



NEWSLETTER

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SPECIAL ANNUAL CONFERENCE ISSUE



**Psychologists' Special Interest Group
Working With Older People**



PSIGE is a Special Interest Group of the Division of Clinical Psychology of the British Psychological Society



Psychologists' Special Interest Group Working With Older People

AIMS

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

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The photographs of Durham scattered throughout this issue were taken by Sinclair Lough during the Annual Conference.

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Views expressed by the authors may not represent views by PSIGE as an organisation.

NOTES FOR CONTRIBUTORS

Articles

Contributions in the form of short articles on any aspect of psychological theory or practice with older people are always welcome. As the *Newsletter* aims to cover a broad cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication. Articles should be submitted three months before publication (January, April, July, October).

Research Updates

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

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

All contributions must be typed. Where possible, please send two hard copies and an electronic version on disk, preferably saved as a Word file. Please submit articles double-spaced in plain text. Full articles should ideally be no more than 3000 words. Language should be inherently respectful to older people and consistent with the British Psychological Society's guidelines.

Letters to the Editors

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

All contributions should be sent to:

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Letter from the Editors

Ian James & Sinclair Lough

CONGRATULATIONS AND THANKS to Northern PSIGE for hosting such a great annual conference this summer. For those of you that were there, we hope the photographs bring back happy memories. There is the usual collection of excellent and varied articles in this edition, however we have received very little by way of copy from this year's conference. Please could those of you who presented submit an article.

Moves to include a peer review section in the *Newsletter* were put on hold at this year's AGM due to a growing general lack of enthusiasm. If anyone has any ideas about changes they would like to see in the *Newsletter* please let us know.

Merry Christmas and Happy New Year to you all.

Ian James & Sinclair Lough, Co-Editors.

Letter to the Editors

Disclosure of dementia

Dear Editors,

A request for examples of models of good practice in the disclosure of dementia.

We are beginning a two-year research project to improve disclosure of diagnosis to people with dementia. The first step is to define and develop an appropriate model of disclosure, secondly to identify factors that influence disclosure by mental health teams and finally develop an intervention that promotes appropriate disclosure.

We'd like to hear from anyone who can provide examples of good practice in disclosure of a diagnosis of dementia.

Please contact **Claire Bamford, Jan Lecouturier or Robbie Foy**, Centre for Health Services Research, University of Newcastle-upon-Tyne, 21 Claremont Place, Newcastle, NE2 4AA. Tel: 0191 222 8709; Fax: 0191 222 6043; E-mail: c.h.bamford@ncl.ac.uk

BOOK REVIEWER REQUIRED!

Please contact Ian James if you would like to review this book:

Camberwell Assessment of Need for the Elderly.

Edited by Martin Orrell & Geraldine Hancock. Gaskell, London, 2004.

Letter from the Chair

Nicky Bradbury

THE AGM AT THE Annual Conference, where the National Committee is held to account by the membership for the performance of the organisation, feels like the close of the year. Summer is always a quiet time for committee activity and the work begins again when we set new objectives at our residential meeting in the early autumn. We were rather handicapped this year by the absence due to illness of our new Treasurer so initial ideas may need to be reviewed in the light of financial realities.

We recognise that PSIGE members value the *Newsletter*, Annual Conference and the opportunity to meet through the Geographical Groups structure.

To continue these remains a priority. We are optimistic that we will be able to offer training subventions again this year and a larger bursary to support conference attendance. However, we would also like to explore how PSIGE can become more effective in influencing national policy in respect of older people. This means raising our profile within and outside the BPS and focusing on strengthening our relationships with other organisations working with and on behalf of older people. If you have any ideas in this area members of the committee would be delighted to hear from you.

Nicky Bradbury, *Chair*.

The British Neuropsychiatry Association Annual Meeting



9/10/11 February 2005 – The Institute of Child Health, Guilford Street, London

Dementia ● Catatonia ● Child psychiatric disorders in adult life ● Neuropsychiatry in literature

The BNPA is pleased to announce that the 2005 meeting will be over three days with Day one being held in collaboration with Institute of Social Psychiatry.

This meeting is especially directed at clinicians (in old age psychiatry, geriatric medicine, neurology), allied health and other professions seeking a broader understanding of and an update on Dementia, its treatment and impact.

Day two will focus on the Neuropsychiatry of the Dementias and the afternoon session on Catatonia.

Day three will be for members papers and Child psychiatric disorders in adult life, Neuropsychiatry and Literature with a special guest speaker.

For a copy of the meeting programme and booking form, or for details of exhibition/sponsorship opportunities, contact

Jackie Ashmenall on 020 8840 9266 (tel/fax) ● E-mail: admin@bnpa.org.uk
or jashmenall@yahoo.com ● Website: www.bnpa.org.uk

Schematic compensation for topographical disorientation

Stéphane Duckett
Royal Free Hospital



Background

THE FOLLOWING IS an account of an 88-year-old retired town planner who was referred for a dementia assessment subsequent to his losing the ability to orient himself topographically within his immediate neighbourhood. He was ultimately able to compensate for his topographical disorientation by creating a visual map or ground plan (schema) a skill, which he had developed over the course of his professional career. As early as 1913 (Trowbridge) psychologists have described our capacity to formulate imaginary maps of our environs. Milgram *et al.* (1972) and Milgram and Jodelet (1992) in a series of fascinating studies both in New York and Paris demonstrated how in large and in personal environments, local inhabitants form internal environmental maps which may actually distort the geographical reality of their environs.

The present individual is a highly successful retired town planner who up until recently had worked as part of a practice and in academia in his chosen profession. What distinguishes his work is the need to be able to successfully visualise (or schematise) spatial environment two-dimensionally as part of a plan. He first complained of memory problems 18 to 24 months ago. The difficulties were fairly innocuous nevertheless embarrassing for him, i.e. not remembering clients' names. However, his condition took a dramatic turn for the worse when he found himself unable to navigate his return by foot to his home, which was approximately 800 yards from his local shop. Whilst he reported recognising the features of his landscape he could not grasp the entire Gestalt of the environs. He had lived in this neighbourhood for in excess of 30 years. He did not report any absences or loss of consciousness (or gap of consciousness) nor did he report unusual fatigue or other motoric problems. There appeared to be no sensory, perceptual anomalies. It is commonly accepted that most well-routinised activities will be governed by procedural memory usually associated with the basal ganglia.

There are several suspected causative factors that

could account for a disruption of this area of the brain, however, given the relative specificity of this patient's deficits a vascular origin must be the obvious candidate. Unfortunately neuro-imaging was not available.

Compensatory strategy

As part of being a town planner this patient was required to formulate a topographical plan of the environment that requires the design intervention. To this end the patient drew, with the aid of a street map, his view from his upper floor windows of his flat and his memory in consultation with his wife, a map. The action of drawing the map allowed him to retain an image internally. In a very deliberate and conscious action he consults the map internally during the course of mobilising through his neighbourhood. What can account for what is going on and do we necessarily have to accept the patient's account at face value? For instance it is possible that the patient's topographical disorientation was transient (TIA) from which he has since fully recovered (see Lezak, 1995, p.348). His reported use of imaging a map, therefore, may simply be a confidence building measure. This interpretation cannot be altogether excluded however the neuropsychological findings would appear to support the patient's contention that he is experiencing visuo-spatial difficulties which are significant and are unfortunately for him, persistent.

There are numerous models of recovery following acquired brain injury. Prior to the work of Rosensweig *et al.* (1962), Lashley's equi-potentiality proved influential for a generation of neuropsychologists such as Luria (1973). This model argued for the plasticity of the entire brain. We now recognise a modified and limited role for plasticity. The concept of cognitive remediation was first initiated explicitly with the work of Goldstein (1939) in World War I (Beach *et al.*, 1960). This model argued for two strands of remediation:

1. Promoting opportunistically recovery through retraining;
2. Seeking to match existing strengths/skills to deficits in functioning.

With progressive rather than static conditions the latter may be at our present state of knowledge the only option. This forms the second interpretation of what has taken place for this patient namely that loss of some function subsequent to a focalised deterioration has been compensated for with the utilisation of an over learnt skill from his professional life. (However, photographic cue-cards may also have been used to mark the route.)

Applications for dementia

Whilst unfortunately many forms of dementia carry more global cognitive consequences there are patterns or clusters of deficits that are typically associated with different forms of dementia particularly in the early stages. It may prove useful for clinicians to catalogue through professional journals successful attempts to match disparate skills to compensate for lost function to aid us, as clinicians, in providing a rehabilitation agenda not simply for patients with static neurological insults but progressive as well.

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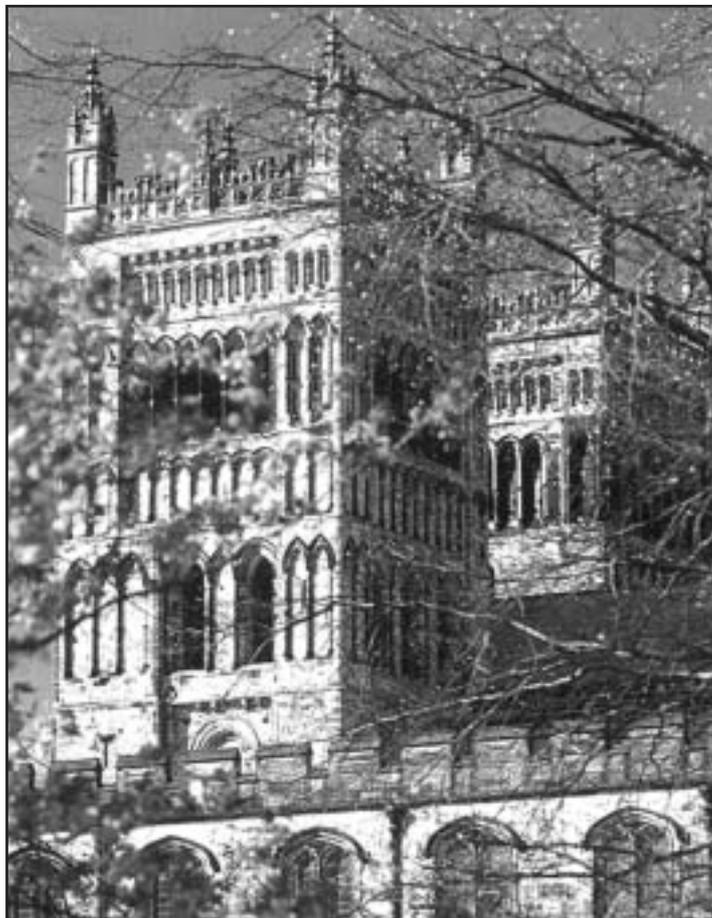
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Psychological therapy with an older adult with post-traumatic stress disorder

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THE EFFECTS OF traumatic experiences, especially in combat, have long been recognised. The two World Wars produced a variety of synonyms for traumatic stress such as, shell-shock, combat fatigue and battle neurosis. However, it was not until 1980 that the American Psychiatric Association defined a disorder called post-traumatic stress disorder (PTSD). The criteria for PTSD have been revised in subsequent versions of DSM and include:

- a. the person has witnessed, experienced, or confronted an event that included actual or threatened death, major injury or threat to physical integrity of oneself or another **and** the person's emotional response involved feelings of intense anxiety, helplessness, or horror;
- b. the event is persistently **re-experienced** through recurrent recollections, dreams, flashbacks, or cues that resemble some aspect of the trauma;
- c. persistent **avoidance** of cues associated with the trauma and numbing of general responsiveness;
- d. persistent symptoms of **hyperarousal**, e.g. difficulty falling or staying asleep, exaggerated startle response;
- e. symptoms should have lasted at least one month.

Averill and Beck (2000) provide an excellent review of existing research and special concerns involved in understanding PTSD in older adults. In summary, PTSD does occur in older adults and can be diagnosed using DSM criteria which were derived from studies of younger people. Prevalence rates vary according to the population sampled: among World War II and Korean veterans prevalence rates range from three per cent to 56 per cent (Spiro, Schnurr & Aldwin, 1994; Op den Velde *et al.*, 1993), prevalence rates of PTSD for former prisoners of war (POWS) are even higher at a lifetime prevalence of 67 per cent (Kluznik *et al.*, 1986), studies investigating the prevalence of PTSD in Holocaust survivors have found rates around 57 per cent (Yehuda *et al.*, 1995), studies of individuals who

have experienced trauma in later life such as natural disasters suggest that older people had similar rates of PTSD when compared with younger people who had experienced the same disaster.

Whilst DSM criteria can be used to diagnose PTSD in older adults the literature suggests that the symptom profiles in older adults may be different in some respects. Most older adults who were traumatised earlier in their life report an episodic course, with symptom exacerbations and remissions over time (e.g. Hyers *et al.*, 1995). Hyers *et al.* (1995) found that the most salient PTSD symptoms in older adults were distress when exposed to trauma-related events and diminished interest in usual activities. This finding is supported by other studies (e.g. McFarlane, 1990), suggesting that older adults with PTSD may be prone to symptom exacerbation when faced with trauma-related triggers. Averill and Beck (2000) suggest that this particular symptom pattern may influence other features of PTSD in older adults, such as avoidance and emotional numbing which may lead to misdiagnosis.

Another interesting feature of PTSD in older adults is that of delayed onset PTSD where symptoms begin many years after trauma exposure. A number of theories have been suggested to explain delayed onset PTSD including: life stresses associated with ageing (retirement, physical ill health); exposure to events that resemble the initial trauma developmental task of old age to reflect on earlier events and find meaning; or perhaps delayed onset PTSD more accurately reflect delayed help seeking.

Case Study

Traumatic event

Mr S is a 66-year-old married man with no children. In 1954 during national service with the RAF he was a participant in an experiment about the effects of a nerve gas on humans. He was offered a 48-hour pass to participate but was not fully informed about the nature of the experiment. The experiment involved a number

of military personnel from different units being shut into a darkened chamber. Gas was then released into the chamber and participants were ordered to remove their gas masks and run around the chamber for several minutes. Eventually, the doors were opened and the participants collapsed on the ground outside where they lay whilst officers walked around recording their symptoms. Mr S recalls great difficulty breathing, extreme pain in his head and eyes, and green fluid coming out of his nose and mouth. He believed that he was going to die. He is convinced that a number of participants died as a result of this experiment but has been unable to obtain any information from the Ministry of Defence. In particular, he believes that a young WAF who collapsed near to him died. Following the experiment he was sent back to his billet and put on light duties. Mr S reports that his whole outlook and personality changed after the experiment and he has been on tranquillisers and antidepressants for the past 40 years.

Relevant history

Mr S was five years old when his father went to fight in World War II and Mr S did not recognise him when he returned six years later. Mr S senior was involved in a lot of heavy active service and Mr S recalls hearing his father shout out in his sleep that the Germans were invading.

Mr S had a heart attack in 1992 and the care he received at that time evoked similar feelings to the gas experiment of being abandoned by those who are supposed to look after you.

Current problems

Mr S reported frequent intrusive thoughts and images relating to the gas experiment, the most frequent of which was seeing the WAF lying in front of him. These intrusive thoughts and images could be triggered by a variety of triggers including, news items relating to military experiments, pictures of the Holocaust gas chambers, or seeing a young blond-haired woman. He also had frequent nightmares which usually contained themes of being trapped and unable to escape from

situations. Mr S was acutely concerned about his own and others safety to the extent that he checked his gas cooker several times before going to bed and giving directions to strangers caused him great anxiety as he felt responsible for any harm that may befall them.

Mr S reported that he felt depressed, always looked at the negative side of things and always felt that things were going to go wrong. He said that he felt uncomfortable in social situations and as a consequence tended to avoid people. Mr S felt guilty for having survived the experiment and felt that he is being punished because he should have done more to help the WAF. He consumed a glass of whisky a night in an effort to gain some relief from his symptoms.

It was only following his heart attack that Mr S told anyone about the gas experiment and at the point when he presented to clinical psychology no-one in his family knew about it. He told his GP who put him in touch with the War Pensions Office (his application is still pending) and referred him to the Community Mental Health Team. He was taking 75mg of Venlafaxine daily.

He completed the Impact of Events Scale – Revised (Weiss & Marmar, 1995) and the Brief Symptom Inventory (Derogatis, 1993). His scores are shown in Table I.

Therapeutic model

The choice of therapeutic model was primarily informed by two sources: ‘Counselling for Post-Traumatic Stress Disorder’ (Scott & Stradling, 1992) and ‘Understanding and Treating the Long-Term Consequences of War Trauma’ (Robbins, 1997). Scott and Stradling (1992) adopt a cognitive behavioural approach and describe strategies for dealing with the symptoms of PTSD such as, containment, desensitisation to the trauma and avoided situations, and cognitive restructuring. The authors provide numerous case examples which are a useful general introduction to this type of work. Unfortunately, all the examples given are of young people and those with ‘chronic’ PTSD do not appear to have been suffering for much longer than six months.

Table 1: Impact of Events Scale – Revised (IES-R) and Brief Symptom Inventory (BSI) scores at Assessment, Discharge and Follow-up.

	<i>Assessment</i>	<i>Discharge</i>	<i>Follow-up</i>
IES-R			
Avoidance	3	3.25	3
Intrusion	3.4	3	3
Hyperarousal	3.1	3.28	2.7
BSI			
Global Severity Index	2.4	2.2	2.2
Positive Symptom Total	48	51	51
Positive Symptom Distress Index	2.6	2.3	2.3

The model adopted by Robbins (1997) was based on the literature on helping Holocaust survivors and on his experience of working with World War II veterans and felt more relevant to working with an older man who had experienced his trauma over 40 years previously. Robbins states that his model is based on principles embodied in debriefing methods, constructing a trauma story, and cognitive behavioural approaches. Treatment consists of four phases:

1. Disclosure of events. Detailed construction of the trauma story carried out in two phases. Initially an overall picture of what happened is obtained followed by a more detailed review of events.
2. Exploration of cognitions and emotions associated with events. Themes relevant to the individual are identified and the link between past events and current thoughts and feelings is established.
3. Behavioural change. Behaviours arising from cognitions and emotions, and the coping strategies used are explored. The potential for change in these areas is explored and implemented.
4. Termination. Issues in this phase include the sense of loss that ending treatment brings, and future contact and follow-up.

Treatment

Mr S was seen for a total of 18 sessions over a period of 10 months. Treatment focused on Mr S constructing his trauma story, which he eventually tape recorded, and enabling him to process the emotional impact of the trauma and reduce his use of emotional numbing and avoidance. An important aspect to the work was providing Mr S with a psychological model and formulation through which he could make sense of his symptoms.

Outcome and discussion

Initially, Mr S was very detached from his traumatic experience. If he spoke about it at all it was in the third person and large proportions of the initial sessions were spent with Mr S producing various scientific documents from the carrier bag he brought with him and discussing the neurological effects of the gas in great detail. As treatment progressed he stopped bringing his bag of documents and was able to recount his trauma story for the first time and was able to begin to talk about his feelings. At a behavioural level he began to increase his activities and hobbies (although he remained a 'loner'), he stopped needing to drink whisky to gain relief from his symptoms, and he began to take more care of himself generally. He maintained these changes at follow-up appointments.

Mr S reported that being able to recount his trauma story and being given a framework for understanding his current problems and symptoms were the most helpful aspects of treatment for him. However, despite these gains, Mr S continued to report significant post-traumatic symptoms and high levels of general

psychological distress. His scores on the IES-R and BSI (see Table 1) confirmed this subjective report.

McFarlane (1990) suggests that older adults with PTSD may be prone to symptom exacerbation when faced with trauma-related triggers. Throughout his treatment Mr S was involved in discussions with the Department of Social Security about his war pension, and with an ongoing police investigation into similar events that took place at a number of military sites. Inevitably, this required Mr S to endlessly recount the factual details of his experience without feeling that he was achieving any sense of progress or gain.

Whilst Mr S clearly gained some benefit from therapy, at least subjectively, there was little change in levels of psychological distress reported on outcome measures. 'The process of writing this case study has led me to reflect that perhaps the goals and aims of therapy with older adults who experienced their traumatic event decades ago may be different to the therapy goals surrounding a recently experienced traumatic event. Is a more realistic aim of therapy to provide a framework for the individual to understand their PTSD symptoms, to facilitate some behavioural change, and to reduce symptoms to some degree rather than to completely resolve them? In addition, does there come a point when the traumatic experience and resulting symptoms become so integrated into the individual's identity and sense of self that one would feel lost or 'miss' the symptoms if they were no longer present? Are there individuals for whom the prospect of creating a new symptom-free self and life is simply too threatening psychologically? 'these ideas do not appear to have been addressed in the literature and would be an interesting avenue for future research.

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Brief Strategic Therapy for older adults with anxiety

Michael Church & Sarah Watts

South Warwickshire Primary Care Trust



The need for alternative psychological therapies in the treatment of older adults with anxiety disorders is suggested by the significant proportion of non-responders to Cognitive-Behavioural Therapy, and the lack of other therapeutic options. A new formulation of Brief Strategic Therapy incorporating advances in the psychobiology of anxiety provides one such promising treatment option. The applicability of Brief Strategic Therapy to older people and adaptations necessary are discussed and illustrated.

ANXIETY IS A major problem in later life, with anxiety disorders more prevalent than depression among people over the age of 65 years. Yet despite this, relatively less attention has been paid to this subject in the growing literature on the application of psychological treatments and psychotherapy to older adults. Moreover, the preponderance of treatment studies described are based a single treatment model – Cognitive-Behavioural Therapy (CBT).

Although preliminary evidence clearly supports the value of CBT in the treatment of a variety of anxiety disorders including GAD, (Stanley *et al.*, 2003; Mohlman *et al.*, 2003) panic attack, agoraphobia and social phobia (King & Barrowclough, 1991; Barrowclough *et al.*, 2001) and obsessive compulsive disorder (Carmin, Pollard & Ownby, 1998; Carmin & Wiegartz, 2000) there is a very real danger of premature closure in the search for additional effective treatments for older adults, not least, because of the 30 to 50 per cent of non-responders found in such studies. The purpose of this article is to introduce an additional approach – Brief Strategic Therapy (BST) – that has potential in the treatment of older adults with anxiety disorders. The article will briefly outline the historical development and rationale of BST, suggest what adaptations need to be made in its practice with older adults, and provide illustrative case examples.

Brief Strategic Therapy

Historical development and rationale

Brief Strategic Therapy was originally developed by Fisch, Weakland, Watzlawick and colleagues at Palo Alto and was based on identifying and short-circuiting ironic process – the repeated problem-solving efforts

used by patients (and/or others) that maintained or exacerbated their problems. The resulting interventions were viewed as strategic in that the aim was to shift the existing psychological homeostasis to become more adaptive, with a reduction in patients' symptoms. In common with other systemic therapies, BST provided a range of interventions for tackling patient non-compliance including reframing, restraining, and paradox (Rosenthal & Bergman, 1986). The validity of such interventions is supported by the variety of research findings demonstrating that attempts to control anxiety can actually exacerbate anxiety (Ascher & Schotte, 1999; Koster *et al.*, 2003).

Over the past 12 years or so, practitioners at the BST Institute, London, have extended the Palo Alto model, incorporating an integrative model of mind/brain/body (Rossi, 1993). Their distinctive formulation of BST draws upon a core concept in the psychobiology of anxiety – State Dependent Memory and Learning, SDML (sometimes called mood dependent memory) – not considered within current models of CBT. Briefly, SDML refers to the process by which memories encoded during a particular physiological state, such as an elevated level of anxiety, become associated with that state. Once SDML is present, the reproduction of the same physiological state during any subsequent experience, *even if this experience is completely unrelated*, can precipitate the re-accessing of the original memory. In the case of anxiety, this re-accessing can lead to a sudden amplification of anxiety for the individual. For example, the raised level of arousal generated by an aged war veteran's arguments with a family member resulting in the re-accessing of the SDML from his war experiences, with a consequent panic attack. In this manner, SDML can

be an important and often covert driver in the generation and maintenance of anxiety states.

The mechanism of SDML is central to the view taken in BST, that affective re-appraisal has a key role in the treatment of anxiety disorders, a role largely neglected in mainstream CBT (which focuses on cognitive re-appraisal). However, in a broader context it might be noted that mindfulness-based cognitive therapy (a recent development in CBT) has incorporated SDML and affective appraisal (MCBT theorists use the term 'differential activation') as an important mechanism underlying depression relapse and recurrence (Williams, 2004). In differential activation, lowering of mood in individuals who have suffered one or more episodes of depression, results in accessing or 'activation' of negative thinking biases not accessible when these individuals are in a normal mood state, i.e. their negative self-referent thinking is state or mood dependent (Myers, 1995).

BST is carried out in three phases, and with older people the duration is typically three to six sessions (although with lifelong enduring anxiety states it may be need to be extended) (Godsall, Emerson & Dupe, 2000). In the first phase, an assessment is made of the pattern of anxiety, its development and current maintaining system. Bio-psycho education is carried out, the patient's symptoms are positively connotated, and a realistic goal for treatment is clarified. The second phase involves accessing and re-synthesis of the patient's SDML. A wide variety of re-synthesis techniques are available that can be adjusted according to the particular patient presentation. In the final phase, the gains made by the patient are consolidated and linked to the future to promote further effective problem solving once therapy has ended. A central strand running through the three phases is the utilisation of the patient's symptoms as a means of creating positive change, within sessions and as homework.

Adapting brief strategic therapy to the treatment of older adults

Cognitive change in normal ageing

There is some evidence that the effects of normal ageing on cognition may have a differential impact on therapy, depending on the approach adopted (Doubleday, King & Papegeorgiou, 2002), and a pilot investigation indicating the added benefit of enhanced CBT for older adults suggests this issue may have implications for practice (Mohlman et al., 2003; Stanley, Diefenback & Hopko, 2004).

It is the experience of the authors that BST is well suited to older adults as it makes less complex cognitive demands than most other therapies. One important contrast with CBT is the clinical observation that the emotional change resulting from re-synthesis used in BST commonly leads to behavioural and cognitive change, *without* the need for overt identification and challenging of negative automatic thoughts (i.e. cognitive re-appraisal and behaviour change *follows* emotional

reappraisal). This limits the necessity for the patient to learn new skills. In addition, much of the education and influence is implicit and covert (e.g. reframing and the use of hypnotic language), and homework prescriptions or assignments tend to be brief and uncomplicated.

Neuropsychological impairment

A significant proportion of older adults will develop cognitive impairment as a result of brain disease. As a consequence, it can be argued that sensitive cognitive screening tools (e.g. 6-CIT) should be routinely used, and brief neuropsychological screening should be considered before commencing therapy (Brooke & Bullock, 1999). There are two reasons for this.

Firstly, specific neuropsychological deficits can be misdiagnosed. One illustration of this is dysexecutive syndrome, which can result in a variety of patterns of behaviour that mimic anxiety disorder (and indeed depression). For example, a rigid pattern of repetitive behaviour with distress at changing the immediate physical and personal environment diagnosed as OCD, or withdrawal from social contact and reluctance to go out diagnosed as agoraphobia.

Secondly, the frequently gradual appearance of such cognitive change, and the lack of sensitivity of most traditional short diagnostic psychiatric tests to particular neuropsychological impairments such as dyspraxia or dysexecutive syndrome mean that such co-morbidity may go unrecognised in anxiety disorders. This issue is important because anxiety must not be viewed simply as a pathological state. From an evolutionary perspective, mild to moderate anxiety protects the individual by producing avoidance of, and withdrawal from activities that might be dangerous, hence counterbalancing the risks of unfettered exploration of the environment.

Consider the older adult experiencing falls who becomes anxious about walking. Although the patient may be fully orientated, neuropsychological screening may reveal a significant degree of dyspraxia combined with a developing dysexecutive syndrome (a common pattern in Vascular Dementia (O'Brian *et al.*, 2003)). Here the anxiety can be seen as preventing further falls, and no attempt at treatment should be made until it can be decided, 'what is a realistic level of mobility, in what environment, with what aids and/or adaptations'. Only then can the proper intervention approach and goals for treatment be decided upon, which may or may not include BST.

Detection of trauma and treatment compliance

It is not uncommon to be asked to provide therapy for older adults who have many years or a lifelong presentation of anxiety disorder. In such cases there is the real possibility of the avoidance of talking about traumatic experiences (Hilton, 1997). The specific focus of BST on identifying SDML suggests it is well adapted to detecting older people with trauma and the underlying SDML that might otherwise be missed.

Related to this, a lifelong a pattern of treatment failure may indicate reluctance or inability to tolerate the direct accessing of anxiety. Indeed, in particular anxiety disorders such as PTSD it has been observed that treatment compliance decreases with the passage of time from the date of the traumatic event (Burstein, 1986). Unlike most other therapies, BST provides a range of different techniques for allowing the processing of SDML without direct accessing to the original events. These include the use of symbolic transformation and the covert utilisation of re-synthesis techniques.

Adequate and stable care system

The physical changes that occur with ageing, which may be gradual or sudden (when acute illness or disability strikes), increase older adults’ dependency on the environment. The efficacy of BST depends on the presence of a stable system of care that adequately meets the medical condition, particular level of dependency and needs of the older adult. For example, failure to provide, or removal of appropriate community care supporting personal activities of daily living is likely to trigger a further episode of acute anxiety, however effective the treatment intervention. As a consequence, for BST to be effective with older adults, it may need to be supported by interdisciplinary and inter-agency working.

Case examples

Two case examples illustrate the use of BST in treating older patients, the second indicating the applicability of BST with patients who have failed alternative treatments and show features of non-compliance.

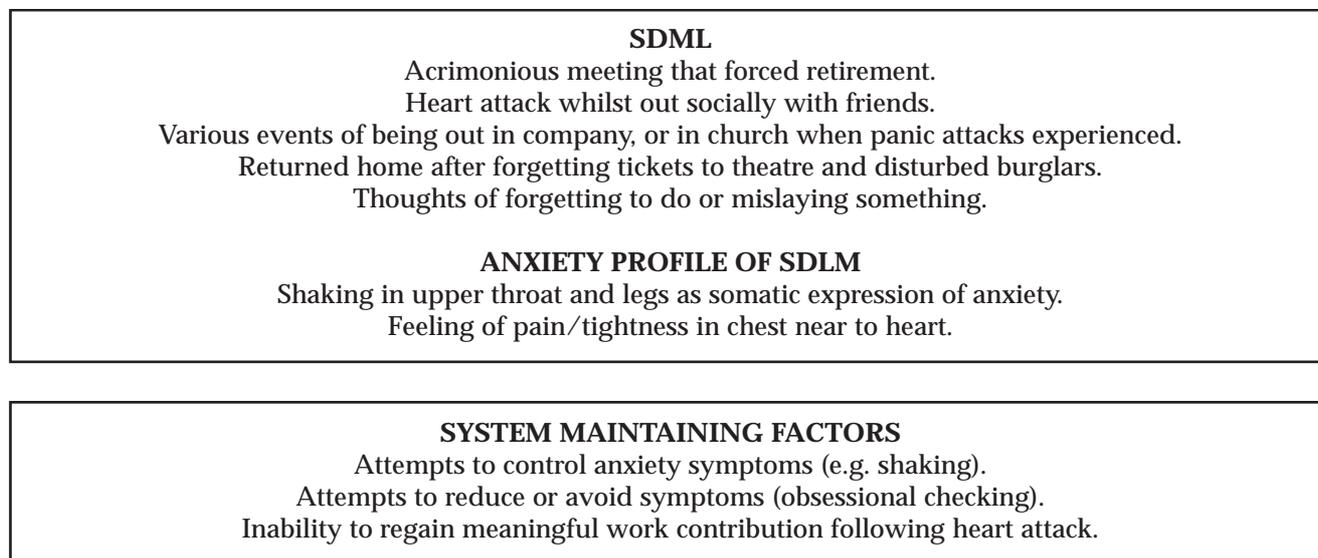
Case 1: Patient with OCD and panic disorder

Mr. A is a retired 71-year-old vicar who was referred for help with his checking behaviour, panic attacks, and low mood. Over the previous four months his mood had made some improvement with antidepressant treatment (Sertraline 200mg). However, in spite of the reduction of his marked agitation, he reported that checking behaviour (two to three hours per episode) and panic attacks had only reduced by 10 per cent and continued to interfere with his home life and attempts to actively engage himself in voluntary ministry activities at his local church. A BST-based conceptualisation of his anxiety problems is shown in Figure 1 below.

A six-session contract was set-up, and following bio-psycho education it was agreed that the initial focus of treatment would be his obsessional thoughts and feelings. Access to the SDML produced a rating of 9 SUD (units of distress 0 to 10 scale) with severe shaking of legs. This motor expression of his SDML was positively connotated ‘that’s excellent, it’s very important that you let out your feelings’ with a paradoxical injunction to ‘increase the shaking as much as you can’, and a symptom overload technique was used for re-synthesis. Over 20 minutes his leg shaking diminished and he became calm (SUD 2), and he spontaneously developed the goal that he would smile more in the next week. Mr A was able to utilise the symptom overload technique over the following week to good effect (he was given the explanation that he needed ‘to let these important feelings run their course’, without preventing them by checking).

Subsequent re-synthesis focused on situations where he suffered panics (e.g. entering church) and it was noted that his feeling of fear were centred in his

Figure 1: Conceptualisation of case of Mr A.



chest near his heart. Sensory tapping techniques were also used to process his experiences of being acrimoniously forced to retire from his hospital ministry, which resulted in the expression and resolution of considerable anger at the way he had been treated.

Since attempts to keep his symptoms under control appeared to be a central ironic process perpetuating his anxiety symptoms, a three-stage homework protocol for the paradoxical treatment of his panic attacks was adopted. By the final two sessions, he had discontinued his Valium, and was unable to bring on his panic attacks on entering church (successfully giving his first sermon for many months). Interestingly, he reported ‘forgetting’ to carry out the prescription (which was positively connotated as a sign of further improvement). It was noted that the negative automatic thoughts (e.g. ‘I’m unimportant... I’m not working’) prominent in the early sessions were never directly tackled, but dissipated *following* the positive emotional changes secured using BST. Mr A remained free from symptoms at one-year follow-up maintained on 150mg of Sertraline.

Case 2: Non-compliant patient with anxiety

Mr B is a retired lorry driver who was referred following a hip operation. Immediately after surgery, Mr B experienced an acute confusional state in which he believed that nursing staff were threatening him. He believed that when he left hospital, they would follow him and attack him. Six months after discharge, he remained terrified to leave his house alone in case this happened. Mr B was a widower and had no family, so being able to go out was vital for him both practically and socially. Mr B refused to take medica-

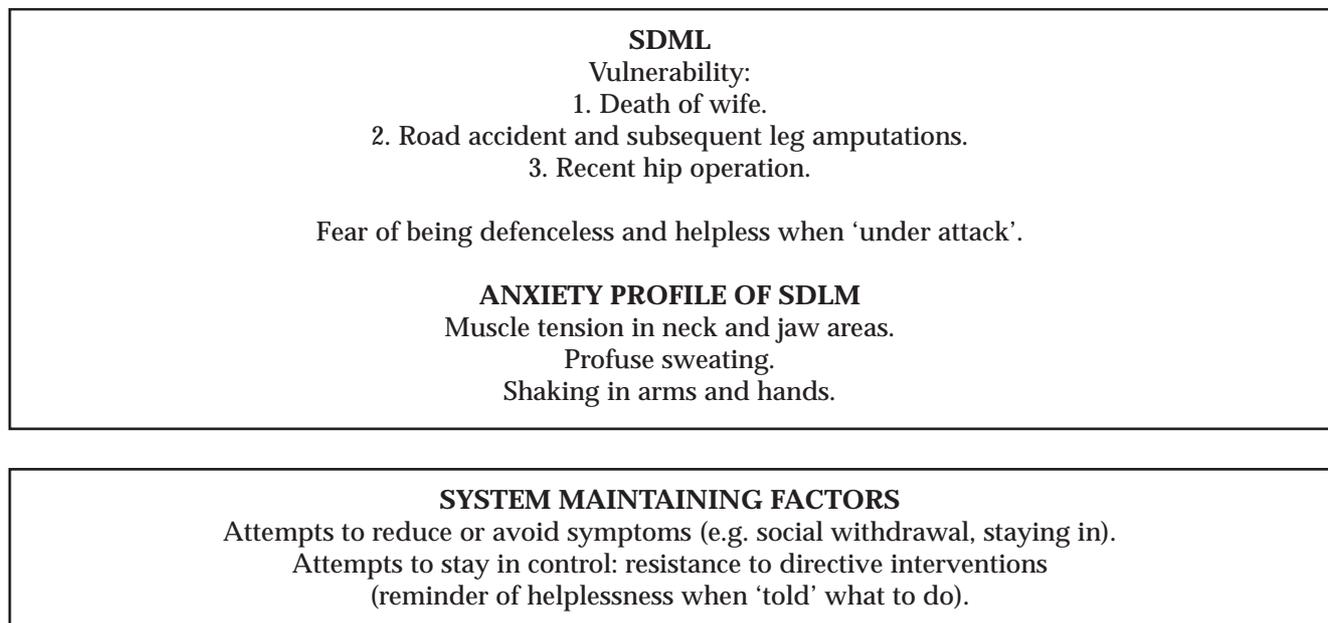
tion as he felt he was not anxious, but justly concerned. Previous interventions had concentrated on the use of in vivo graduated exposure to going outside, but this had not been successful.

At the outset Mr B stated that although he wanted to go out, nothing would convince him to try, as it was too dangerous. He stated that he did not see how therapy could help him. This resistance was used constructively by telling Mr B that his intuition was probably correct: it would be unlikely that therapy could help. Furthermore, he was told that under no circumstances should he attempt to go out, as this would undoubtedly make things worse (a restraining approach). Mr B appeared rather taken aback by this discussion, and by the end of the initial interview decided that he would continue to attend, as he had ‘nothing to lose’.

A six-session contract was established, with the aim of treatment being to enable Mr B to go out when he wished. Access to the SDML produced a rating of 10 SUD (subjective units of distress, scale of 0 to 10) with muscle tension, jaw clenching and a feeling of intense fear. This response was positively connotated by discussing how Mr B was beginning to gain control of the feelings of anxiety as he could bring them on voluntarily. As homework, he was asked to spend fifteen minutes each day focussing on the anxiety to see what came to mind. Mr B reported a rating of 10 SUD every day, which was positively connotated as gaining further control and being able to ‘bring on’ the symptoms at will.

Two approaches to re-synthesis were used. The first, scales polarity (an indirect ideomotor technique) involved balancing the main weight or burden in his

Figure 2: Conceptualisation of case of Mr B.



life, identified as a fear of being attacked, with an opposite feeling, which he chose to represent by his affection for his late wife. Following re-synthesis of the SDML, he talked about how vulnerable he had felt since his wife's death. He also revealed that some years ago, he had had bilateral below-knee amputations after an accident in his lorry, which had also left him feeling defenceless. Two days after this session, Mr B spontaneously walked to the shops alone. Again, restraint was used; Mr B was told that it was too soon for him to go out and that he should stay in for the next few weeks until therapy was finished.

A second re-synthesis technique – colour polarity – involved re-experiencing his somatic symptoms of anxiety as a colour (he chose dark green for his muscle tension) and experiencing this with a colour representing the opposite feelings (he chose pale yellow which he later revealed was the colour of his late wife's favourite roses). Interestingly, after the exercise Mr B eventually realised that his car was dark green, and that he depended on his car for going out. Following this session, Mr B decided to go for a meal with his friends and drove himself there. He told them for the first time of the difficulties he had been experiencing and they were very supportive of him.

By the final session, Mr B reported that he was going out freely. It was noted that Mr B's beliefs were never challenged during the therapy and the use of restraining techniques meant that the resistance was harnessed and used constructively. At the same time, the emotional processing enabled by the re-synthesis approaches used led to cognitive change, so that he was able to acknowledge how vulnerable he really felt and realised it was not a sign of weakness to ask for help. Mr B remains symptom free and continues to go out when he wishes to six months after discharge.

Summary

Many older adults experience anxiety in later life. Bearing in mind the high numbers of older adults not responding to treatment in the small number of treatment studies published, it is vital to develop new approaches that can address the needs of this patient group. We suggest that Brief Strategic Therapy is one such treatment approach. BST is founded on an integrative model of mind/brain/body in which SDML and emotional appraisal play a central role, with treatment techniques that target emotional re-appraisal with consequent cognitive re-appraisal and behavioural change. Clinical observation indicates BST can be very effective with older adults with anxiety disorders, and has particular value with those who demonstrate resistance to therapeutic input, or who have been unresponsive or non-compliant with other forms of treatment.

The relatively recent development of this distinctive formulation of BST and small number of practitioners trained in BST, have contributed to the lack of outcome research and to the very limited the access of

older patients to this approach. Clearly, there is an urgent need to test the validity of the clinical observations of the value of BST through proper outcome research. We hope that this overview of BST helps to stimulate the interest and research necessary to enable the further development of this treatment option for older adults suffering from anxiety.

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Glossary of BST techniques mentioned in this paper

Paradoxical injunction – Asking the patient to produce/increase the problem/symptom that he or she is avoiding or trying to eliminate.

Positive connotation – Providing a positive explanation for a symptom or other experience that the patient views negatively.

Reframing – Altering the patient's conceptual and/or emotional viewpoint in relation to a set of experiences, providing a different meaning (usually positive e.g. positive connotation) that fits the facts equally as well or even better.

Restraining – Encouraging the patient to go slow in meeting his or her treatment goals

Colour polarity – A symbolic processing technique using colour as symbols for feelings of anxiety and opposite state (calm), enabling change through the simultaneous experience of opposite colours (and hence feelings).

Scales polarity – A symbolic processing technique using automatic (ideomotor) movements to process SDML. The exercise uses right and left arms/hands weighing scales, experiencing 'the problem' as weighing down one hand, and then an experience representing the opposite feeling in the other hand. The patient is encouraged to allow a natural balancing between the two opposing sides feelings.

Sensory tapping – Enabling the processing of SDML through providing sensory input in the form of tapping parts of the body (e.g. palms of hands) while accessing SDML.

Symptom overload – Enabling the processing of SDML by paying attention simultaneously to the accessed SDML and a range of different body sensations.

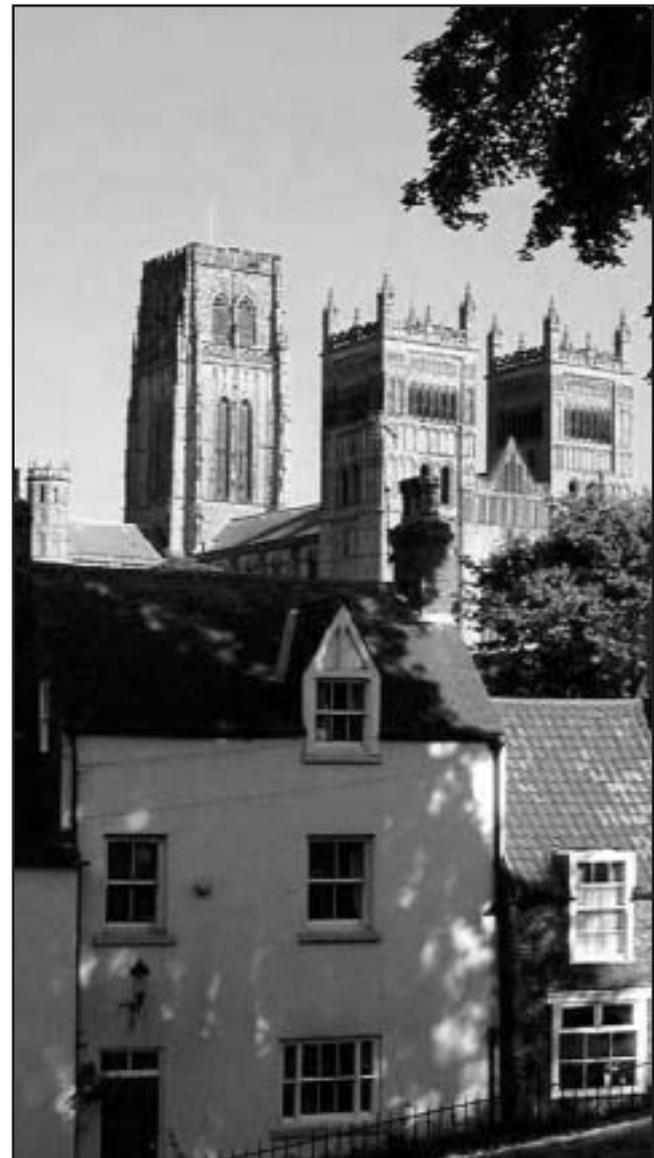
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Absence, loss and misappropriation

A bereavement counsellor's reflection on some of the themes older people bring to therapy

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Bereavement and loss have a significant impact on health of older people, and are often part of the emotional distress that brings them to seek help from a therapist. This personal reflection, from an integrative perspective, considers three themes of absence, loss and misappropriation in relation to theories of bereavement and grief, and the practice of therapy with older people.

*'And now in age I bud again,
After so many deaths I live and write;
I once more smell the dew and rain,
And relish versing: O my onely Light,
It cannot be
That I am he
On whom Thy tempests fell all night'*
(Herbert, 1633, p.248).

THE EXPERIENCE OF loss is an inevitable and painful part of the human life cycle. Something of this universality is evident in George Herbert's poem, which despite being almost four centuries old is still a pertinent statement of recovery or respite from feelings of sadness and grief. Those of us who are old, and/or who work with older people, will be only too well aware of how coping with loss is an important component of physical, psychological and social well-being (Horowitz, 1995; Orbach, 1996; Charlton, 1999; Rees, 2001; Richards, 2001). Without overemphasising the negative aspects of later life, nor discounting older people's capacity to be healthy and happy, bereavement and loss are undoubtedly significant public health issues (Murray Parkes, 1998; Charlton, 1999; BPS, 2002; APA, 2004b).

Traditional theories of bereavement, loss and grief have their origins in medical and psychoanalytic models (Holmes, 1993; Humphrey & Zimpfer, 1998; Murray Parkes, 1998; Payne, Horn & Relf, 1999). The medical model sees grief as a temporary, but disease-like set of symptoms, and psychoanalysis holds that reaction to loss is grounded in early attachment experiences. Challenges to, and extensions of, these models come from constructionist, narrative, systemic,

sociological and multicultural paradigms (Ingram, Hunt & Robson, 2000; Neimeyer, 2001; Rees, 2001; Kellehear, 2002; Stroebe, Stroebe & Henk, 2003).

I work as a bereavement counsellor in a service funded by an urban Health Action Zone for people aged over 50 years. My training and therapeutic practice are integrative, and from this perspective, I hope this article provides a worthwhile exploration of the complex experience of loss for older people, across intrapersonal, interpersonal and cultural levels, and the considerations that arise for the practice of therapy. The article is informed both by the literature and the themes raised by many older clients in counselling, but makes no pretence of being scientific. It is a personal reflection, and its wider value, if any, lies in the resonance it may have for you, the reader, so I very much invite your comments.

Absence, loss and misappropriation

The majority of older people have sufficient personal resilience and resources to cope with the losses associated with later life. For some however the nature or number of losses and pre-existing vulnerability can mean that the experience of loss is distressing and debilitating, and these are the people for whom an intervention such as counselling may be useful (Murray Parkes, 1998; BPS, 2002; APA, 2004b). Those older people referred by professionals, or who self-refer to the service in which I work describe their experiences in terms of three broad themes that also arise in the literature:

- **Absence** – that which was never there;
- **Loss** – that which is going or gone;
- **Misappropriation** – that which has been taken away.

Absence – that which was never there

*'Quite underground; as flowers depart
To see their mother-root, when they have blown'*
(Herbert, 1633, p.247).

I often find that older people who are struggling to cope with recent bereavement also experienced significant losses or absences in childhood. Psychoanalytic and attachment theories of grief and loss begin with 'cathexis', or the emotional bonds made with carers in early life. Those people who have had secure attachments in childhood go on to make close relationships in adulthood and when bereaved can express their sorrow and achieve 'decathexis', or the letting go of attachments to those who have died (Holmes, 1993; Payne *et al.*, 1999). However, for those with insecure or ambivalent attachment patterns, for whom consistent care was absent, loss in later life can be problematic, resulting in inhibited or chronic grief, or depression. From this viewpoint, the aim of therapy is to encourage mourning and catharsis as a means to disengage from who or what has been lost (Orbach, 1996; Humphrey & Zimpfer, 1998; Kellehear, 2002).

Psychotherapists writing about therapy with those who have experienced abuse in childhood, or traumatic events such as violent crime, war, disaster or forced migration, employ a synthesis of attachment and trauma theory in their efforts to provide effective interventions. They say how their clients report the re-emergence of early absence, loss and trauma in later life following bereavement or other difficult events. Prior breaches, or lack of protective childhood attachments seem to leave a person more vulnerable. Therapy in this instance can be a journey where the therapist helps the client find a meaningful path through their experiences, even though some may be too horrific to revisit (Hunt, 1997; Bloom, 2000). Walker (1999) remarks how trauma can be transgenerational in its effect, causing disturbance in relationships with children and grandchildren, and the role of therapy is to provide space for the expression of loss and trauma, to prevent its unconscious transmission between parent and child.

Whilst the focus of psychoanalytic and attachment theory remains on the intrapersonal realm, older people and those who write about them speak of other kinds of absences that can be deleterious to mental health. Those who are frail can find themselves with diminishing, or little access to, social and support networks, compounded by the challenges of rural and urban geography and demography (though this may alter as the newest cohort of older people is organising for change) (Craig, 1998; APA, 2004b). With isolation in mind, the location of therapy is an important consideration, and ideally services are easy to access and operate in partnership with other providers. An article about the impact of physical touch on health suggests that it may be absent for older people living in care homes, hospices and the like, and that the popularity of hairdressing, pet animals, and 'hands on' complemen-

tary therapies warrants further study of their compensation for deficits in touching (Turp, 2000). I have wondered if the number of older clients who take hold of my hand in counselling sessions indicates the same need for contact.

In her book titled *Counselling, Class and Politics*, Kearney (1996) refers to absences that inhibit good outcomes for older people in therapy. She describes how inequity of class and language between client and therapist negates any notion of neutrality, and dominant ideologies of normality, disability, age and social stratification can undermine older people's sense of value and power in the therapeutic relationship. Moreover, clients and therapists do not always share a vocabulary for their feelings, thoughts and experiences. I have certainly worked with older people who learned to talk well before the advent of psychobabble, and more seriously, with those who find it difficult to articulate their feelings for reasons as disparate as infirmity, sensory impairment, cultural values, and never having been asked to do so before. This implies to me at least, that the therapist should endeavour to engage with the older client's frame of reference as fully as possible, using creative and various means of communication, but without imposing a supposedly superior 'way of talking'. Of course this assumes the older person has found a therapist at all. Old age can incur poverty, so private therapy is beyond the financial reach of many, and the amount of publicly funded psychological and therapeutic services falls short of the level of identified need in the population (BPS, 2002).

Loss – that which is going or gone

*'Who would have though my shrivell'd heart
Could have recover'd greenness? It was gone'*
(Herbert, 1633, p.247).

As you might expect, most of the clients I see as a bereavement counsellor have lost someone significant relatively recently. Many have had several friends, siblings, children or partners die within a few years of each other, leaving them at increased risk of health problems associated with loss (Murray Parkes, 1998; Charlton, 1999; Rees, 2001). Furthermore loss extends beyond bereavement for older people. Ill health and frailty can mean the loss of mobility or physical functions, and research cited by the RNIB showed older people losing their sight were more likely to report symptoms of depressive disorder than their sighted peers (Horowitz, 1995). For older people who require increasing levels of personal care, adjusting to the loss of independence can be difficult, and fear of dependency and death can make for a stark horizon (Richards, 2001). Humphrey and Zimpfer (1998) identified 'anticipatory grief' experienced by those caring for friends or relatives who have dementia or life threatening illnesses, asserting that interventions should reaffirm the individual's resourcefulness across physical, emotional, social and spiritual levels.

Grief is the human response to loss, but the slightness of the word belies little of the complexity it represents. The anatomy of grief is conceptualised in Western psychology as a process of sequential stages or cycles of intense feelings including numbness, sorrow, anger and guilt, with recovery dependent on the individual doing 'grief work' by expressing emotion at each stage until they rescind their attachment to the dead person and move on (Holmes, 1993; Murray Parkes, Relf & Couldruck, 1996; Albery, Elliot & Elliot, 1997; Payne *et al.*, 1999; Kellehear, 2002). For some the focus may be on letting go of the dead, but deatheaesis is not necessarily the only healthy outcome (Stroebe *et al.*, 2003). According to Rees' (2001) survey, up to half of widowed people reported a spontaneous and vivid 'sense of presence' by way of dreams, hallucinations, and spiritual communication, and said they were pleasant and helpful phenomena.

Definitions of normality and pathology of grief, like other features of mental health, are constructed in a social and cultural context, and contributions from historians and anthropologists among others, have revealed that grief has many meanings and manifestations (Ingram *et al.*, 2000; Neimeyer, 2001; Rees, 2001; Kellehear, 2002; Stroebe *et al.*, 2003). For instance, a shrine to the dead in the home of a bereaved person might be interpreted as quite appropriate, or as somewhat bizarre or obsessive, and definitions of problematic, delayed or chronic grief are also contingent on convention.

Many suggest that catharsis and deatheaesis are positive coping strategies for the bereaved, improved by communion with other people by way of ritual, and even the employment of 'keeners' to lead the mourning (Albery *et al.*, 1997). However, there are cultural permissions and injunctions that regulate grieving, with TV news displaying the diversity on a regular basis. Older clients respond very differently to loss, and for some a brittle tension exists between control and expression of emotion within their sense of self, and between their peers, family and community. For example, an English wartime attitude of gritting one's teeth and getting on with life can conflict with baby-boomer inclinations to let it all hang out. Punjabi culture sometimes regards talking about oneself as self-indulgent. Those living in circumstances of multiple traditions may tread a delicate path between congruence and inconsistency. Cultural disapproval can interfere with grieving in the case of ambivalent or negative relationships, when admitting a sense of relief or even gladness at the death of another is seen as bad taste.

A successful 'psychosocial transition' is said to indicate recovery from major loss, as is finding new meaning and purpose when loss shatters our assumptions about the world (Murray Parkes, 1998; Neimeyer, 2001). If, as the literature suggests, experience of and capacity to cope with loss is linked to the inner world of attachments and the outer world of

culture, then interventions surely need to be sensitive to the multifaceted meaning of loss for any individual (Ingram *et al.*, 2000; Stroebe & Henk, 2001).

Misappropriation – that which has been taken away

'Dead to the world, keep house unknown'
(Herbert, 1633, p.248).

Misappropriation is a kind of loss I hear about in the background of older clients' stories in therapy. It inhibits their ability to cope with other losses and lowers their quality of life. By 'misappropriation' I am referring to the loss of personal identity and worth that results from invisibility and discrimination in society, by no means unique to older people, but nonetheless a distressing aspect of later life. Sociologists have paid more attention to it than psychologists, and it was disregarded in the practice of therapy until quite recently (Craig, 1998; Dittmann, 2003).

I have heard it said that in technological societies the value of senior citizens declined as the printed word and silicone chip replaced human memory in oral traditions as the archive of knowledge and wisdom. Older people now face ageism in a society whose culture and media are preoccupied with a youthful consumerism that subsumes the talents and qualities of maturity. Those from minority groups can find that ageism compounds the effects of other discrimination related to ethnicity or sexual identity (Gallagher-Thompson & Thompson, 1995). Ageism traverses structural, economic and political levels wreaking collateral damage on older people's role, status and wealth as well as their sense of identity, purpose and meaning (Kearney, 1996; Craig, 1998; Gershaw, 2001; Dittmann, 2003). At its worst, ageism degrades into outright abuse of older people, and like abuse of younger people, it is most likely to occur in their own home (APA, 2004a).

Ageism, just like other forms of discrimination, permeates society, and thus the mind-sets of institutions and services, but some writers have challenged the detrimental effects of academic ageism on the health of older people in critiques of traditional psychosocial perspectives such as disengagement and activity theories (Craig, 1998; Gershaw, 2001). For older people who require institutional care, the transition can be a dehumanising experience that diminishes their dignity and sense of self. When care standards are high residents' psychological needs will be incorporated into care planning and delivery, but this is not always the case, and most of you will know how minimum pay, staffing shortages, low moral and other factors can contribute to unhappy atmospheres and practices. It is shameful that the demanding work done by the residential sector is so undervalued given that good care is fundamental to the health of those who live in it.

Psychological therapies have been developed with the intention of ameliorating the effects of ageist misappropriation, and indeed other forms of inequity and exclusion in younger age groups, by helping to restore an individual's sense of self worth by way of 'reviewed and renewed meaning' (Harris, 1999). These therapies have been influenced by ideas from psychoanalytic, systemic, narrative and cognitive therapies, and go under several names such as psychobiography, life-story work, life review, and validation therapy (Murray Parkes *et al.*, 1996; Harris, 1999). Gallagher-Thompson and Thompson (1995) remark how these therapies were initially developed for use with people with dementia, but latterly have been shown to improve self-esteem and feelings of personal power and life satisfaction. Dittmann (2003) cites research that showed those with a positive image of aging lived longer and reported a better quality of life than those with a negative image.

Universality and uniqueness, theory and practice

Bereavement and loss are universal but the process of grieving and recovery is specific to individuals within their social and cultural context, and this is reflected in the differing perspectives on absence, loss and misappropriation in the literature. Given such divergent opinion, it is interesting to note that several practitioners who report using a single model of therapy actually use techniques from several, melding gestalt or narrative approaches with their psychoanalytic, psychodynamic or attachment frameworks, and their clients find them useful and effective (Murray Parkes *et al.*, 1996; Humphrey & Zimpfer, 1998; Lofgren-Forrest, 1999). Does this then suggest that integrative approaches to bereavement care and therapy might be the most appropriate? I argue yes; because the older people I see as a counsellor concur with many writers in telling of the complex meaning of loss, and its impact across physical, intra- and interpersonal, social, philosophical and spiritual levels of experience. It would seem that some of the key tasks in grief therapy for older people are:

- Revisiting the past, reviewing life events, relationships, beliefs and values;
- Expressing sorrow and gladness in ways and proportions accorded by culture and individual need or inclination;
- Finding, restoring, and redefining the meaning and experience of absence, loss and misappropriation;
- Maintaining or initiating personal resources and networks;
- Envisioning a future and moving towards it.

Therapy for older people experiencing loss has implications for practitioners and their therapeutic relationships with clients. Firstly, it is quite likely that the therapist is much younger than their clients, and this has an impact on how client and therapist perceive each other (Richards, 2001). Secondly, therapists are

required to engage with a great amount and depth of sadness, as well as other intense feelings, and this can take its toll on energy levels as well as evoking their own experiences of loss (Orbach, 1996; Culverwell & Martin, 1999). I have occasionally come across a certain machismo amongst mental health professions in relation to the emotional demands of the work, but nonetheless I advocate sensitive and supportive supervision that not only monitors work with clients, but also nurtures practitioners as people.

But is therapy for older people experiencing bereavement and loss efficacious or cost effective? Statistics show that people consult with General Practitioners and other professionals much more frequently in the first year after major bereavement, with up to 40 per cent increase in mortality, and a considerable rise in mental health problems such as major depression, anxiety states and substance abuse (Murray Parkes, 1998; BPS, 2002). Murray Parkes (1998) concludes that whilst most people do not need bereavement counselling and do as well without it, intervention for those at high risk of distress from multiple or traumatic losses, or pre-existing vulnerability, helps give the same outcome as for people at low risk. There seems to be a genuine benefit, and reduction of health inequalities, for older people who are struggling to cope with bereavement if they can easily access supportive and therapeutic services at the primary care level (and being a little cynical, I will point out here that counsellors come a lot cheaper than psychologists).

Absence, loss and misappropriation are issues that pervade the psychological health of older people, and are not just the concern of bereavement counsellors or psychologists, as they will inevitably appear in all our lives to some extent, sooner or later. I hope that dialogue in journals such as this will continue the development of therapy that is sensitive to the complex meaning of loss for us as people and practitioners, but most importantly for the well-being of our clients.

'To make us see we are but flowers that glide'
(Herbert, 1633, p.248).

Respectfully and gratefully dedicated to the older people who have taught me so much about dying and living.

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The Memory Group

A need-led group for those affected by a diagnosis of early-stage dementia

Victoria Carek

The Calderdale Royal Hospital



THE INITIAL CONCEPTUALISATION and development of support groups for people newly diagnosed with early-stage dementia can be accredited to Robyn Yale (1989, 1995). Yale's work has been instrumental in making the transition from aiming literature and support services at the caregiver to the realisation that many people with early-stage dementia are 'willing and able to share their feelings, concerns and experiences when given the opportunity'.

Yale (1995) focuses on the abilities, skills and strengths of people with dementia and this focus on the positive is a central tenet of our memory group. 'It is important to acknowledge that people with dementia have abilities that need maximising so they can remain active participants in life' (Alzheimer's Society International, 2003).

Increasing awareness of dementia leading to earlier diagnosis and the utilisation of pharmaceutical treatments has resulted in a client group of increasing size with complex psychosocial needs. These needs were identified locally by both statutory and voluntary organisations. Parties from Psychology Services, the Day Service Unit, Dementia Advice and Support Services (DASS, Calderdale Age Concern) joined together to form a steering committee.

Summary of the Memory Group conceptualisation

The Memory Group is a time-limited support, information and activity group developed for people recently diagnosed with early-stage dementia and their guest (carer/partner/friend). The group seeks to offer those in the early-stages an opportunity to meet with others in a similar position and to attend with their guest, as opposed to services currently available locally which are offered separately for client and 'carer'. We avoid the term 'carer' as many of those attending the group do not see themselves in this role.

Other people with dementia are a vital source of support to someone else with the same diagnosis. They are the only people who truly know what the experience is like. Marshall (2003) promotes the benefit of meeting people in a similar situation, who are dealing with similar difficulties. Peer support is valuable as sharing experiences and gaining a greater understanding of living with dementia helps to reduce stigma; fears and worries can be shared openly, any embarrassment is reduced via the realisation that they are not alone, and coping strategies can be exchanged.

Marshall (1999, 2001) evaluated group therapy with older adults who had functional problems or early dementia, and found that meeting others with the same problem was stated as the most helpful aspect of the groups. Marshall (2003) discussed the importance of peer support in gaining a balance between denial of the diagnosis and being overwhelmed by it (Clare, 1999; Cheston *et al.*, in review).

Groups have the potential to aid in the identification and expression of emotions, an important element of well-being. Groups offer an opportunity to share thoughts and experiences with peers who have knowledge unique to those in a similar situation. Emotional experiences will fluctuate along the journey hindered by denial, self-blame and catastrophic thinking. The support of others who understand these experiences first hand is key to an acknowledgement and acceptance of the situation and regaining a sense of control. Having an opportunity to converse with other people affected by a diagnosis of early-stage dementia in a safe environment also illustrates how varied people's experiences can be. The Memory Group did not specify the type of dementia or whether a person was medicated when recruiting for the group.

A fundamental aim of the group was the maintenance of existing relationships, be this with a partner, relative, friend, or neighbour. The Memory Group

wanted to amalgamate the benefits of peer support for both clients and their guests. Attending together allowed an opportunity to gain insight into each other's experiences, thoughts and feelings. As well as the large collective group there were opportunities to split into two smaller groups (one for the clients and one for the guests) to allow off-loading and open expression of emotions without guilt or embarrassment. It was in these smaller groups that frustrations and concerns were discussed.

The aims of the Memory Group

- **Self steering.**
- **Support** for all members.
- To **share** coping strategies.
- **Socialisation** with others affected by a diagnosis of early-stage dementia.
- **Empowerment**, e.g. the opportunity to make decisions and lead the group when necessary.
- **Strengthen** the client-guest relationship; through education, information, learning new skills together.
- **Increase** self-esteem and **boost** self-confidence for all members.
- Share feelings, experiences and concerns in a **supportive environment**.
- If a need, health or otherwise, is recognised, the facilitators will record details (with the consent of the member) and **seek appropriate help** from services.

A previous article published in *PSIGE* by Robinson (2003, No. 82) mentioned the vicious cycle of forgetfulness (Harris, unpublished). In this cycle Harris noted that both physical factors such as tiredness and psychological factors such as anxiety affect concentration. When a client notices that they are forgetful, they might begin to have negative thoughts about this (fear, shame). They may begin to feel bad (low, negative outlook), and this leads to poor concentration and makes them less likely to remember things in the future.

In addition to this Clare (1999) noted that due to the level of insight present in early-stage dementia, clients often experience feelings of shame and embarrassment that can create further negative thoughts and feelings (psychological factors). The Memory Group provides an opportunity for members to attempt to break this vicious cycle via empowerment, support, increasing self-esteem and self-confidence, to reduce confounding factors and avoid a presentation of increased impairment. *'You don't want to appear worse than you are, you want to appear as strong as you can be'* (Client comment, Alzheimer's Association).

Yale similarly noted that the cognitive impairment in dementia is exacerbated by poor mental health causing 'excess disability'. Yale cites anecdotal evidence that stimulation, socialisation, and the support provided improve the mood and maximise the cognitive functioning of people with early-stage dementia'.

Yale further promotes the role of support groups in enhancing a sense of well-being and belonging at a time when so many other life-long roles are being lost. After diagnosis it is common for many tasks to be abandoned completely when they are still achievable, partners may become overprotective and take over many roles. Again this relates to the balance required between denial and being overwhelmed by the diagnosis. The Memory Group is outlined in this article as a model for reducing 'excess disability' by focusing on the positive and enhancing feelings of achievement and self-esteem.

The model focuses on the interactions and relationships (between clients, guests and facilitators) within the group as central, promoting the benefits gained from sharing experiences, thoughts and feelings with others in a similar situation. Support is seen to be the key product of this interaction and the driving force for achieving the group's aims of increasing self esteem and so on. Support is also achieved through the information and activities offered within the group.

Content of the Memory Group

The pattern within the memory group was typically one skill session and one discussion topic each week, planned from issues arising in the group and member requests. Handouts were created after each session to summarise and reinforce topics raised by members and these were distributed the following week. Information was collated on topics discussed and handouts were then tailor made for the group so they had ownership of the items produced, often handouts would include quotes or tips from members themselves. Information was produced on topics including; remembering names, what is memory, memory aids, dementia and coping. This is an outline of the programme that resulted from the self-steering nature of the Memory Group:

- Week 1 Introductions and ground rules.
- Week 2 Further introductions, emotions.
- Week 3 How memory works, relaxation.
- Week 4 Quiz, emotions, new skill.
- Week 5 Name game, emotions.
- Week 6 Baking, carer experiences.
- Week 7 Name game, baking, quiz.
- Week 8 Evaluation, party, info, pack.

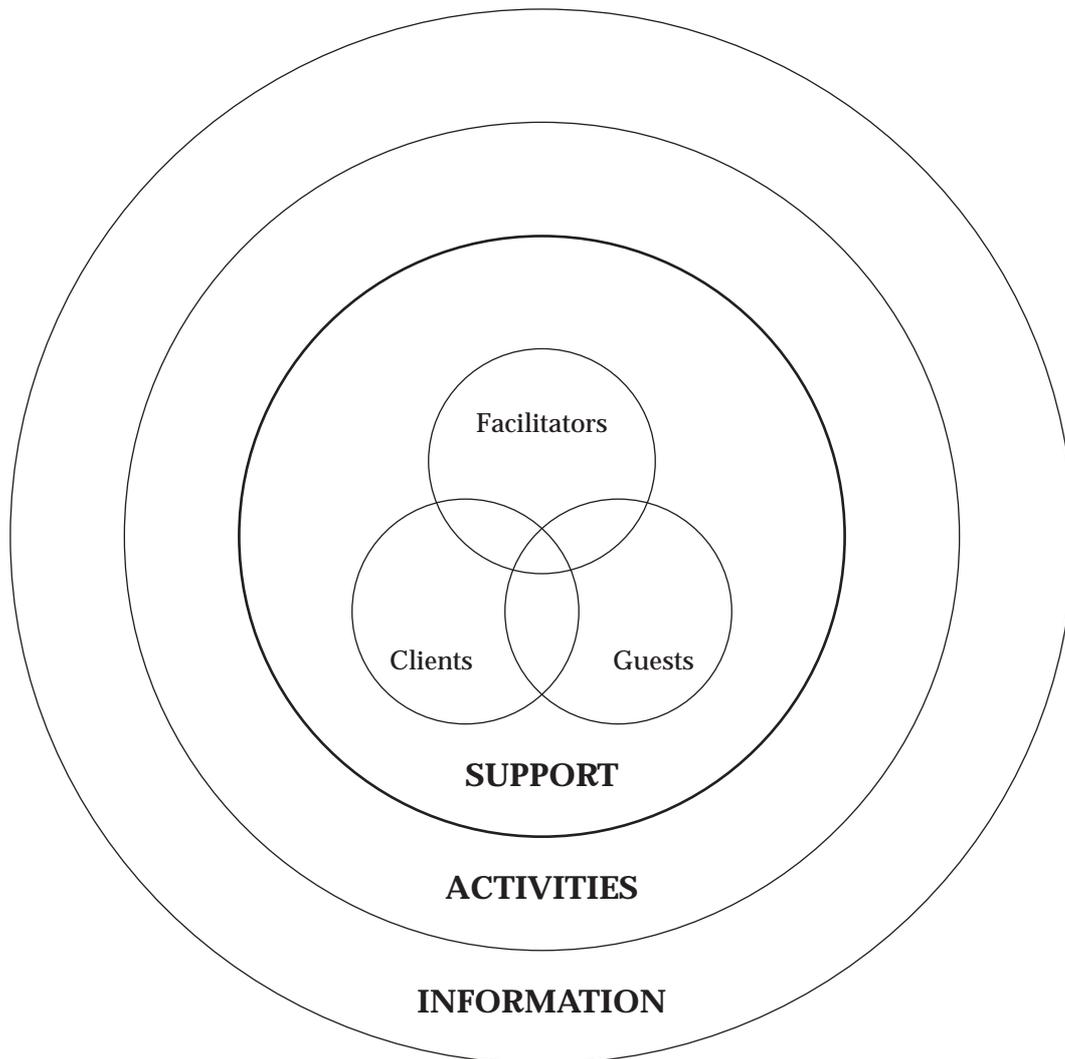
Evaluation and feedback

The group members gave informal verbal and written feedback of the Memory Group, their comments highlighted four main areas of benefit from their attendance at the group:

- **Support**

They felt that the Memory Group had been supportive, a very good innovation, most instructive and wonderful support...'. They felt that a central benefit of the group was peer support, 'It's good to

The Memory Group model – a potential route to avoiding a presentation of ‘excess disability’.



know you're not the only one... An opportunity to meet people with the same problems... Don't get a chance to talk like this anywhere else.'

● **Information**

Members of the group felt that the sessions offered an opportunity to '...share and learn about the difficulties experienced from day to day', to share coping strategies.

● **Socialisation**

They also felt that the social aspect of the group was very important, 'We have enjoyed our visits and looked forward to them each week. It is nice to have met people with the same condition that I have...'

● **Feelings and emotions**

The members reported a change in how they felt, 'We could relax and say what we wanted to, not like sometimes when you can't get out what you want' and in how they related to each other, 'We continued with

conversations at home on matters we had discussed in the group, things which may not have been talked about otherwise.'

Conclusions

There is a need for a balance between being factual, informative and supportive; giving the right amount of information for the current time, while preparing for the future. The roles of such groups in providing support and chaperoning the members through this early-stage is vital to the client's level of functioning as outlined in Harris' 'cycle of forgetting'.

Another Memory Group is due to commence shortly, feedback from the previous groups has been utilised and this group will now be based in a community venue at the local fire station and will run for ten weeks. The aims and objectives of the group remain the same as does its self-steering nature. The programme will constantly change to meet the needs of the current members.

Acknowledgements

Thank you to the group facilitators, Sarah McCormack, Caroline Marshall and Susan Ackroyd, for their contributions and continued support. Thanks also go to my supervisor David Wallace, the members of the Memory Group, and all those involved in supporting its planning and initial pilot.

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Committee members engaged in communicating issues of grave national significance!

A few days in Durham

Daniella Wickett

Assistant Psychologist, Birmingham



HAVING ATTENDED THE conference last year, I was very grateful for the opportunity to go to this year's conference in Durham. In many ways the experience was similar to that of the previous year – slight apprehension about being there alone and great relief at finding so many engaging and friendly people to talk to (including some familiar faces from last year).

The Laura Sutton workshop provided me with an introduction to Cognitive Analytic Therapy that incited curiosity and openness to different approaches. The presentations, which covered a wide variety of topics, were evidence of the good clinical practice and research being conducted within Older People's Services across the country. It was really helpful and inspiring to hear the work that others have been doing and to consider how that could be applied locally. Again, the only problem I faced was in choosing which presentations to attend – a varied role leads to varied interests, but it is inevitable and unavoidable to need to run simultaneous streams.

One of the differences I perceived may have arisen as a result of my increased experience within Older People's Services since last year. I felt that having had more clinical experience, training and supervision (within my post as an Assistant), I was able to process the information presented utilising a wider frame of reference and greater understanding, and thus gained more from the conference.

My only disappointment was in managing to secure funding for only two days of the conference (for which I am very grateful to PSIGE) and I would very much have liked to have stayed for the final day of the presentations.

I felt the conference was educational and enlightening. It provided a wonderful opportunity to meet with enthusiastic and motivated psychologists working with older people and I very much hope to be able to attend the conference again next year (but next time as a Trainee!).

A mind full of mindfulness

Georgina Woodruff
Assistant Psychologist, Hull



SITTING THERE, in the workshop, listening to the instructions, concentrating on my breathing, as Alistair Smith said, 'Now I shall read a short poem'. Suddenly, the cymbals chimed, and I awoke, but from what? Had I fallen asleep or entered into an altered state of consciousness? Mindfulness-based cognitive therapy (MBCT) has become an increasingly popular over the past few years. Curious to discover more, I attended the mindfulness one-day workshop at the PSIGE Conference.

Mindfulness has been described as a method of meditation, using a form of attention, which is both non-judgemental and focuses on the present moment (Segal, Williams & Teasdale, 2002). Whilst initially developed as a stress reduction technique in America, it has been adopted and adapted by Segal and colleagues, into a more structured eight-session cognitive therapy programme for depression. Interestingly, early results indicate that for individuals with 3+ episodes of depression, MBCT has been shown to almost halve the relapse/recurrence rate of depression compared to usual treatment. Furthermore, the use of MBCT for older people is already indicating positive results, although this is early days.

It was great to discover what has and is happening nationwide within the older people's speciality. It was also exciting to learn how psychology for older people is becoming increasingly important as the life expectancy rises and the positive aspects of increased longevity are acknowledged. Furthermore, it was really encouraging to see how 'we' are improving quality and creating a more person-centred service for older people (Williams; Moniz-Cook). I also found it fascinating to become more aware of the new research into both alternative psychological models (James), and alternative therapeutic interventions, including Mindfulness, aromatherapy and multimedia reminiscence. Honest research. Positive researchers. Exciting results.

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Experiences from the Annual Conference

Kathrin Hicks

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University of East Anglia*



I THOUGHT IT WAS a fantastic occasion – well-organised, stimulating, lots of fun, and held in really beautiful surroundings.

The Conference started with a day of workshops on Wednesday the 7th of July. I attended the one ran by Caroline Williams on ‘Pre-diagnostic counselling for older people reporting memory problems’, which provided a valuable opportunity to think about the implications of memory testing and how we communicate these implications to clients.

That evening, we were treated to a wine-tasting at the Oriental Museum. I found the combination of delicious wine and Far Eastern deities intoxicating in more sense than one!

On Thursday, Georgina Charlesowrth, Jason Hepple and Bernie Hayden held a symposium on ‘Comparative case conceptualisations’. They formulated a case from cognitive, interpersonal, CAT, and systemic perspectives. As a trainee, I found this very enlightening.

Professor Tom Kirkwood then held a keynote address entitled ‘Positive Ageing’. I had expected him to extol the positive aspects of ageing; instead, Professor Kirkwood argued that ageing is not an inevitable process. By making inter-species comparisons, he argued that the human life-span is very malleable.

On Thursday afternoon, Bob Knight spoke about ‘Adaptations in Psychotherapy with Older Adults’, using video clips from his therapy sessions to break up material that was already familiar to many from his book. Liz Doherr and Anna Forrest presented ‘An investigation into scoring ambiguous responses on the MMSE’, an elegant if alarming illustration of the potential for variation in scoring the MMSE.

That evening, the conference dinner was held, followed by a lively Ceilidh.

On Friday morning, Helen Forster spoke on ‘An integrative model of therapy for older people’, in which she advocated a life-span developmental approach to helping older adults to construct an integrated identity. Ian James made a fascinating attack on the popularity of cognitive models in his talk ‘Utilising models of memory in therapy: beyond the declarative’, daring to suggest that the notion of maladaptive schema may be of limited usefulness. Finally, Nada Domovic and Nicole Rossotti presented ‘The use of RBANS in predicting dementia in patients diagnosed as having mild cognitive impairment’, arguing that the RBANS is a useful tool but needs to be supplemented by further measures of executive functioning.

The morning’s symposia were followed by a keynote address by Professor Ivy Blackburn on ‘Conceptualisation of depression – an historical CBT perspective’. She said she did not have much experience in working with older adults but gave an overview of various efficacy studies of CBT.

After this address I had to return home. The PSIGE conference gave me a lot to think about. I am very grateful to PSIGE for awarding me a student bursary and thus enabling me to attend.

National Secretary is a Closet Kleptomaniac!



*Spotted removing wine for gross personal consumption from welcome reception.
National Treasurer denies any involvement.*



Caught on Durham CCTV after abortive attempt to nick PSIGE direction sign.

Positive perspectives on ageing

Maggie Ellis

University of St. Andrews



WELCOME TO COLLINGWOOD' read the sign above the door of the college I was to call home for the next few nights. I chuckled to myself (movie buffs will know what I mean) and hoped that this would mark the start of a rewarding conference experience. Needless to say, it did.

This conference also marked a significant point in my academic career – my first presentation. A daunting prospect, I'm sure you'll agree! However, after I had been introduced and the butterflies had flown, I found myself thoroughly enjoying the experience. I can only assume that I held the interest of the audience members as I found myself fielding some very thoughtful questions. More importantly, no one nodded off!

The experience of writing the talk forced me to think about what it is about well-delivered presentations that inspires us. I quickly came to the realisation that the enthusiasm and positive approach of the speaker is key. Keeping this in mind, I viewed the rest of the conference through my fresh presenter's eyes and found these essential elements in abundance. This ardour was also reflected in the topic of the conference itself – positive perspectives on ageing.

Positive perspectives on ageing were evident throughout the conference and the far-reaching possibilities of this outlook became increasingly evident. For example, Professor Tom Kirkwood's keynote address on 'positive ageing' concluded that as the population ages, our lives will no longer just be about 'winding down'. Rather, increased longevity will mean that we will both live for longer as older people and will be healthier in these years than ever before. These changes will undoubtedly necessitate a positive shift in attitudes towards the older population. Good news for us both as professionals and as potential centenarians!

The importance of creativity and flexibility in our approach to working with older people stood out as significant aspects of a positive attitude. As such, focusing on the positive in ageing calls for a concentration on what can be achieved as opposed to what cannot. It became clear to me that this approach can also be applied to wet-behind-the-ears presenters!

My presence at this year's PSIGE conference was undoubtedly beneficial to my personal progress. However, the obvious progress being made with regard to older people is that which will inspire my attendance next year!

My thoughts from Durham

Mona Lesforis

Homerton Hospital



THIS WAS MY second consecutive attendance at a PSIGE conference. Thanks to a successful application to the bursary fund, I was able to attend the whole three-day conference, which included a one-day workshop as well as an array of symposia.

I attended Dr Graham Stokes' workshop on understanding challenging behaviour in dementia that offered an enlightening perspective on why a client with dementia may exhibit specific behaviour, as well as clear practical approaches to deal with such presentations. The workshop was delivered in an empathic and humourous way that hit home the fact that anyone of us could be facing this illness in 30 to 40 year's time.

Professor Kirkwood gave an enthusiastic presentation on Positive Ageing, which I felt encapsulated the essence of the conference, offering hope to all of us who would like to slow down the ageing process!

I also enjoyed the comparative case conceptualisation lectures that offered three different therapeutic formulations of the same case study.

I am always pleased to see a variety of clinicians providing presentations such as psychologists (consultants, trainees, assistants), psychiatrists and nurses. It gives the conference a diverse mix of insights and experiences. I always return from the PSIGE conference more inspired, motivated and insightful about my work with older adults and Durham was no exception.

The PSIGE conference is a great opportunity to update your skills, be privy to the latest research as well as hear experienced clinicians working within the field of older adults. You will get an idea of the growing expertise and knowledge dispelling the myth that such a client group lacks dynamism and professional rewards.

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My first PSIGE conference

Rachel Bruce

Trainee Clinical Psychologist



Mindfulness training for older people – one-day workshop, led by Alistair Smith, Consultant Clinical Psychologist

I WAS KEEN TO attend this workshop to find out more about the similarities and differences between mindfulness and some of my other areas of interest – yoga, including meditation, and hypnosis. I would like to work in older adults when I qualify and am particularly interested in interventions that might be helpful in managing chronic painful conditions.

The workshop began with an experiential exercise. Everyone was given one of two raisins and asked to feel, look at, smell, listen to and taste these. People were asked to comment on their experience and several said how much more they had noticed about the raisins than they usually did.

Definition of Mindfulness:

Paying attention in a particular way: on purpose, in the present moment and non-judgementally.

The seven pillars of mindfulness are:

- non-judging,
- patience,
- beginner's mind,
- trust,
- non-striving,
- acceptance,
- letting go.

Daily practice was recommended.

It seemed that awareness was central to mindfulness and I was struck by the commonality of this theme across therapies, although within models different terms may be used to refer to this. The differences between mindfulness and other interventions seemed to include the emphasis on the present and on sensory experiences – sight, sound, touch, smell and taste.

There were several more exercises, including walking mindfully – walking with attention to the experience. Thirty of us walking around slowly and silently prompted people to comment on being reminded of scenes from 'Sean of the Dead'! The afternoon closed following an opportunity to do some yogic stretching mindfully.

I felt that my practice would be influenced by the principles of mindfulness and that it may be particularly useful for intervening with people experiencing painful health problems as well as those with depression and anxiety.

Training

North Wales Centre for Mindfulness Research and Practice

www.bangor.ac.uk/mindfulness

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AGM Report

Chris Allen
Secretary, PSIGE



AGM, 8 July 2004, University of Durham

THE NATIONAL COMMITTEE has been involved in a number of activities over the last year. The committee has been strengthened by the inclusion of Welsh and Scottish representatives, particularly as legislation and health initiatives are now being developed separately by their respective national assemblies. PSIGE has had a strong role in commenting on the Mental Incapacity Bill and guidelines will be issued for all psychologists by the BPS shortly. Two briefing papers, one on services for early onset dementia and one on purchasing have been completed over the year and should be available in 2005. A workshop was held on the NSF for Older Adults and a section in the *Newsletter* is planned on this topic for 2005. Additionally a special edition of the *DCP Forum on Older People* is being prepared for publication in 2005.

Both the Norwich 2003 and Durham 2004 conference were successes and received positive evaluations. Norwich did make a financial loss but figures for Durham look more promising. The plans for Chester 2005 are well under way and this is to be supported by the BPS rather than Procon. The BPS are also liaising with PSIGE in relation to sponsorship, media and website issues. The *Newsletter* has been produced regularly despite the ill health of the editors and has not been sued for libel yet! I would just like to add that in relation to the photographs published in this issue that I had taken the bottle of wine for my dinner table with the permission of the wine tasters. I was impressed that Durham this year did have good signing for the conference, a precedent for Chester to match.

Geographical Groups Convenors – Annual Reports



EAST ANGLIA

Having organised last year's conference, this year has been relatively quiet.

We've seen a change in geographical convenors, as Claire Lussignea retired from her post as chair after several years of hard work and has been replaced by Vanessa Garfoot and Kathryn Sams, Clinical Psychologists working in Kings Lynn.

Meetings are still being held bi-monthly at Fulbourn Hospital, Cambridge, and have been well attended of late. The branch now has 22 qualified members, as well as various assistants and trainees who attend. The group is thriving and members are very supportive of each other, which may be a result of planning last year's conference together.

During the year, various meetings have taken place. At Christmas an extraordinary meeting was held with all qualified psychologists, who came together for a full day, to discuss common themes in our services, such as the tension between neuropsychology and therapy work, the psychiatric dominance of older peoples services, management of caseloads, developing psychological therapy services and demands such as supervision, training research etc. This was a very successful day and is planned to be repeated on a yearly basis.

In our regular meetings, presentations have been heard on topics such as 'Brief Solution Focused Therapy' and discussions on the implications of copying correspondence to clients. Focus has also been on liaising with the local clinical psychology training course and ensuring students are able to have at least one older adult placement during their training. Links have also been forged with the course to influence the teaching timetable and ensure there are relevant older adult modules.

Kathryn Sams

Geographical Convenor – East Anglia Group.

ESSEX AND HERTS.

The Essex and Herts. Branch of PSIGE is a new branch, which formally met for the first time in December 2003.

Geography

The Branch is attended by psychologists working in the following areas: North/East Essex: Colchester, Chelmsford, Clacton, Saffron Walden and Uttlesford. West Essex: Harlow, Epping, Loughton. South Essex: Basildon, Brentwood, Goodmayes, Welwyn-Garden City, Barking, and Romford. Hertfordshire: Bishops Stortford, Harpenden.

Membership

The Branch has a mailing list of 31 Clinical Psychologists, Counselling Psychologists, Trainee and Assistant Clinical Psychologists and Trainee Counselling Psychologists.

Meetings

The Branch meets every two months at the Petersfield Centre in Harold Hill, Romford. Meetings last between two and three hours and have taken the format of a clinically relevant presentation or half-day workshop followed by an informal discussion.

Since the Essex and Herts. Branch of PSIGE was formed, presentations have covered:

- Running groups for older people;
- Introduction to the principles of group psychotherapy;
- A multigenerational case example of systemic working;
- Family work with younger people with dementia;
- Pain management with older people.

Training courses

Trainee Clinical Psychologists attending placements within the geographical area covered by the Branch come from the University of Hertfordshire, University College London, Royal Holloway and the University of East London courses. A new training course based in Essex is due to receive its first intake of trainees in October 2005. Trainee Counselling Psychologists also have placements within the geographical area covered by the Branch.

For further information on the Branch please contact: **Sara Banks** on (01279) 827276 or Psychology.Secretary@haveringpct.nhs.uk

NORTH EAST

The group has met for five business meetings this year (average 15 people) and an away-day where 20 people were present. There was always a good mix of qualified, unqualified and doctoral students from the two local courses.

Range of topics at business meetings:

- Planning for the 2004 conference;
- Reports back from local/national conferences and workshops;
- Reports back from local and national subgroups;
- Doctorate courses teaching and placements.

Each business meeting has been followed by presentations on topics such as 'Presentation from the Teesside course on their academic and placement changes, project examining the inpatient services in South Tyneside', 'The way in which we lie to people with dementia' and 'Attributions of staff carers'.

The Annual away-day in April 2004, was hosted by the Teesside doctorate course.

Representatives of PSIGE have been active on a variety of groups associated with the two local courses as well as providing a range of teaching.

As usual we have been able to provide the two local courses with all the required basic and elective placements.

Thank you to all the local reps for their hard work on the various committees and to Claire Martin for secretarial duties (Jean Parker and Trish Roe for sending stuff out) and Daniel for his role as treasurer.

Neil Sabin

Geographical Convenor – North East Group.

NORTHERN IRELAND

The Northern Ireland group has not really got off the ground as yet. There is just one PSIGE member working in Northern Ireland and a further five who are resident in the Republic of Ireland. All members have been contacted and invited to get in touch with ideas as to how we might form a group and what functions a group might serve. Three members have been in touch so far although one is not currently working with older people. The main difficulty is the distances involved in meeting, Belfast and Cork being over 200 miles apart. I have appreciated receiving minutes of the meetings of the National Committee and have offered to circulate these to members if they would find this useful. During the coming year I would hope that we could arrange a meeting of even a small number of us for mutual support and information exchange. In Northern Ireland I am currently sitting on the Dementia and Older People with Mental Health

Problems Sub-Committee of the Bamford Review of Mental Health and Learning Disability Services in Northern Ireland. In August 2003 I wrote a paper entitled *Clinical psychology services for older adults in Northern Ireland* for use by the Northern Ireland Specialty Advisory Committee which meets annually with the Chief Medical Officer at the Northern Ireland Department of Health to advise on workforce issues affecting Clinical Psychology.

Brenda Carney-Gallagher

Geographical Convenor – Northern Ireland Group.

NORTH WALES

Geography

The North Wales Region encompasses the following NHS Trusts: North West Wales, Conwy and Denbighshire, North East Wales and Powys. Contact is maintained with the North West PSIGE group in the neighbouring geographical area.

Local Clinical Psychology Training Courses

There is one training course based at the University of Wales in Bangor, with an annual intake of nine trainees.

Membership

There are eight permanent members in our group, who are all qualified Clinical Psychologists. Trainees and Assistant Psychologists attend whilst on placement and when they are working with PSIGE members.

Meetings

We meet every two months at a central venue, for about two hours. Meetings tend to comprise a business component followed by a presentation. In the last year presentations have included:

- Driving and dementia;
- Decision making and care;
- Psychometric properties of the revised CAMCOG – a small-scale study;
- Sharing a diagnosis of dementia;
- Case discussions.

Posts and workforce planning

At each meeting representatives from the different NHS Trusts provide an update on workforce planning issues, including whether new posts have been established. There have not been any new posts established over the past year.

Training issues

The following local issues may be of interest:

- Although the North Wales Clinical Psychology Programme has not increased their intake, there remains an ongoing pressure on supervisors to provide core and specialist placements, sometimes up to three trainees per year.

- The North Wales Clinical Psychology Programme has a joint placement planning meeting with the heads of psychology services, in an attempt to offer appropriate placements to all trainees.
- Where possible, older adult placements are sought with Clinical Psychologists who work within older adult services. The North Wales Clinical Psychology Programme views this as the optimal and preferable way of trainees developing competencies in working with older people.
- The qualified Clinical Psychologists are responsible for planning and providing the majority of teaching on the older adult curriculum and for supervising a range of research projects.
- The older adult speciality is represented on all course management teams.
- The North Wales group welcomed the recent PSIGE document on training competencies, but viewed the specific suggestions about minimal experiences (example numbers of clients etc.) as being too prescriptive.

2005 National Conference in Chester

The North West region is responsible for organising the 2005 conference. The North Wales PSIGE has been invited to join in the organisation and intends to provide a stream of sessions at the conference.

Carolien Lamers

Temporary Geographical Convenor – North Wales Group.

NORTH WEST

Geography

The North West Region includes the following counties: Lancashire; Greater Manchester; Merseyside; Cheshire. It also includes the Isle of Man, much, if not all, of Cumbria and north west Derbyshire. There are a few members in neighbouring areas such as North Wales and Staffordshire.

Local Clinical Psychology Training courses

There are three major training courses based in Liverpool, Manchester and Lancaster. The first two will have an intake of 25 trainees this autumn. Lancaster has an intake of 24.

Membership

There are 39 members in our group. These are mostly Qualified Clinical Psychologists, with some trainees and assistants and three psychiatrists.

Meetings

We meet every two months at venues around the region. Meetings last between two-and-a-half and three hours, and tend to be well attended. They alternate between a long business meeting and a short business meeting followed by a presentation. In the last year presentations have been on:

- Quality of life issues/measurement (Sonia Collins);
- Work with the police and other agencies on crime vulnerability (Amanda Thornton);
- Service user involvement (Salford Reach Beyond project team);
- Falls (Stuart Lerner).

Posts and workforce planning

At each meeting we update on workforce planning issues, including whether new posts have been established. Over the last year, a small number of new posts have been established in the region and many services are pursuing workforce plans, and getting increases in Older Adult psychology posts agreed in service strategies. However, there are still some services in the north west with no older adult specialists and some of our members are actively working to develop services in such areas.

Training issues

The following local issues are worth noting:

- All North West courses are increasing their intakes, the total intake this year over the three courses is 75, and there are rumours that this will increase next year.
- The three North West courses have a joint placement plan which maximises our ability to offer placements to all trainees.
- All courses intend to do their best to supply older adult placements and certainly see this as the optimal and preferable way of trainees developing competencies in working with older people. So far the courses have been successful in getting placements for trainees
- There is excellent collaboration from older adult supervisors. In exceptional circumstances individual supervisors have taken three trainees. It would be useful to write up such experiences from the trainee's and supervisor's perspectives .
- The speciality is represented on all course management teams.
- The North West Group welcomes the recent PSIGE document on training competencies, but most felt that the specific suggestions about minimal experiences (example numbers of clients etc.) were too prescriptive.
- There are indications that the comprehensive training experiences offered to trainees in our speciality is resulting in a significant number of trainees considering jobs in the speciality.

Research register

Over the last two years we have surveyed members on their research interests, and sent the results to all members and the three local courses. This is partly to facilitate potential collaboration between colleagues and also to inform trainees on the three North West courses of potential research opportunities in the speciality. There are indications from the courses that

this is succeeding in that more trainees are proposing to do their major doctoral research in our area. A copy of this register is available on e-mail request from the North West Regional Convenor

Continuing Professional Development

North West PSIGE has been extremely active and successful in the last year in organising CPD events for our members.

We have been helped in getting events off the ground by financial grants from the local Strategic Health Authority, and by the appointment of a CPD organiser with an interest in Older Adult work (Polly Kaiser). Specifically we developed the following over the last year:

Older Adult Neuropsychology Course

Six whole training days spread over two months held in north Manchester This was organised by three of our members Vicky Pike, from Chorley, and Rachel Domone and Sue Watts from Salford. It was loosely modelled on the course held at Solomons last year.

The course was very well attended, including PSIGE members from outside our region (especially Yorkshire and the West Midlands).

It was, in fact, oversubscribed leading to a financial surplus which we are using to subsidise further CPD events.

Older Adult Clinical Psychology Post Qualification Training Programme

We have also organised four one-day workshops to be held between June 2004 and February 2005 on the following topics: Approaches for complex cases (especially CAT); Working in teams; Systemic therapy and complex cases; Medication or consent.

Communication methods

In late 2003 we 'balloted' our members on switching from using the post for communications to an all e-mail system. There were no objections to this and it considerably cuts down on administration time.

We have also conducted a number of local surveys by e-mail, used the e-mail system to get feedback on issues brought up by National PSIGE, and also use e-mail to advertise local jobs.

Surveys

We are using e-mail to survey member's experiences on various issues.

Recently we did one on working in community teams and are just about to do one on approaches to outcome measurement.

It may be possible to summarise these for the *Newsletter*.

2005 National Conference in Chester

The North West region is responsible for organising the 2005 conference.

It has now been agreed that this will be held at Chester College. This is a compact campus with excellent accommodation, facilities and parking close to the centre of Chester. We have developed a conference organising committee under the excellent leadership of Rachel McCobb, Clinical Psychologist at Chester. The academic programme committee is chaired by Rebekah Proctor, from Manchester.

We have recently decided to use the BPS as conference organisers and will not be using Procon.

The conference dates are the 12th to 15th July 2005. We are aware that this will be the 25th anniversary conference, and intend to mark this in various ways, including some kind of display looking back over all previous conferences (see flyer with early request for help in relation to this.)

Profiling North West PSIGE

We intend to undertake a full descriptive profile of older adult psychology services throughout the region, looking at the following issues:

- Staffing and interests;
- Services offered;
- Workforce planning /service development;
- Service information leaflets;
- Supervision and CPD activity;
- Gaps in service.

David Powell

Geographical Convenor, North West Group.

SOUTH THAMES

South Thames Branch had 53 people on its mailing list in June 2003. The South Thames Committee has organised a number of training events between July 2003 and July 2004:

1. Research presentations and workshop on impact of recent changes in clinical psychology training – organised by Padmaprabha Dalby.
2. Mid-life transition and individuation at the end of life – organised by Clare Crellin.
3. Group analysis and creative writing with older people – organised by Clare Crellin.
4. Person Centred Care and Diogenes Syndrome – organised by Patrick McGuinness and Tina Lee

One of these events was part funded by South Thames DCP. Our next event is planned for 30th September 2004 at Salomons. Regional psychologists will have the opportunity to present their research and the three regional courses will provide an update on recent changes which have taken place in response to the move to core competencies. Vassilis Mouratoglou has kindly agreed to offer a training session on Solution Focused Therapy with Older People in November.

Jeni Brooks has stood down from the regional committee and Elizabeth Field has left for maternity leave. We would like to thank both of them for their

hard work and contribution to South Thames PSIGE. David Matthews has also had to stand down due to other work commitments. Idit Albert, Jo Cook, David Gracey, Adrienne Little and Margaret Williams have kindly agreed to join the committee. The other current committee members are Reinhard Guss (treasurer), Clare Crellin (link to South Thames DCP committee), Patrick McGuinness (link to National PSIGE committee), Padmaprabha Dalby (joint convenor and link to Salomons training scheme) and Tina Lee (joint convenor). The committee meet five times a year.

Padmaprabha Dalby is currently completing a survey of the research interests of local clinical psychologists. This will be shared with trainees in an attempt to encourage them to complete research in the specialty.

South Thames PSIGE are organising the National PSIGE Conference in 2006. We have developed our Conference Organisers Committee and it is likely the conference venue will be the University of Sussex.

Padmaprabha Dalby & Tina Lee

Joint Geographical Convenors – South Thames Group.

SOUTH WALES

We've had a good year in South Wales with several new people joining us, and some old ones returning! We hope to continue to grow in numbers, with several vacancies in the south east of the country, which we would be very pleased to fill! Currently we have 18 members covering a large area: all the NHS Trusts of South and East Wales: from Gwent in the east, to Dyfed and Ceredigion in the west, to Powys in mid Wales.

As a group we continue to meet every three months at venues across south Wales. We have been delighted to host Laura Sutton and Esme Moniz-Cook this year to lead workshops on 'Cognitive Analytic Therapy' and on 'Challenging Behaviour', respectively. Both were well attended and enjoyed by psychologists and nursing staff. Local presenters have led the group in thinking about topics as diverse as change in olfactory function in dementia, and therapeutic memory groups. Some of our members are looking forward to linking up with colleagues in mid and north Wales to develop a forum for people interested in psychotherapy and dementia. Members also continue to play a role in the local DCP, which has provided a helpful forum recently in helping us to negotiate Agenda for Change.

The Welsh Assembly Government is currently developing a Welsh NSF for Older People. Several of our members are actively involved in the groups writing the NSFOP standards for Mental Health, Stroke, Intermediate Care and General Hospital Care.

Like other regions, we are also negotiating expansion of the South Wales Clinical Psychology Doctoral course. This has led to an increase in course staffing, trainees, and major changes in the course structure. We now have

two members on the course team and many of us are involved in teaching and supervising. Inevitably many of our meetings this year have focussed on liaison with the course and implications for supervisors. We are of course hopeful that this expansion will create further opportunities for generating fresh interest in working with older people within the profession!

Roslyn Offord

Geographical Convenor, South Wales Group.

SOUTH WEST

Meetings

We currently have 34 members. Once again, regional meetings have been well attended and have generated much lively discussion. It would be good to try and meet more regularly as a large group but the size of the region and people's other commitments make this difficult. We have had two main gatherings since the last conference.

September 2003

Sinclair Lough facilitated an excellent one-day workshop on 'Fronto-temporal Dementia' which was very positively received by the group. Feedback suggested that people valued the opportunity to think in detail about this challenging and varied form of dementia and particularly enjoyed Sinclair's use of vignettes and video footage.

April 2004

In April we met to share news from around the region and also heard from Isabel Ewart (Clinical Psychologist, Plymouth Older Adult Services) who presented a piece of research looking at the factors influencing Clinical Psychologists' choice of speciality. This provided much food for thought in terms of our efforts to attract newly qualified Psychologists into Older People's services. In the afternoon we continued our discussions about training issues. Cath Haslam and Rob Hallet (Exeter) reported on the use of problem-based learning (PBL) approaches on the Exeter Training Course. Kate Anderson (Plymouth) and P.F. Joyce (Newton Abbot) also described recent innovations in the Older Adult teaching on the Plymouth Course.

Future events

Andrew Balfour (Tavistock Clinic) is presenting a day workshop focussing on psychodynamic perspectives on ageing in September 2004.

Change of Convenor

As of September 2004, Liz will be standing down as the north area convenor for the region. Philippa Wilson, based at Barrow Hospital, Bristol, will be taking over.

Liz Curtis (North) & Neil Bathurst (South)

Geographical Convenors – South West Group.

TRENT

Our branch has continued to meet bi-monthly from 2.00 p.m. to 4.30 p.m. The meeting time is split between business and a presentation or discussion.

We now meet in a central location in Mansfield. Previously we moved around the region, but a stable venue seems to suit the membership.

We have also been providing lunch from 1.00 p.m. with the aim of encouraging attendance and of providing an informal space for networking.

Meetings are generally on Mondays. We used to vary the days Monday/Friday, but found better attendance on Mondays. Average attendance in 2003/2004 has been around 15.

Presentations

Presentations have been as follows:

July 2003 – Dementia Protocols for Memory Clinics;

September 2003 – Driving and Dementia;

November 2003 – The Observation;

January 2004 – Business Meeting;

March 2004 – Teaching and Training;

July 2004 – Memory Rehabilitation in Dementia.

The business component of our meetings has generated wide-ranging discussions. Topics have included accreditation criteria and the effects on specialist placements; note keeping and copies of correspondence to clients; use of video by trainees for case studies; memory clinics and assessment.

Rhona Nicol

Geographical Convenor, Trent Group.

WALES

Within the past year, the national PSIGE group has responded to concerns about the diversity of the political environments in the regions, and has invited regional representatives to become co-opted members of the national committee. Since November 2003, Janice Rees (South Wales PSIGE Chairperson) has been welcomed on to the national committee to represent a Welsh perspective on the many health initiatives and policies affecting our services.

Within Wales, the Welsh Assembly Government (WAG)'s powers are not as extensive as the Scottish Parliament, and Wales will continue to share a legal and statutory framework with England across all relevant areas of law. Thus, the Mental Health Act remains applicable in Wales, and we will be subject to the Mental Health Act revisions. Similarly, the awaited Capacity Act will be applicable to Wales, along with all other existing civil and criminal law. The Department of Health's numerous NICE guidelines are also applicable to Welsh health service treatments.

However, WAG formulates its own health and social policies and has its own Health Minister and a strategy for older people. There are currently plans to appoint a commissioner for older people. It has recon-

structed Health Authorities into 22 Local Health Boards (LHB) which are co-terminous with Local Authorities, although greatly variable in size – with over 65 populations ranging between 9000 and 40,000 for each LHB area. Health and Social Services agencies are required to work jointly within LHBs to plan services with joint vision, although budgets remain separate for these services. Trusts, however, are not co-terminous with LHBs – one Trust may be required to work with up to five LHBs. Primary care Trusts do not exist in Wales. All trusts provide services for a range of needs, sub-divided into appropriate Divisions such as Mental Health, Adult Medicine etc.

A further discrepancy is the development and adoption of regional National Service Frameworks. WAG is currently developing a Welsh NSF for Older People. Several of our members are actively involved in the groups writing the NSFOP standards for Mental Health, Stroke, Intermediate Care and General Hospital Care. Other members continue to play an active part in shaping service development in Wales, through the Welsh Dementia Service Development Centre and projects such as workforce planning.

Following from the DOH's commissioned review by Derek Wanless, WAG has commissioned a Welsh review (also by Wanless) published in 2002. The conclusions are similar to those for England, with an emphasis on a range of health-enhancing strategies to reduce dependency on acute hospital-based services. In many areas, members are involved in the implementation of these strategies.

Finally, the BPS has established a Welsh Branch office with a Liaison Officer to allow a channel of communication with WAG on key issues when consultation is sought. The DCP Welsh Branch is active, and has organised meetings on a range of clinical and professional affairs issues.

Roslyn Offord

Geographical Convenor, Wales Group.

WESSEX

Membership

About 15 members. Usual attendance at meetings is around 12 – nine qualified psychologists and three trainees.

Meetings

Meetings are held four times a year, in Salisbury. Two hours duration – one hour business meeting, one hour presentation.

Business meetings – issues

Sharing of information and developments from the different trusts within the group, such as staffing, research projects, organisational changes.

Feedback from national PSIGE meetings

The changes in clinical psychology training both nationally in terms of core competencies and major local organisational changes.

Presentations

October 2003: Feedback from conference.

January 2004: Delis-Kaplan Executive Function Test – Nicola Benbow, the Psychological Corporation.

April 2004: Fronto-temporal dementia – Sinclair Lough.

June 2004: Borderline personality disorder in older people – Liz Young.

Future events

A PSIGE/Southampton University joint workshop on insight in early dementia is planned for October to be run by Linda Clare.

Ann Marshall

Geographical Convenor, Wessex Group.

YORKSHIRE/HUMBERSIDE

Our group currently has around 30 members. We have met four times since the last GGC meeting with an additional half day for a training event and a further meeting to plan teaching on the Leeds DClInPsych. Our meetings last for about two hours with the meeting split between business and a presentation. Attendance at our meetings has been good with more involvement from academic psychologists at Leeds University.

Geographical boundaries of the Group

I do not think that we have a clear idea of what defines this as it never seems to have been an issue. We have some academic members, some retired and many employed by the local trusts. It seems that in practice the boundaries are more or less defined by the areas that the two training courses draw upon for placements.

Topics discussed at meetings over the year

- Capabilities for Working with Older People document.
- Trying to gain clarity over how placements will be allocated by the Leeds DClInPsych course – to ensure that all clinical psychologists working with older people who want to supervise will be given a fair chance to.
- Adapting teaching sessions to the core competencies approach on the Leeds DClInPsych course.
- Links with local DCP branch.
- Ensuring that some of trainees' small-scale research projects are focused on older peoples' services.
- What to do for our GG web page.

Talks at our meetings

- Self image in people with dementia – Jayne Hawkins (Consultant Clinical Psychologist – Leeds Older Peoples Psychology and Therapies Services).
- Cognitive ageing research – clinical applications – Chris Moulin (Lecturer in Cognitive Neuropsychology at Leeds University).
- The value that older people find in a Psychotherapy Group – Michael Jubb (Clinical Psychologist – Leeds Older Peoples Psychology and Therapies Services).

Events

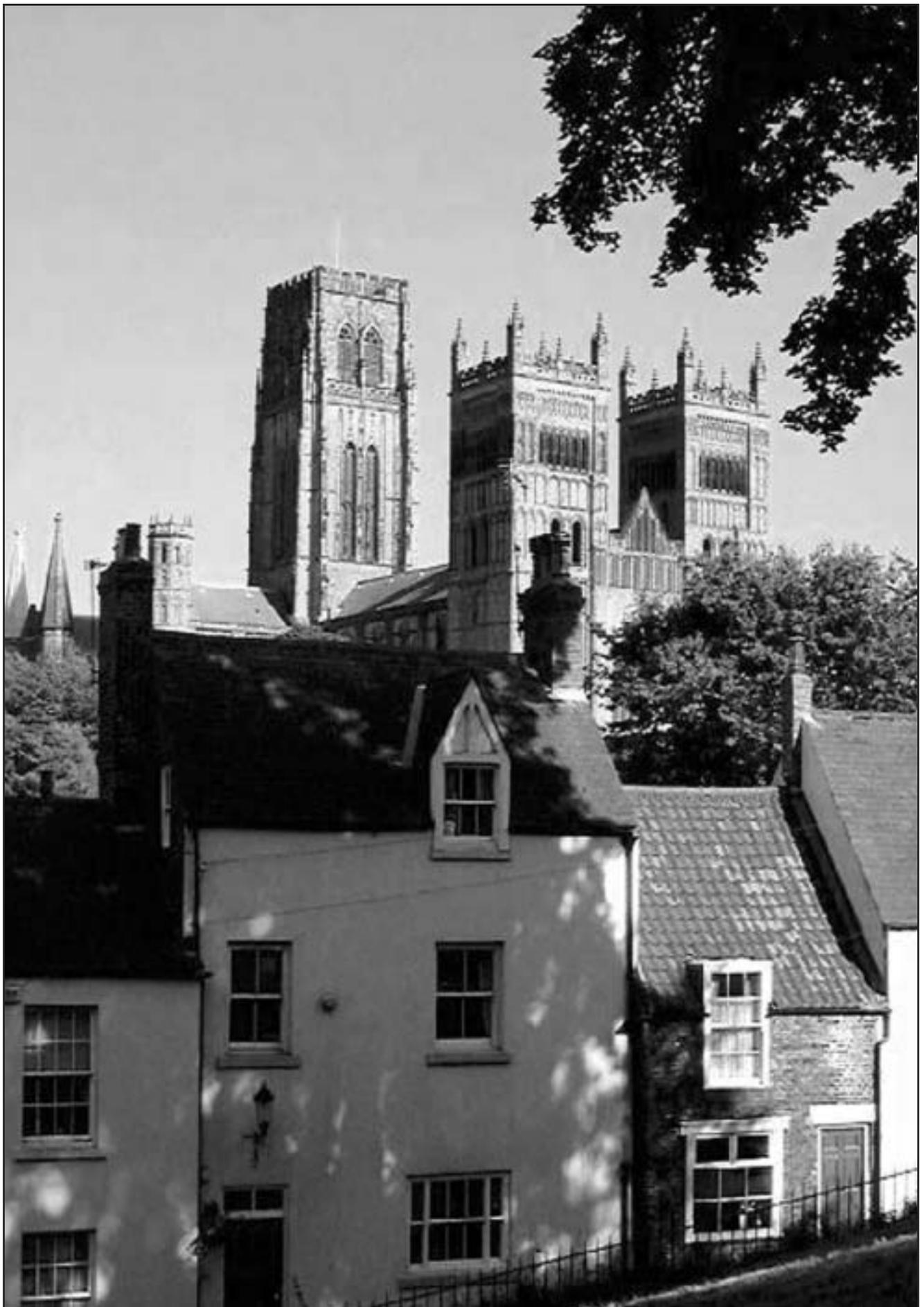
1. Ian James from Newcastle provided an afternoon workshop on applying CBT to Older People and their carers and staff and to other areas of our work as clinical psychologists.
2. Supported workshop on challenging behaviour facilitated by Mike Bird.

Planned events

1. Input to local DCP branch annual conference on challenging behaviour across the lifespan.
2. We are also thinking about putting on some event in the future about older people and sexuality.

Michael Jubb

Geographical Convenor, Yorkshire/Humberside Group.



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