for mental health graduate workers has, with a few exceptions, concentrated on working age adults (‘A collective responsibility – A consensus statement’; 2008). This was certainly the case in the East Riding where issues of training were highlighted as a priority and the training received by the IAPT workers centred on working age adults.

Other factors that might account for the low numbers of older people accessing our IAPT programme to date include issues around social isolation and older people’s attitudes and views towards psychological therapies. There is considerable evidence of social isolation among older people in England, with 36 per cent of older men and 31 per cent of older women having little or no contact with family members and 18 per cent of men and 11 per cent of women reported feeling they severely lack social support (Craig & Mindell, 2007). Social isolation can prevent older people accessing psychological therapies (Positive Practice Guide, 2008). This is particularly poignant when considering rural geographical areas, such as the East Riding of Yorkshire. Alongside social isolation the sense that mental health problems are shaming, or believing that feeling low is just part of ageing and ‘not wanting to cause a fuss’ may all prevent older people from seeking and receiving psychological interventions (Positive Practice Guide, 2008).

Finally, although there has been a recent move toward the inclusion of older people within the IAPT programme as a whole, this does not seem to have been widely acknowledged on the ground. Anecdotal evidence from clinicians working with older people suggests that IAPT is perceived as a service for working age adults, driven by the aim of getting people back to work. This is perhaps further obscured by the underlying message of the original pathfinder bids; older people were seen as a ‘special interest area’, perhaps implying that if not ‘chosen’ they are not automatically included in the IAPT programme. Furthermore, some of the questionnaires used within the pathfinder projects were not validated or standardised for older people (i.e. PHQ9 and GAD7) suggesting again that older people were not an integral part of the IAPT project as it was originally conceived.

The above goes some way to explaining the poor uptake of IAPT by older people within the East Riding of Yorkshire. In retrospect, because of the pressures of project deadlines, as a group we did not fully consider the potential impact of these issues before starting the project and, therefore, mistakes have been made. In retrospect we could have worked harder to promote the fact that older people were part of the IAPT project and are able to benefit from psychological therapies. We did try to address issues
of training by providing local workshops focusing on recognition and treatment, but this was only once in the year in each local area and was perhaps not enough or did not reach enough people. In addition, we did not follow this up or explore specific ways people could use us if they had a query about mental health issues and older patients. Furthermore, the GMHWs have reported feeling ill-equipped to work with some older people as the training and resources they use (such as the work books) focus on working age adults.

Benefits and current plans
One of the aims of the pathfinder project sites was to identify benefits and barriers to improving access to psychological therapies for particular sections of the community including older people. The barriers outlined above do go some way to explaining the low uptake of the IAPT service by older people. Having said this, in terms of the benefits, those older people who did go through the IAPT programme in the East Riding showed significant improvement on anxiety and depression scores and were either mostly or very satisfied with the service they received. More broadly, research has continually shown that psychological therapies are effective when treating anxiety and depression in older people (Positive Practice Guide, 2008) and there are also examples of very successful primary care psychology services for older people (e.g. Sue Watts and colleagues in Greater Manchester West Mental Health NHS). The IAPT Positive Practice Guide, (2008) states that ensuring IAPT services meet the needs of older people can help to reduce mental health symptoms, improve quality of life, improve effective management of physical conditions, reduce attempted and completed suicide attempts, enable older people to have productive roles and potentially reduce wider economic costs to health and social care.

The project group in the East Riding of Yorkshire, therefore, feel it is imperative to continue to work towards ensuring the IAPT does meet the needs of older people and barriers to access are properly addressed. This is now even more pressing as we have just secured a further three years’ funding. We have consequently spent some time thinking about the ways we may address some of potential barriers that older people might face in accessing IAPT services and a plan comprising six key aims is now in place:

1. Engagement – highlighting the barriers to low referral rates and developing a plan of action to address issues regarding primary care staff, referrers, service users and the third sector.
2. Training and supervision – assessing the training and supervision needs of people working within IAPT and locally co-ordinate relevant training and supervision, as well as working towards the development of specialist skills.
3. Develop information around any adaptation needed within IAPT service for older people through a biopsychosocial model of assessment and service delivery.
4. Feed into both the local and national IAPT Older Peoples special interest groups.
5. Research: to continue to collect and analyse data on a regular basis to aid continued improvement to service and intervention offered to older people through the IAPT.
6. To work towards addressing issues around social isolation and older people’s attitudes and views by being more flexible in terms of service delivery.

Conclusion
IAPT services are already beginning to demonstrate their effectiveness and we, therefore, have to ensure that older people get equitable access to these services. If the needs of older people are met, IAPT could be hugely beneficial across the lifespan. Although initial communications about IAPT seemed not to be inclusive of older people, this seems to be changing and it is our hope that the results of pathfinder
projects such as ours will encourage all emerging IAPT services to take the needs of older people seriously and not see them as an optional extra. We still have opportunities to become involved in the design and development of these services and help to ensure that older people with mental health problems are recognised more effectively and get access. A crucial part of this is documenting evidence of older people not being able to access IAPT services and clearly defining their needs and the investment required to make these services responsive to age and need.

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References
Early psychosocial intervention in a Memory Clinic: Addressing isolation in older people with early dementia

Hannah Wilkinson, Sue Whiteing, Karen Hawcroft, Elaine Twidale & Clare Hilton

**Concept and philosophy**

THE TREND towards early recognition and diagnosis of dementia and the growth of memory clinics worldwide (Jolley et al., 2006) is accompanied by new aspirations for interventions. These have their conceptual origins in the health promotion literature (Beavis 2007) where outcome is focused on prevention (Vellas et al., 2008), including prevention of ‘excess disabilities’ and reduced well being (Moniz-Cook et al., 2009).

A known protective factor against mental health problems in later life is social involvement in the local community (Hollander-Feldman & Oberlink, 2003). For example, engagement in social activity and networks is associated with reduced risks of cognitive decline in older people (Fratiglioni et al., 2004). Social involvement also increases the potential for enhanced health status and well-being (Findlay, 2003) with diminishing social networks associated with co-morbid mood disorders (Grant & Wenger, 1993). Social support may help maintain well-being in people with a diagnosis of dementia by protecting against adverse life-events (Waite et al., 2004). This is acknowledged in recent NHS strategies and recommendations, including the National Service frameworks for Mental Health and for Older People (Department of Health, 1999, 2001) and Everybody’s Business (2005), which emphasise reducing social isolation to enhance well-being and quality of life in older people with and without dementia. In this context isolation is defined as:

‘The subjective feeling of loss of companionship and the objective absence of contacts and interactions between an older person and a social network.’

(Cattan et al., 2005, pp.42–43)

A diagnosis of dementia marginalises older people (Bond et al., 2004) and may herald the sense of loneliness and helplessness noted in subjective accounts of the experience of living with dementia (Keady, 1996). This in turn runs the risk of ‘learned helplessness’ (Flannery, 2002) and associated progression to mood disorders in the person with dementia. Facilitating social activity is now emerging as a key intervention in memory clinics to promote mental health in people with a diagnosis of dementia (Vellas et al., 2008; Moniz-Cook et al., 2009).

Cattan et al. (2005) reviewed the effectiveness of interventions to prevent social isolation and loneliness among older people and concluded that while educational and social activity group interventions targeting specific groups have promise, the evidence for befriending and home visiting schemes is unclear. There has also been a growth in gender-based group work in early stage dementia (Lees, 2006), particularly in relation to social activity (Manthorpe & Moniz-Cook, 2000).

This paper describes the structure and progress of a group for older women identified as vulnerable to mood disorders following a diagnosis of dementia. The aim of the intervention was to facilitate integration into local community facilities rather than mental health services. This was based
on the findings of a previous study suggesting that premature entry into mental health day services ran the risk of exacerbating family distress and associated excess disability for the person with early-stage dementia (Richards et al., 2003)

Participants and intervention

'The Ladies'
Six women (describing themselves as ‘the ladies’) aged over 65 years with early-stage dementia were identified following assessment at the Hull Memory Clinic, which has a long history of provision of psychosocial interventions. All but one of the ladies were widowed and lived alone and were supported by adult-children or grandchildren. The sixth lady lived with her husband who was a somewhat frail gentleman following treatment for cancer.

Vulnerability to mood disorder was identified using the detailed psychosocial profile, which reviews psychological status of both the person with a diagnosis of dementia as well as the designated informal ‘carer’ (see Moniz-Cook, 2008, for a description). This revealed that the participants’ social networks were predominately family-based. The psychological assessment also indicated that the family supporters had their own concerns and demands and presented with significant stress even though their relative with a diagnosis of dementia did not present significant day-to-day difficulties at this time.

The six ladies shared similar personal histories and interests and all lived within four-mile proximity of their local community centre. All reported the desire to have more social contacts, but their high levels of worry about attending a new place and/or meeting new people on their own, prevented them for engaging in their community facilities.

The social integration intervention
A graded support programme (Box 1) was used over eight weeks to introduce each lady to the community facility. This was agreed with them, their family and staff at the community centre. With their consent, contact was maintained with the family who received information on the outcome of the graded programme. The process was monitored each week through feedback from both the person with dementia and their family. At the end of the eight-week period a communication procedure was established between staff at the memory clinic and the community centre whereby the latter would alert the former on day-to-day concerns that the ladies might report during attendance at the centre. This would occur routinely at least once a month, but more regularly if needed. The rationale was to maintain a ‘longitudinal tracking’ case management system which is common in developing primary care-based disease management programmes (Moniz-Cook & Vernooij-Dassen, 2006), thus allowing efficiency in case monitoring on the one hand, whilst promoting autonomy and maintenance of normal social networks and friendships on the other.

Group evaluation and outcomes
Quantitative data – cognition and mood
Measures of cognition were conducted before and after the intervention using the Mini Mental State Examination – MMSE (Folstein et al., 1975); and mood and quality of life were measured using the Hospital Anxiety and Depression Scale – HADS (Zigmond & Snaith, 1983), The Short Anxiety Screening Test – SAST (Sinoff et al., 1999), the Geriatric Depression Scale – GDS30 (Yesavage et al., 1983) and the Quality of life in Alzheimer’s disease Scale – D-QOL (Brod et al., 1996) measure.

Pre- and post-analysis using paired t-test indicated a statistically significant reduction in anxiety following the intervention ($t=2.528, df=5, p<0.05$, two-tailed), a strengthened sense of belonging ($t=3.896, df=5, p<0.05$, two-tailed) and improved positive affect ($t=2.501, df=5, p<0.05$, two-tailed).

Qualitative data
Participants were interviewed, using semi-structured interviews, before and after the
Early psychosocial intervention in a Memory Clinic

Box 1: The Social Integration Intervention.

Week 1:
- Lifts to the community centre by memory clinic staff.
- Introduce to staff and transport facilities (bus driver) at the community centre in preparation for the following week.
- Cognitive stimulation session (memory clinic staff).
- Ladies and memory clinic staff leave the centre together, before lunch.

Week 2:
- Telephone calls to the ladies in the morning to remind about community transport arrangements for that morning (memory clinic staff).
- Memory Clinic staff meet ladies on arrival at the community centre.
- Cognitive stimulation session (memory clinic staff).
- Ladies and memory clinic staff have lunch at the centre and leave together.

Week 3:
- Ladies use community transport with prompting; meet memory clinic staff on arrival at the centre.
- Cognitive stimulation session (memory clinic staff).
- Memory clinic staff leave; ladies remain for lunch.
- Return using community transport.

Week 4:
- Ladies use community transport without prompting; meet memory clinic staff on arrival at the centre.
- Cognitive stimulation session (memory clinic staff).
- Memory clinic staff leave; ladies remain for lunch and the afternoon session.
- Return on community transport.

Week 5:
- Ladies use community transport without prompting; meet memory clinic staff on arrival at the centre.
- Final cognitive stimulation session, by memory clinic staff.
- Memory clinic staff leave; ladies remain for lunch and the afternoon session; return on community transport.

Week 6:
- Ladies use community transport without prompting; meet memory clinic staff on arrival at the centre.
- Memory Clinic staff greet and leave.
- Remain for the rest of the day; return on community transport.

Week 7:
- Ladies use community transport without prompting; memory clinic staff not present on arrival.
- Telephone contact between memory clinic and community centre staff.
- Remain for the rest of the day; return on community transport.

Week 8:
- Ladies use community transport without prompting; memory clinic staff not present on arrival.
- Telephone contact between memory clinic and community centre staff.
- Remain for the rest of the day; return on community transport.
group intervention and qualitative interview data were collected again after 12-months. This included questions around their social life with both family and outside the family circle. Here we report the pre- and post-interview data although some 12-month reports are also included.

**Social contacts**
The number of contacts with family, friends and others can be seen in Table 1. Each participant had more total contacts in a typical week post-intervention (Table 1). These comprised a social network outside the family with contacts at the community centre also extending beyond that of the initial group of six ladies, i.e. the ladies made friendships with new people at the community centre.

**Thematic reports**
The common themes were drawn from both the pre- and post-semi-structured interviews and from this four main themes were identified in their narratives. These were: Inclusion, Esteem, Networks and Role Reversal/Dependency. Over time there were subtle but positive improvements on each of these. Following the eight-week intervention participants reported less of a sense of loneliness (i.e. improved inclusion), improved social confidence, wider social contacts and an improved sense of autonomy.

**Inclusion:** All six ladies reported that they felt less socially isolated after they had started attending the community group (Table 2).

The lady who resided with her husband noted that prior to the intervention her husband’s illness had precipitated her sense of loneliness:

‘We used to go out a lot, me and my husband … before he became ill … we had a lot of friends really. I have lost contact with them for one reason or another.’

At 12-month follow-up this lady continued to report improved social activity including re-establishment of a past friendship:

‘I have an old friend who comes here so it is nice to see him and have a chat with him. I knew his wife.’

**Esteem:** Prior to the intervention all six ladies indicated that they no longer had the confidence they once had, since they were worried that their memory problems (or word finding difficulties) would be noticeable (Table 3.). These concerns prevented them from going out and meeting people.

One lady would only go out on her own to walk her dog and was otherwise isolated, apart from when her adult-children (who were usually at work) visited her at the weekend.

Table 1: Pre-post intervention reported social contacts – a typical week.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Number of contacts with family</th>
<th>Number contacts with friends</th>
<th>Number of contacts with others</th>
<th>Number of contacts times per week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>3–4</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>3</td>
<td>6</td>
<td>1–2</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>
Early psychosocial intervention in a Memory Clinic

Table 2: Comments referring to social isolation (pre-intervention) and social inclusion (post-intervention).

<table>
<thead>
<tr>
<th>Pre (N=8)</th>
<th>Post (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social isolation</td>
<td>Social inclusion</td>
</tr>
<tr>
<td>P3 – ‘Friends seem to drop away when you are not in a couple.’</td>
<td>P6 – ‘I feel less isolated.’</td>
</tr>
<tr>
<td>P5 – ‘Most of my friends are either dead or can’t get out of the house!’</td>
<td>P3 – ‘There are more people than in the house, and more people to talk to.’</td>
</tr>
<tr>
<td>P4 – ‘They are at work all day so I don’t do very much in the daytime.’</td>
<td>P5 – ‘I have made friends with the other ladies, I class them as friends.’</td>
</tr>
<tr>
<td>P1 – ‘Feel like you are not alone.’</td>
<td>P1 – ‘Feel like you are not alone.’</td>
</tr>
<tr>
<td>P4 – ‘We are all good friends, and can have a laugh and a joke.’</td>
<td>P4 – ‘We are all good friends, and can have a laugh and a joke.’</td>
</tr>
</tbody>
</table>

Table 3: Comments referring to social withdrawal and social confidence (post-intervention).

<table>
<thead>
<tr>
<th>Social withdrawal (N=6)</th>
<th>Social confidence (N=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P5 – ‘I used to be involved in a lot of things really, church activities mainly, but I don’t feel I can as much now.’</td>
<td>P4 – ‘Having friends has made me happy ... slightly more confident.’</td>
</tr>
<tr>
<td>P6 – ‘I just don’t feel as confident as a used to about going out.’</td>
<td>P1 – ‘This has made me feel more confident.’</td>
</tr>
<tr>
<td>P3 – ‘I think people will notice I am having memory problems – my family always point it out.’</td>
<td>P5 – ‘I feel as good as anyone else here.’</td>
</tr>
<tr>
<td>P4 – ‘I can talk here its more interesting. Otherwise I would be walking the dog and sitting around at home.’</td>
<td>P4 – ‘I can talk here its more interesting. Otherwise I would be walking the dog and sitting around at home.’</td>
</tr>
<tr>
<td>P6 – ‘Coming here has made me more outgoing.’</td>
<td></td>
</tr>
</tbody>
</table>

Interviewed after integration into the community group she reported:
‘I am more talkative, I do more interesting things. It’s changed my day to day life.’

None of the ladies reported embarrassment or fear about having memory problems at follow-up. Rather the ladies referred to the community centre as ‘their Memory Club’. They openly admitted to their ‘trouble with their memory’ but no longer saw this as problematic and would often laugh and joke about how they could not remember each other’s names!

Networks: This theme confirmed the qualitative data on social contacts outlined previously.
Prior to the intervention the ladies had few social contacts outside of their family networks. At the post intervention interview they all described the positive effects of having the opportunity to mix with other people at the community centre.

Dependency and Autonomy: The five widows in the group all reported a sense of role-reversal in that their adult-children had slipped into providing them with care, which for some undermined their sense of control. A typical comment was:
‘Things seem to get sorted out for me now these days.’
Post-group interviews suggested that to some extent friendship networks had moderated this sense of emotional and social dependency. For example:
‘I feel I can talk and my friends will listen.’
Table 4: Comments referring to family networks (pre-intervention) and friendship networks (post-intervention) (pre-intervention).

<table>
<thead>
<tr>
<th>Family networks (N=10)</th>
<th>Friendship networks (N=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2 – 'I only ever really see my daughter'</td>
<td>P1 – 'Within the six ladies we are all good friends.'</td>
</tr>
<tr>
<td>P3 – 'I tend to go out with family only really'</td>
<td>P2 – 'I have met new people. I like mixing with these people in the group.'</td>
</tr>
<tr>
<td>P4 – 'In a week I go to my daughters on a Wednesday and stay over night. I see my sister once a week and the grandchildren pop in and take me out. That's about it. My daughter's mother-in-law is at her house on a Wednesday too, so I see her.'</td>
<td>P6 – 'Family is my life ... Never done anything like this, either caring for family or working. Now its time for myself ... it's good for me.'</td>
</tr>
<tr>
<td>P5 – 'I come for the company, especially when family is working during the day.'</td>
<td>P5 – 'Its time to do other things away from my husband:'</td>
</tr>
</tbody>
</table>

Table 5: Comments referring to role review and dependency (pre-intervention) and regaining independence and autonomy (post-intervention).

<table>
<thead>
<tr>
<th>Role reversal and dependency (N=6)</th>
<th>Independence and autonomy (N=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2 – 'It's funny when the mother starts to become the one that gets looked after'</td>
<td>P4 – 'I wouldn't come if I didn't enjoy it. I need to find things to do during the week ... this is a good thing:'</td>
</tr>
<tr>
<td>P4 – 'I used to look after them'</td>
<td>P2 – 'I can do day-to-day tasks and keep doing my own thing now:'</td>
</tr>
<tr>
<td>P3 – 'They used to come to me for Sunday lunch, now we alternate between them.'</td>
<td>P1 – 'There's always someone to talk to here:'</td>
</tr>
</tbody>
</table>

Conclusion
The aim of this community-based group intervention was to enhance social integration in six participants with early-stage dementia whose perceived loneliness rendered them vulnerable to distress and depression in the longer term. The intervention was developed around involvement in local community facilities as opposed to mental health services. This is in contrast to other examples of long-term group support for people with a diagnosis of dementia (Bender, 2006; Randeria & Bond, 2006). The benefits of the current approach is highlighted by the continued attendance of the six participants at the community centre after the end of the eight-week intervention with several reporting increased attendance at the 12-month follow-up.

The secondary advantage of this intervention was the opportunity to develop a mental health promotion case management system in primary care (Moniz-Cook & Vernooij-Dassen, 2006) for people with early stage dementia following diagnosis in a community-based memory clinic. The key to this approach was flexible communication between staff at the community centre and the memory clinic. In this case the intervention was prophylactic in nature, based on formula-driven predicted clinical outcomes associated with depression.

This study of six participants highlights the value of strengthening the formal support networks of people with early-stage dementia to moderate limited informal social networks. The effect included enhanced autonomy (Duner & Nordstrom,
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2007) and social confidence, through a sense of collective strength (Clare et al., 2008). However, long-term group support aimed at social integration is not for all. A detailed assessment of personal and family systems is required (see Moniz-Cook, 2009) and participants need to be matched to others with shared interests and circumstances. This is one type of post-diagnosis ‘step one’ (Moniz-Cook & Manthorpe, 2009) psychosocial intervention in early stage dementia that could be maintained in primary care, with support from staff working in specialist memory clinic services.

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ODIFYING unhelpful or ‘dysfunctional’ beliefs is the foundation of Cognitive Behavioural Therapy (CBT). Of the numerous techniques developed to address problematic beliefs, metaphors and analogies are commonly used therapeutic tools in CBT. The distinction between the two is often unclear and is probably of more academic interest than of clinically utility within the arena of psychotherapy (see Blenkiron, 2005, for further details). The function of metaphors analogies within therapy is perhaps as varied as their application. Beck (1995) suggested that using metaphors can allow patients to distance themselves from their beliefs by reflecting on a different situation. Sanders and Willis (2005), however, claimed that metaphors reflect a predominantly visual-based modality and can provoke a required emotional response that circumvents problems where verbal responses might represent avoidance of high affectivity.

CBT is seen as an efficacious psychological treatment for many late-life anxiety and depressive disorders (Laidlaw et al., 2003), although adaptations in its delivery are often needed for older people (Knight & Satre 1999; Laidlaw, 2006). For example, many older people may struggle with the process of self-disclosure and, although not a universal challenge within psychotherapy with older people, this can be a particularly salient issue for a cohort where emotional exploration has not been common practice and self-reflection is potentially shaming. The use of metaphors and analogies as a means of bridging discomfort during personal reflection within psychotherapy with older people can help engage the patient by providing a rationale for a desired intervention. In this paper I will outline how metaphors and analogies may be used in clinical practice to assist patients in understanding and engaging with often complex and abstract CBT conceptualisations of their experiences.

Particularly salient issues attached to working with older people are the cognitive processes of worry and rumination (see Rewston et al., 2007). Within the spectrum of anxiety disorders in late-life worrying is a prominent clinical feature, as indicated by the high prevalence of Generalised Anxiety Disorder (GAD) in older people (Beekman et al., 1998). Equally, depressive rumination is relevant in mood disorders across the adult life span (Kraaij et al., 2002). Both rumination and worry have been linked to experiential avoidance (Cribb et al., 2006; Roemer et al., 2005) and may, therefore, function broadly to regulate affect, particularly since problem-solving resources and support systems often decline in ageing.

Metaphors and analogies in clinical practice with older people
I will now outline examples of metaphors and analogies that I have incorporated into clinical practice.

Engaging with depressive rumination
‘Can you think of a film that you have seen … one which you did not enjoy and left you feeling fed-up or gloomy? Now imagine what life would be like if you agreed to watch this film again, not just once but every afternoon for the next month or so. Whatever you were doing, or planning to do, has to stop because it was time to sit and watch this miserable film again. What do you think about that idea?’

At this point patients typically express dissatisfaction with the suggestion. Additional
exploration of the metaphor helps direct the person towards a better understanding of the link between their action and their mood.

‘You seem to be saying you wouldn’t want to sit and keep replaying this miserable film when you know it makes you unhappy right? Okay but I’m wondering, isn’t rumination a bit like that? I mean, in your recording sheets I see you frequently keep mulling over or replaying the same thoughts that also seem to make you unhappy. Isn’t ruminating just like repeatedly replaying a miserable story in the mind even though it interrupts your life and makes you depressed?’

Rumination on the causes of depression
Ruminating on the causes of one’s depression is a common feature of low mood. An excessive focus on the past can be an unhelpful obstacle to fruitful working in the ‘here and now’. This is often encountered with older people who seem to somatise their distress and understandably become preoccupied with attempting to find reasons for their symptoms. High rates of co-morbid physical ailments and a lack of familiarity with the talking therapies frequently result in many depressed older people becoming caught-up in rumination about the causes of problems during therapy. Older people often gravitate to possible side effects of medications as explanations for their current distress, at the expense of problem-solving. This is not to say that an understanding of the events surrounding the onset of depression has no relevance to either the patient or the therapist, but rather that this ruminative process often persists irrespective of alternative or more credible explanations. Thus, as noted previously, ruminating, as a process, may represent an attempt to regulate affect and the tentative nature of a formulation may well be insufficient to prevent a person’s continued ruminative responses within therapy.

An example of how a metaphor can be useful in highlighting the negative consequences of becoming engaged in a repetitious and unhelpful analysis of the reasons for being depressed is illustrated below.

‘Can you picture a time when you have had a bad cold or flu and you were housebound or maybe laid-up in bed?’ ‘How did you feel when you were so unwell?’ ‘Now tell me, when we are unwell like that and feeling so miserable, do we spend our time brooding over who we caught the flu off or why we are unwell and others are not?’ … ‘No of course not, our concern is generally about when the illness will end and finding an effective remedy, right? It is pointless and unhelpful to keep mulling over why we have caught flu. Even if we could find the answer, we could never really prove who it was we caught it from nor could we go back and change it. The depression you are experiencing is also an illness, but I notice that unlike your attitude to flu, you seem to see it as important that you find out why you are depressed or what caused it. Like flu I wonder if we can really say with certainty it was because of this or that … we can at best make some guesses but is that really what matters or is finding a remedy of greater importance?’

In my experience, the above analogy between depression and flu as sharing similar characteristics in relation to onset, goals and remedial action allows most patients to begin to recognise the inconsistency of their responses to different illnesses. This then allows them to avert a defensive response during therapy that might otherwise lead to a block in the working alliance.

The power of unhelpful beliefs
Many older people find the idea that the strength of a belief can directly influence one’s behaviour and emotions a somewhat abstract concept. I have found the following example useful in demonstrating this idea.

‘There was once a time when the world was believed to be flat … everyone held that view … if about 2000 years ago you asked anyone they would have all said ‘Yes, the world is flat I believe it completely without a shadow of doubt’ … even though today we know the world is a sphere, in those times they would not have believed us. They held their belief so
strongly that even sailors would avoid the horizon for fear of falling of the edge … it seems reasonable, does it not, that if you are sure of your belief it makes sense to stay away from the horizon? The problem is this fear was unfounded as we now know you cannot sail off the edge… however, it must have taken some courage to challenge the idea that the world might not be flat but thankfully someone did and now we don’t need to fear the horizon because of what we have learnt… the old thought that the world is flat is no longer relevant or a problem.’

The patient is encouraged to draw some comparisons between the above, the beliefs they hold and their behaviour. The discussion would therefore focus on the potential impact if some beliefs could be shown to be inaccurate.

**Mindfulness**

So called ‘Third Wave CBT’ has seen a shift from directly modifying the content of ‘dysfunctional thinking’ towards addressing the person’s response to tacit thought processes. The following analogy is particularly useful in highlighting the fundamental philosophy underpinning cognitive-based mindfulness work with patients.

‘Imagine you are lying on a beach enjoying a perfect blue sky with no desire or pressure to leave. Suddenly you become aware of a shadow passing over you and you look up to see a small dark cloud passing over the sun as it crosses the sky. Would you respond to this cloud by breaking off from enjoying the beach to contemplate its meaning, to wondering if it heralds the beginning of rain? Would you pursue the cloud, leaving the beach behind, just to make sure that it does not threaten bad weather? No … of course not, but thoughts are like clouds, sometimes even when we are really enjoying something a dark thought can cross our minds just like the cloud in the story. Many people feel compelled to pursue dark thoughts as they pass over their minds even if it means that what they were enjoying has been lost.’

**Exposure work**

The following analogy seems to be particularly helpful in allowing patients to distance themselves from their anxiety, whilst still able to explore the benefits of preventing avoidance of fearful situations.

‘I don’t know if you can recall a similar experience to me, but when I was a child there was a creepy looking abandoned house nearby which all the children used to say was haunted. I don’t think it is uncommon for children to make up scary stories about haunted houses. Although I knew deep down there were no ghosts in there, I was still petrified. As a child, every time I saw the house or walked up to it I felt a fear creep over me and I had to run away. On some occasions, my friends and I would challenge each other to see who would dare walk up to the house or even push open to broken front door.’

The first part of the story aims to draw out an understanding and appreciation of the sensitising of the situation irrespective of rational thought.

‘No one ever made it inside because we were all so scared. Now imagine if your job was to convince me that the house was not haunted. You could try and sit me down at home and persuade me but I might not believe you … after all I would only have your word for it. How might I learn that the house is nothing to be feared? Well what do you suppose would happen if I challenged myself and entered the house and just sat and waited, I can hear the wind blowing and the house creaking, how scared would I be? Okay pretty frightened then. Then let’s say I didn’t try to escape, in fact I stayed there another hour, I can still hear the house creaking the wind blowing, am I still as frightened as I was when I first entered the house? Maybe, but let’s say five hours have passed and I remain sat there with the wind blowing and the creaks, am I still as frightened? Let’s then suppose I go home, only to return the next day, I do the same thing over again. Again, there are some creepy noises but nothing happens, what do you suppose is happening to my level of fear about the house.’
I find that patients often need encouragement to recognise the universal process of habituation to fearful situations, but that this can reduce sensitivity to potentially anxiety provoking features in the environment. It is helpful to ask the patient to offer an example from their own life-experience where this type of fear was overcome (examples might include taking the stabilisers off one’s bicycle or ‘first day at school’ memories) in order to further strengthen their appreciation of habituation.

Conclusion
The metaphors and analogies outlined above have been beneficial in engaging many older patients with the models that underpin CBT. Although they are not intended to be used in every encounter, they have been helpful for those who feel uncomfortable about the direct exploration of negative emotions and responses. The above metaphors and analogies are examples that clinicians can use to allow the older person the opportunity to recognise the normality of their emotional experiences across age groups and the life span. This in turn can therefore increase levels of confidence in self-reporting and reflection throughout the therapeutic process.

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Making more sense of verbosity in cognitive behavioural therapy (CBT) with older people

Chris Clarke

VERBOSITY, what might be termed excessive, off-topic talking, has been identified as posing a suitability problem for CBT generally (Safran et al., 1993) and may create procedural problems in CBT with older people in particular (Laidlaw et al., 2003). Pragmatic strategies for addressing excessive talkativeness have been proposed (Laidlaw et al., 2003) but a conceptual account of verbosity in relation to therapy and psychological distress is absent from existing literature. The aim of this article is to describe some of the psychosocial factors that might contribute to verbosity in older people who are receiving therapy for depression and/or anxiety. A broad literature encompassing the verbal behaviour of older people, the nature and functions of storytelling and cognitive/emotional avoidance processes is used to shed more light on this complex area.

Verbal communication and verbosity in older people

Pushkar-Gold et al. (1994) define ‘off-target verbosity’ (OTV) as ‘extreme amounts of irrelevant speech’ involving loosely relevant ideas and reminiscences that quickly drift away from the original topic of a conversation. Verbosity might be characteristic of up to 20 per cent of non-clinical older people (see Pushkar-Gold et al., 1994) and cross sectional studies suggest that psychosocial factors such as stress, loneliness and dissatisfaction with social support account for around 10 per cent of the variance in OTV (Arbuckle et al., 2004; Pushkar-Gold et al., 1994) In addition, Arbuckle and Gold (1993) found significant associations between OTV and specific neuropsychological factors, namely verbal inhibition and working memory. Although younger adults have not been included in this research, it has been proposed that OTV, therefore, represents an age-related impairment in verbal inhibition; some older people are less able to inhibit the verbal expression of thoughts unrelated to a topic under discussion and this results in verbosity (Pushkar-Gold et al., 1994).

More recent work suggests that OTV is more likely in older people but that it is also context-specific. James et al. (1998) rated ‘off-topic speech’ in 40 younger and older people when they were discussing personal topics (e.g. family, holidays, and education) and when discussing pictures and drawings. More ‘off-topic’ speech was produced by older people but only when talking about personal topics, i.e. drawing on autobiographical memory (AM). In a subsequent study, the authors found that the ‘stories’ produced by older people who were most off-topic were, conversely, also rated as more interesting and informative than those produced by younger people. Younger raters were more likely to judge older people’s responses as ‘off-topic’, perhaps indicating the subjectivity that is likely to be involved in judging the extent of verbosity. James et al. (1998) argue that goals for verbal communication change with age and that older people become more motivated to convey personally meaningful information in a narrative, story-based form that may appear to others to stray off topic.

Telling stories about one’s personal experiences is associated with AM and has key functions for the individual (Baumeister &
Newman, 1994). Existing work suggests that maintaining self-concept and regulating emotion could be particular functions of story-telling in late life. For example, Pasupathi and Mansour (2006) demonstrated that older people are more likely than younger counterparts to show ‘autobiographical reasoning’ when discussing ‘crises’ that had occurred in their lives; they describe autobiographical events in ways that reflect key aspects of their own self-concept. It is suggested that this process reflects changing psychosocial goals in later life that relate to identity and emotion. Carstensen et al. (1999) proposed that goals related to emotion regulation take up more prominence in our social lives as we age and begin to recognise that time is limited. Research supports this ‘socio-emotional selectivity theory’ of ageing; emotions become more salient for older people and they prioritise social experiences and goals that are emotionally satisfying (Carstensen, 1995; Löckenhoff & Carstensen, 2004). These broader concepts tie in with the findings of James et al. (1998) and their proposal that OTV could result when motives for communication shift toward being more narrative-based, the caveat perhaps being that this way of communicating reflects an emotional regulation function of AM recall in late life.

Autobiographical memory, avoidance and verbosity

There could be additional mechanisms linking verbosity with memory and with affective disorders and these may be applicable to older people. The maintenance of depression and other disorders has been linked with an ‘over-general’ style of retrieval from AM in which people tend to recall broad and summarised categories of events rather than specific memories (Harvey et al., 2004). Empirical research has not yet explored whether over-generalised recall from AM is linked to verbosity in therapy. However, the ability to recall specific memories probably relies on the successful inhibition of general memories in the same category (Harvey et al., 2004). As discussed, inhibitory deficits have been implicated in verbosity and impairments in working memory can contribute to reduced specificity of AM (Phillips & Williams, 1997) a notion demonstrated to be relevant to older people with affective disorders (Birch & Davidson, 2007) and suggestive of a link between over-generalised recall from AM and verbosity in older age.

It is striking that problems staying focused in therapy can often appear to relate to the avoidance of painful thoughts and memories and associated emotions. This notion finds some support in existing literature. Williams (1996) suggests that the tendency to recall non-specific memories from AM is effectively a strategy aimed at the avoidance of the upsetting emotion that is linked with negative ‘event-specific knowledge’. Attempts to retrieve specific memories are repeatedly ‘aborted’ because they generate emotion perceived to be intolerable. This pattern becomes recursive as negative affect triggers the recall of negative thoughts and memories that are in turn avoided resulting in over-general memory recall and the perpetuation of negative affect (Harvey et al., 2004).

Moore and Garland (2003) regarded varied avoidance strategies as crucial in maintaining recurrent and persistent depression.
They suggested that cognitive and emotional avoidance manifest not just in the obvious suppression of certain thoughts and feelings but also in a ‘flitting’ between descriptions of different problems and experiences. As such, clients may relate details of current or previous problems ‘but seem to stop short of considering underlying personal meanings, causing them to repeatedly ‘jump ship’ onto another area of their life that is not going well’ (Moore & Garland, 2003, p.31). A broad and persistent tendency to avoid painful meanings and internal distress has been operationalised more broadly as ‘experiential avoidance’ (Hayes et al., 1996). Experiential avoidance has been implicated in the maintenance of depressive rumination (Cribb et al., 2006) and Generalised Anxiety Disorder (GAD), a problem that is particularly prevalent in older people (e.g. Beekman et al., 1998). GAD is underpinned by pathological levels of worry which, in content, tends to shift amongst multiple concerns without a solution to each being properly devised or implemented by the person, a characterization strikingly similar to the verbose yet avoidant style of interaction possible in chronic depression, as described above by Moore and Garland (2003).

Clinical implications
Laidlaw et al. (2003) outlined several useful procedural modifications that can be made to CBT with older people when excessive ‘story-telling’ arises. They suggest that therapists should provide frequent summaries in session, elicit feedback very regularly, seek permission to interrupt the client and actively re-direct the focus of the discussion. Additional procedural modifications to therapy may also help. Beck (2005), for example, suggested that a ‘collaborative agreement’ be made with the talkative client to speak freely for the first 10 to 15 minutes of the session and that the therapist should then summarise what has been said, get feedback from the client and agree a problem focus based on the client’s report.

These techniques are undoubtedly helpful but they also implicitly frame ‘story-telling’ as a relatively peripheral procedural problem that only requires clearer boundaries and more ‘socialising’ of the client in order to be resolved. It is possible that there are additional specific ways in which an understanding of the factors potentially underlying verbosity might aid therapy:

- Differing styles of and goals for social communication have the potential to affect rapport and collaboration between therapists and older clients. Younger therapists might differ from older clients in their judgement of what is deemed ‘off-topic’. At the same time, less experienced therapists might be less confident and adept at interrupting the client without rupturing the working alliance. Accordingly, it could be useful to proactively explore with the talkative older client their own expectations and experience of the therapeutic discourse itself and how they decide on what is ‘relevant’ to a topic being discussed. Discussing any previous experiences of ‘talking therapies’ in relation to this could be helpful since these could shape clients’ expectations/beliefs about how they should use therapy. This may aid socialisation to the current therapy and add valuable context to the strategy of agreeing with clients a procedure for interrupting and getting back on track (Laidlaw et al., 2003).

- It could be useful for therapists to track the themes conveyed by the ‘stories told’ by verbose clients. Even if it is not immediately obvious, it is possible that such themes reflect important aspects of the client’s self-concept and interpretative style (Pasupathi & Mansour, 2006; Baumeister & Newman, 1994). In cognitive-behavioural terms, clients’ stories may, therefore, give valuable clues as to underlying beliefs and assumptions regarding self, world and future that are relevant to the aetiology and/or maintenance of their presenting problems.
Verbosity could be linked to interpersonal/social problems (including loneliness, isolation and/or dissatisfaction with social support networks), which in turn relate to the client’s presenting problems. For older people with mental health problems these issues can be particularly prominent and deleterious (Tiikkainen & Heikkinen, 2005). It may, therefore, be important that therapists frame verbosity as a potential marker for interpersonal/social problems, carefully explore the presence and impact of these factors and include them in contextualised psychological formulations.

Similarly, links might be drawn between a talkative client’s verbal behaviour in session and the process of their thinking, particularly with regard to the possible underlying operation of cognitive and emotional avoidance strategies, worry and rumination. Monitoring patterns of verbosity in session and establishing to what degree the exploration of potentially threatening or upsetting material is antecedent are useful starting points for this. This could contribute to a ‘live’ understanding of emotion regulation processes that require intervention through therapy. In this regard the therapist faces the task of naming verbosity with the client in a sensitive, collaborative way. This probably requires a good humoured, careful and exploratory approach and therapists may benefit in this regard from using the broader strategy of ‘meta-communication’ described by Safran and Muran (2000). Using this strategy the therapist invites the client to ‘take a step back’ and observe patterns in their here-and-now interaction and think about how these patterns might connect with underlying thinking processes and linked behaviours. Sharing an understanding of verbosity and using a metaphor to give it a ‘name’ that is acceptable and meaningful to the client (e.g. ‘drifting’, ‘veering off’, ‘sliding’) is also likely to be valuable.

Mild problems with verbal inhibition, and possibly executive function, could affect the client’s ability to process and prioritise therapy information in and out of sessions, adversely affecting the course and perhaps even the outcome of therapy. Screening for an underlying impairment in verbal inhibition and broader executive functions could therefore be useful. Such problems might be compensated for by using frequent summaries, regularly eliciting feedback with clear prompts, working on specific goals and adjusting the pace and length of sessions (see Laidlaw et al., 2003; Ballard et al., 2001).

Summary

Two broad issues seem central here. First, verbosity emerges in interpersonal contexts where interlocutors may have differing expectations about the nature and purpose of a verbal interaction (i.e. therapy). A range of factors, including relative age and various previous experiences, could influence these expectations. Second, verbosity in therapy could be related to contextual and neuropsychological factors that are also linked to a person’s presenting problems and the relative weight of each of these factors could differ between people. Older people may derive psychological and social value from trying to tell ‘rich’ stories about their experiences and so define what is and what is not ‘off-topic’. Further research examining interactions between these factors in the context of psychological therapies could guide therapists in how they should define, label and respond to apparent verbosity.

From a more clinical perspective, there is growing evidence of links between autobiographical memory, cognitive/experiential avoidance and the maintenance of psycho-
logical problems such as depression and anxiety. The degree to which verbosity in therapy is linked with cognitive and emotional avoidance processes and autobiographical memory is an area of empirical enquiry that is waiting to be explored. It is possible that such factors influence or become manifest in the verbal behaviour of depressed and/or anxious older people and interact with neuropsychological factors that might underpin verbosity in some individuals. Exploring these issues in the individual case could add valuable context to procedural modifications to therapy and help therapists formulate and work alongside apparent verbosity most effectively.

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(3) Paper in a book:

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 these submissions below 500 words.

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.

Book reviews
Submissions up to 250 words reviewing a text of relevance and interest to the PSIGE membership will be considered. These submissions must include full details of the book (including publisher).

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

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 photograph 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
All submissions must be written in language that is inherently respectful to older people and consistent with the British Psychological Society's guidelines.

All contributions must be word processed. Formatting should be consistent with the British Psychological Society's guidelines.

Please submit articles as a Word file via e-mail to the Editor, Dr Arlene J. Astell: aja3@st-and.ac.uk

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, all reports of research should 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.

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