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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*Pictures scattered throughout this issue were taken at the 80s Disco at the Conference.*

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IT IS A GREAT PLEASURE TO INTRODUCE this post-conference edition of the Newsletter. Following our 25th successful conference this year, there has been occasion to reflect on the history and development of PSIGE and to look ahead to the exciting opportunities that lie ahead. Although our three days in Chester were jam-packed, there was still time to bask in the glorious sunshine, take in the historical architecture and dance around our handbags at the 80s disco!

The feeling of enthusiasm and energy at this year’s conference (both on and off the dance floor!) didn’t go unnoticed by our visitors. The academic programme provoked much exciting debate, and hopefully some opportunities for new and productive ways of working. Many of us were moved and inspired by the keynote address provided by Mervyn Eastmann, which opened up possibilities for new and productive partnerships in our work. The historical account of PSIGE provided by Bob Woods was both fascinating and highly amusing, it certainly demonstrated how far we have come in 25 years!

We would like to thank all of the speakers at this year’s conference for providing an academic programme bursting with imagination and diversity. The presentations were of a particularly high quality this year, and many of us welcomed the opportunity for further time for discussion in the seminar sessions. The range of workshops and presentations demonstrates the commitment of PSIGE members to working with older people and the difficulty of keeping up with so many developments.

Many thanks are also due to the organising committee who worked so efficiently and cohesively. Particularly, Rachel Glynn-Williams who ran a tight ship keeping us all on target as Conference Chair. We would like to extend our gratitude to Lorna and Collette from the BPS who helped us to administer the conference for the first time, and did such an efficient and professional job. We are also grateful for the local assistant psychologists and trainees who acted as stewards.

The papers in this edition of the Newsletter represent a small sample of the many excellent papers that were presented at the conference. For those of us that were there, it is a good chance to catch up on parallel sessions that were missed and an aide-memoir to those sessions you did attend. If you did not attend, we hope that this selection of papers will show you what you missed and inspire you to attend future conferences. We hope you enjoy this edition of the Newsletter.

Dr Rebekah Proctor
2005 Conference Academic Chair.

EDITORS’ NOTE

Many thanks to Rebekah, whose gentle electronic cajoling made this Newsletter happen. In addition to the conference papers we have the start of a series of papers from the NSF (remember that!) Review Day held in March 2004 with the intention that over the course of the next few editions progress reports on all standards will be published.

Sinclair Lough & Penny Fooks
AGM Report 2005

Chris Allen

Over the period 2004–2005 we had the following objectives and made the progress noted:

Strengthen links with other organisations involved with older people
Age Concern made a presentation at the Conference, and I have been representing the Society on the Inquiry into Mental Health and Well-being co-ordinated by Age Concern. We submitted evidence to the Inquiry in relation to Health Promotion and a report from the Inquiry is due at the end of the year. There will be a further call for evidence in relation to mental health in 2006 to which we will contribute.

We represented the Society on the NICE guidelines for Dementia Services group and submitted evidence to that group, the final report is also due in 2006, and we also submitted evidence to NICE on the consultation regarding anti-dementia medication, again the final report has been delayed to 2006. We have had representation at CHI for the period 2004–2005. We are planning a scoping exercise identifying the links clinical psychologists (not just committee members) have with various organisations in 2005–2006 and will report on this next year.

Links with the Division of Clinical Psychology (DCP)
The DCP are increasingly asking us to respond on theirs and the Society’s behalf on issues relating to older people. The chair of the DCP attended one of our committee meetings to discuss our relationship, and DCP has been providing administrative support and expenses for our committee meetings. We expect this relationship to continue and develop.

Website
We decided not to become part of the new Society website but do have a link to it. We will monitor the progress of the Society’s site and review our decision if this appears appropriate. We commissioned a new website design and our new website is now active and includes past newsletters. We think it is a significant improvement on our past site, please look for yourself at www.psige.org.

Media communications strategy
We have had a meeting with the Society’s Media Officer and plan to link more with them to develop our response to media issues. There will be further meetings in 2005–2006 concerning this.

National Training Days
Bursaries were up this year with £4000 being allocated for individuals to attend the conference. Funding remains dependent on a conference report. Training events have been planned and taken place over the year and further ones are planned on supervision in December 2005 and capacity in 2006. Money has been made available to geographical groups for putting on a national training event with a deadline of proposals of November 2005. Look out for these events in 2006 they will be free but places will be limited.

Other news
The Newsletter has appeared regularly and there will be a handover of editors in 2006. Briefing papers were written and are going to print for workforce planning and early onset dementia, look out for these shortly.

A special edition of DCP Forum co-ordinated by Catherine Dooley was written over this period and should be appearing in 2006.
We remain in a fairly healthy financial position but this could change depending on the DCP’s continuing support and the success of our annual conference. A new committee was elected at the AGM, see the Newsletter for details.

Dr Chris Allen
Secretary 2004–2005
GREETINGS FROM YOUR NEW chair-person! For those of you who got to the AGM at the Chester Conference in July you will already know who your new-look Committee are (and I’m not only referring to the 80s themed disco that evening!). If not, the list should appear at the back of this Newsletter.

- **Strategic objectives for 2005/2006.** Six objectives were set at our strategy meeting in September, following the AGM. These include:
  - Influencing the development of the NICE Dementia Guidelines.
  - Providing professional guidance to members.
  - Facilitating training for members.
  - Building towards long term financial security for PSIGE.
  - Improving the efficiency of the Committee.
  - Improving communication with the media.

- **Website.** Please take a moment to look at the new and improved PSIGE website (www.psige.org) and check out the bulletin board. It’s all a bit clever for me but some of you computer literate PSIGE members may figure out a use for it! Thanks to Patrick McGuinness and Jayne Hawkins for their work on the website.

- **Finances.** It has come to my attention that 65 PSIGE members and subscribers have still not updated their subscriptions to £30 per year, despite this increase having been approved three years ago! We also have almost 120 members/subscribers who have not sent payment by cheque or Standing Order for this year’s subscription. To add to this, we paid over £125 last month on administrative costs to chase up non-payment of subscriptions! I estimate that this is reducing PSIGE’s income by over £4000 per year! We will be working with the Geographical Convenors to try and rectify this over the coming year, but if you are aware that you are one of these members I would be most grateful if you would send your subscriptions to our administrator Ange Brown (details on the website – click on ‘Join Us’).

- **Conference.** A huge thank you to Rachael McCobb and the Chester Conference Organising Group for hosting such a fantastic event in July. The Chester conference looks set to have made a surplus this year, which will all be ploughed back into training initiatives for PSIGE members.

Next Summer’s conference, ‘Equality and Diversity in the Third Age’, is hosted, in Brighton, by my home Geographical Group (South Thames). Check the PSIGE website for more information and watch out for calls for papers and application forms in due course. Good luck to Tina Lee and the Organising Group.

Have a great Christmas!

Steve
ONLINE METHODS (Horton, 2000) can give the potential for challenging the myth among trainee clinical psychologists that working with older people is unchallenging, a poor use of their skills and competencies as a clinical psychologist and as a clinical speciality that it offers poor career development. Online methods may help to readdress the workforce undersupply of clinical psychologists working with older people in Scotland (NHS Education for Scotland, 2003).

The online course has been developed at the University of Edinburgh with a grant from National Education Scotland (NES) and is now in its second year. The aim of the project was to cover the core curriculum that PSIGE recommends for training clinical psychologists to work with older people (Clare & Oyebode, 2004). Our aim was to do this in an interactive, inspiring and clinically relevant way.

At the start of this last year the first author of this paper was relatively naïve in terms of knowledge and understanding in the older adult specialty, but through experiences, gains and being centrally involved in the production and development of materials and learning activities has had her eyes opened to the opportunity afforded to working in the field.

I can see first hand from originally being an inexperienced participant observer the use of these online materials provides a much more enriched learning experience when it comes to learning and understanding the challenges and ultimate rewards of working with this client group.

Materials and development
A recent innovation in the online course is to have transcripts and video extracts of clinicians’ own personal experiences of their career and personal development when working as a clinician with older people. Many PSIGE members from the east of Scotland have enthusiastically contributed this part of the online course and this has been greatly appreciated.

In its first iteration (Laidlaw & O’Shea, 2004) the original aim of the course was to adapt an American online Psychogeriatric course from the University of Southern California (Gero 522). While this aim was never fully realised in the original development of the course the plan over the next year is to blend the material from Gero 522 to our own course which has already expanded to include 13 topic areas consistent with the PSIGE National Guidelines on Clinical Training (Clare & Oyebode, 2004). The 13 areas are: Anxiety; Caregiving; Caregiver Family Therapy; CBT; Dementia; Depression; Intimacy; Psychosis; Psychotherapy; Society; Stroke; Suicide; and the overheads for all the topics.

Over the last year another innovation has been to seek active contributions from leading psychological therapists in the US, including Professor Bob Knight, who contributed extensively to the psychotherapy topic, in terms of lecture material and his own personal thoughts on the subject, and Associate Professor Rebecca Logsdon, who contributed to the caregiving and dementia topics and allowed us to add tools that her team in Seattle had developed for use in...
clinical practice. In addition Professor Sara Honn. Qualls wrote the lecture and gave much of her time to the development of the caregiver family therapy topic. Our course explicitly aims to instill in the trainees a knowledge of local, national and international issues in working with older people.

Our aim over the next year will be to seek more contributions from our colleagues in national PSIGE across the UK and it is our hope that we can enthuse others to develop online courses as a way of promoting our specialty amongst trainees.

The e-learning activities are explicitly aimed at meeting the clinical needs of trainees while on placement and preparing them in advance for some of the common situations they would face on placement. The rationale for this is that trainees then have a more clinical relevant opportunity to test out clinical decision making skills when working with this client group. So, for example, one of our recent learning activities is part of the ‘Depression’ topic area and is where a client not only presents with symptoms of depression, but also subjective memory complaints. This case example and learning activity is presented using a mixture of audiovisual material developed using actors and textual material hyperlinked to relevant web-based clinical material such as questionnaires and formulations. The trainee has the opportunity to make a number of clinical decisions and formulate the case using the information given.

Evaluation of the project
We have developed an evaluation questionnaire which is given before the older adult’s placement and then after the placement is completed. This incorporates attitudes to ageing questions (Laidlaw, Quinn, Power & the WHOQOL-Old Group, 2003) and measures trainees’ comfort with using web-based learning materials, practitioner resources and activities.

We are also developing a selection of DVDs containing the audio visual skills development material in response to the trainees who may find download times too long for such material.

Summary
In summary the older adults online course is in its second year of development and there is still work to be done and we hope to build on our previous successes in providing a supportive online placement experience for trainees.

The benefits of using online material while on placement are that trainees can consult material at their leisure and as an important means of addressing any inequalities that may exist in terms of material or opportunities in placements across our catchment area.

We really value comments and collaboration from PSIGE members in developing this resource further.

We are happy to provide interested members of PSIGE with a pass to view online material and only ask that our colleagues provide us with critical, evaluative feedback!

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References


Predictors of disability in older adults with heart failure

A.D.M. Davies, L. Loftus, D. King, V. Ludgate, E. Rodrigues & B. Stephens

The realisation that future, ageing populations are likely to include many with chronic disabilities has led to a resurgence of interest in both the conceptualisation of disability in later life and, empirically, in how people with a chronic disease fare as they grow older. Psychologists know little about ageing in such samples. The classic studies such as the Kansas City Study of Adult Life (Cummings & Henry, 1961) explicitly excluded people with a chronic disease (Llewellyn & Hogan, 1999; Putnam, 2002). Patients suffering from heart failure provide an interesting study group. Heart failure is one of the most significant of cardiovascular problems with an estimated prevalence of 13 per cent in people over the age of 65 (Cowie, 1997). There are many causes of heart failure, it being the end stage of many cardiovascular conditions, when cardiac output becomes insufficient to meet the body’s metabolic needs. Heart failure is the commonest reason for admission and re-admission to hospital in industrialised countries and mortality rates are high. Diagnosis is made on clinical grounds, there being four key criteria: breathlessness; fatigue; oedema; and impaired exercise tolerance (Rich, 2001). Of these fatigue, is the most difficult to assess. It has been defined as ‘a subjective, unpleasant symptom which incorporates total body feelings ranging from tiredness to exhaustion creating an unrelenting overall condition, which interferes with individuals’ ability to function to their normal capacity’ (Ream & Richardson, 1996). Fatigue is often accepted by the patient as an inevitable consequence of chronic illness and is rarely reported unless the patient is specifically questioned (Piper 5, 1998) despite the fact that it is known to impair quality of life (Drexler & Coats, 1996). However, in heart failure, low impact exercise such as home walking and muscle strength training, reduces patients’ ratings of fatigue and breathlessness. Recommendations to take such exercise might reduce the impact of symptoms on the patient’s quality of life (Radzewitz et al., 2002). The present study aimed to identify the main correlates of disability in older heart failure patients.

Methods

Design and Procedure

The study was part of a larger two-phase longitudinal study of heart failure patients and their primary caregivers. Data presented here came from phase one of the study in which patients and their caregivers were interviewed at home twice one week apart. The first interview focused on the patient, though the caregiver was present for some of the interview to corroborate what the patient said. The measures reported here were from that interview.

Measures

Functional disability was measured by the Instrumental Activities of Daily Living scale (Lawton & Brody, 1969); Fatigue by the Dutch Exertion Fatigue Scale (Tiesinga, Dassen & Halfens, 1998); Breathlessness by a Visual Analogue Scale for Dyspnoea (Subratty, Manraj & Baligadon, 1994); Oedema by a measure developed for this study. The cognitive status of patients was documented by the Mini Mental State Examination (MMSE; Folstein, Folstein &
McHugh, 1975). The number of co-morbidities suffered by patients was assessed using the Carlson index. Additional clinical information about patients, such as left ventricular ejection fraction and forced expiratory volume in one second, was available for all patients.

**Sample**

Participants were 173 heart failure patients (109 men, 64 women) referred from specialist heart failure clinics in two centres on Merseyside. The overall mean age of the sample was 75.6, SD=7.3 years (men: 74.7, SD=6.9; women: 77.1, SD=7.6 years). Severity of heart failure as measured by the New York Heart Association four point classification was: Class II (mild) 68, (39.3 per cent); Class III (moderate) 98 (56.6 per cent); Class IV (severe) four per cent. To be included in the sample patients had to have a MMSE score of 23 or over. All patients were judged capable by clinic staff of giving informed consent for participation.

**Results**

Of the sample, 95 per cent reported some degree of disability and disability level increased with heart failure severity. There were no significant differences according to age or gender. Multiple regression analyses with functional disability as dependent variable showed that 60 per cent of the variance in disability was explained by three variables. Fatigue explained 50 per cent \((p<0.001)\), number of co-morbidities added a further one per cent \((p<0.01)\) and mental status accounted for a further nine per cent \((p<0.001)\). The more fatigued a person felt and the greater the number of co-morbidities, the greater the functional disability, whereas the higher the MMSE score the less functional disablement was reported. Once fatigue was entered into the equation, heart failure severity and other physical variables such as breathlessness, oedema, left ventricular ejection fraction and forced expiratory volume did not significantly increase the per cent of variance explained.

**Discussion**

This study indicated that self-reported fatigue is the major correlate of functional disability in heart failure patients. Functional disablement was not significantly predicted by symptoms of breathlessness, oedema, forced expiratory volume or left ventricular ejection fraction once fatigue was taken into account. Clinical studies of heart failure patients have not yet shown the causative physical mechanisms underlying fatigue in heart failure patients, though Drexler and Coats (1996) suggested impaired peripheral perfusion during exercise, reduced oxidative capacity of skeletal muscle, or reduced muscle strength as candidate explanations. The subjective nature of fatigue has hitherto been regarded as making the construct problematic. However, it is possible that it is precisely because of its subjective nature that fatigue is useful in the prediction of functional disability. It has been known for a long time that physical impairment maps onto functional disability imprecisely and that psychological and cultural variables may play a larger role. For example, ‘rational choice’ models of disablement (whereby individuals reject becoming disabled for highly valued activities more readily than for activities valued less highly) may be more appropriate in understanding the options available to the older person with a chronic illness (Williams, 1979). Viewed in this light the presence of co-morbidities and lower cognitive competence can be interpreted as further narrowing the individual’s freedom of action, choice and control over the environment, thus increasing disablement.

The measurement of fatigue has posed problems in some studies because of the implicit or explicit overlap between symptoms of fatigue and those of depression. Depression is known to be important in heart failure, being both a predictor of future heart failure in depressed people who have not yet shown symptoms of heart failure as compared to controls (Williams et al., 2002) and in being a consequence of the disease once diagnosed (Koenig, 1998).
However, this was not the case in this study. The measure of fatigue used had no explicit common content with symptoms of depression, being designed specifically for heart failure patients and focusing on the extent of activity possible before becoming ‘fatigued’.

It is clear from this study that levels of fatigue should be assessed routinely in the examination of heart failure patients. This is particularly important because exercise training improves capacity and ameliorates fatigue. Cardiologists and specialist heart failure nurses are in a good position to give the necessary advice and facilitate such training.

The data reported here are cross-sectional. Future studies will investigate whether fatigue is also useful in predicting functional disability longitudinally.

In order to understand the nature of functional disability in late life it is likely that we will have to measure the context in which disablement occurs in a variety of physical conditions. This may allow us to ascertain to what extent there are commonalities in the correlates of disablement with particular symptoms such as fatigue.

Acknowledgements
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Facing up to ageing

Jeff Garland

MYTHS (BELIEFS THAT ARE widely held but not necessarily well founded) influence the way ageing is viewed in society (Friedan, 1993; Gullette, 2004).

Some are generally negative: ‘the elderly’ may be viewed as a drain on resources, in terms of pensions and consuming more than their share of NHS treatment, as being out of touch and disengaged from society, as being eccentric and grumpy.

Later life does of course have a dark side, and gerontologists acknowledge this. For example, human ageing has been defined as ‘An increasingly disorderly and undirected process of biological and behavioural disorganisation and degeneration, culminating in death’ (Bromley, 1988, p.27).

An understandable reaction among apologists and advocates for older people is to generate counter-myths that stress positive aspects of ageing. These can highlight wisdom and richness of experience, learning opportunities of ‘the Third Age’, and the social capital that retired people represent, and opportunity to rise to the challenge of existential crisis – holding awareness of fear and the certainty of extinction but going on with life nevertheless.

How important is it for the practitioner to understand such beliefs and how they may influence clients and practitioners, and apply this understanding in practice?

Slater (1995, pp.129–132), reviewing research on wisdom and successful ageing comments that psychologists appear to have fallen for the temptation to profile the wise older person in their own image – wisdom is defined as being psychologically-minded. He is reminded of J.P.Donleavy’s definition of ‘psychologist’ – *complacent son of a bitch*.

He also points out that for psychology to hold up wisdom as a goal to be achieved in late life may be dispiriting for people who definitely are old but who do not see themselves as particularly wise. Rather than being uplifted and aspiring to be consulted (Berezin, 1978), they may end up with yet another reason for feeling inadequate.

It could be helpful for older people to remember, suggest Dangott and Kalish (1979), that if adult life is to be seen as a process of continuing development, then in later life it may be more realistic for us to relax into enjoying a process of movement towards wisdom rather than to consider a settled wise state into which we can smugly snuggle should be the target. Accordingly, they advise (prescribe?): ‘protect yourself from … prescriptions. Practice your own version of experience. Ageing can be a time to express your bold demands for enhanced personal freedom, uninhibited sensuality, the joy of earned idleness, and euphoric sensations’ (p.110).

Myths and counter-myths seesaw between pessimism and optimism: are older adults in general to be viewed as lessened in the sense of diminished – a growing down; or lessened in the sense of being able to draw on what they have learned from living?

Perhaps the contrasting views can be held in creative tension and even reconciled. We need to recognise that how an individual faces up to ageing is a function of resources (economic, health, social status and social support), and of personality predisposing to choice of lifestyle and preferred methods of coping with challenge.

Where does PSIGE stand? It is politically correct not to appear to discriminate against older people, but in our eagerness to prove ourselves au fait in this respect we risk becoming unrealistic and unscientific in putting undue emphasis on positive ageing.
Like any body of professionals we should understand and counter the pervasive Niskanen Effect whereby the needs of the professionals have undue weight in determining how a service is presented and delivered.

If we wish to listen to the clients and understand how they view their own ageing we may tap into their life review. This is a continuing reflective process starting in childhood with the development of autobiographical memory. It has three aspects: focusing on what has been learned about the self in relation to others; considering whether this learning is still relevant; and editing (recognising what should be retained, revising what is unclear, and discarding what is no longer required). In the course of listening over a continuing working life of 40 years I have noted many clients invoke one or more maxims (rules for behaviour) that they have adopted in ageing. Seven of those most frequently cited are:

**Respect yourself** (No calling yourself names, no odious comparisons with others).
Relates to ego integrity. An individual makes identification with humankind, comes to grips with the contribution he or she has made to society, and is forced to make a reconciliation with the realities of life in comparison with what he or she had hoped to accomplish. Ego integrity ‘is a quality of ‘serenity’ and ‘wisdom’ derived from resolving personal conflicts, reviewing one’s life and finding it acceptable and gratifying, and viewing death with equanimity’. (Butler 1975, p.417)

**Open up** (There’s no business if you don’t).
Openness to experience (OTE) is free expression of feelings, ability to accept uncertainty, wide repertoire of behaviour, and flexible self-concept. Those low in OTE find it difficult to adapt to age-associated changes in role, health and function that accumulate over time – and are more at risk of suicide in later life. (Duberstein, 1995)

**Become your real self** (You don’t have to change).
Individuation seen by Jung as seeking wholeness. ‘Consciousness should defend its reason and protect itself, and the chaotic life of the unconscious should be given the chance of having its way too – as much as we can stand. This means open conflict and open collaboration at once. That, evidently, is the way human life should be. It is the old game of hammer and anvil: between them the patient iron is forged into an indestructible whole, an ‘individual’’. (Jung, 1939)

**Take charge** (Who, if not you?)
Successful ageing equated with developing primary control directed at the external environment, involving attempts to change the world to fit the needs and desires of the individual; and secondary control of the way we view the world and stay motivated. Selection processes regulate the choice of action goals so that diversity is maintained and positive and negative trade-offs between performance domains and life stages are taken into account. Compensation processes help us to learn and carry on after failures. (Heckhausen & Schulz, 1995)

**Try something new** (Never too late)
‘Wisdom is adapting an age-appropriate programme … re-evaluation, reflection … new departure. Each season of life has its own particular character, value, and developmental tasks. We would not live as long as we do, if this longevity had no purpose or meaning for the species. The afternoon of life has just as much significance as life’s morning and midday, but it is different. It is foolish to try to live out the afternoon of our lives according to the programme developed in our childhood and youth. In my experience, mid-life is a time for re-evaluation and reflection and examination of the roads we have taken thus far, and the roads not taken. Very often for many people the later years provide opportunities to explore some of those roads not taken earlier.’ (Staude, 1981, p.13)
It's who you are (Not what you do)
Ego differentiation. An individual becomes able to redefine his or her sense of personal worth, shifting the focus from what he or she ‘does’ to what he or she ‘is’. Peck (1955) identifies body transcendence and ego transcendence as vital in later life. For the former a person redefines happiness apart from the context of good health, attending to the capacities that remain in old age, rather than physical capabilities diminished or lost. For the latter, an individual comes to understand that life goes on through others, and passes down wisdom to younger generations.

This is it and that is that (No ‘if only’ regrets)
Martin Grotjahn, an analyst, recovering in late life from a heart attack: ‘I feel like an old man. I don’t work and what’s more I don’t walk. It’s strange but it doesn’t bother me. Suddenly 50 years of work is enough. I no longer take care of patients, and I no longer accuse myself of not understanding them or knowing how to help them. I feel liberated from the guilt that accompanies our work and feeling that I will never be as adequate as one would hope. It’s for others to take up the banner. I’m through with my practice and with problems. I sit in the sun, watching the leaves fall in the pool. I think. I dream. I draw. I feel liberated from the world of reality. I still love, in a tranquil way, and I still feel loved by my family and friends. I have time. I don’t know how much time remains to me, but I’m not in a hurry … Now, I understand better.’ (Woodward, 1991, p.180)

How useful might it be for a practitioner to elicit a client’s maxims and how these are applied, and to discuss the relevance of others not advanced?

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References
Working with clients who express prejudices: How best to respond?

Jennifer Crean & Polly Kaiser

This article describes the collective effort of a group of mental health professionals in trying to work out how best to respond to clients who express prejudiced views. It refers to work with older people, but it is hoped that the points raised may be of use to those who face such difficulties with other client groups.

There is a lack of research in this area. Racist remarks can be expressed by a client of any age and can be difficult to deal with. The focus of this article, however, is how this was dealt with on an older adult placement. It considers how ageism may combine to make dealing with these remarks even harder. It describes an attempt by a team to address this.

There is a major lack of writing or research in the area of expressed racism (or indeed any other type of prejudice) by clients, and recommendations of how, as therapists we can deal with such issues. In the work that can be found, there seems to be a focus on white therapists working with non-white clients, and to a lesser extent, non-white therapists working with white clients (Littlewood & Lipsedge, 1982). In a recent issue of Clinical Psychology this topic was viewed from a new perspective by Halsey and Patel: ‘Interestingly, racial issues within the white psychologist/white patient dyad have not been reviewed in the literature. This is disappointing, since anecdotal evidence from white psychologists suggests that they often feel extremely uncomfortable but are unsure how best to respond when faced with their white patients who make racist statements.’ (Halsey & Patel, 2003)

So what do we do when we work with clients whom we may superficially share a similar cultural background with, but who make prejudiced comments that make us feel uncomfortable? How do we best respond? This article acts as a starting point for thinking about such issues, and what we can do about them.

The first author, having recently completed a placement with older adults as part of her clinical psychology training, and having previously worked as an Assistant Psychologist with older adults, felt that facing such difficulties in working with older people was not uncommon. It was surprising then that upon searching, references in the area tended to focus only on how therapists should overcome their ageist assumptions when examining the role of prejudice in working with older people. Such texts frequently include a discussion on how Freud’s legacy has had a powerful influence on thinking and practice associated with working therapeutically with older people. Freud’s view that older people cannot benefit from therapy is still held by some people today (yes, even psychologists!), and is, therefore, an important point that still needs to be reiterated (see Hepple, 2002). But surely it is just as important not to ignore such prejudices in our clients?

From discussions with colleagues who work with older people, this appears to be an issue which many face on a regular basis, and yet one in which very few feel comfortable or competent to deal with. Many feel that it is only to be expected in working with older adults that they will express certain views on race and yet, this in itself could be considered an ‘ageist’ viewpoint. Would we expect racist, sexist or homophobic remarks when working with other client groups? Furthermore, would we deal with them in the same way?

These thoughts became the focus of supervision on the first author’s recent older adult placement, when working with an
older lady who was experiencing difficulties with anxiety and low mood. The client began to make very subtle racist comments, mainly related to the fact that she was frightened to live in an area which was becoming extensively non-white. This led on to some derogatory comments about the way that such communities raised their children. To make matters more difficult, these comments were usually said at the very end of the session, as the trainee was preparing to leave, and caused confusion about how to address the issue appropriately. Although the statements were in no way directly linked to the therapeutic work that was being carried out, the first author became aware that they were negatively affecting both feelings towards the client, and the work. This led to dreading sessions, and becoming irritated by descriptions of the client’s difficulties which had previously invoked empathy.

Although ways of confronting the client about the difficult feelings were suggested in supervision, the first author found many excuses not to follow these through! There was a concern that confronting the client would negatively affect the client’s depression, harm the therapeutic relationship and a worry about offending the client by being honest! More so, there was a responsibility to hold onto the burden of being upset and angry, rather than sharing it with the client. There was also a feeling that the client would be horrified to learn that she had caused any offence, as it is an easier option to convince ourselves that there was none meant, without ever giving a client the chance to explain what their viewpoint actually is. In that respect, the first author felt that she fell into Halsey and Patel’s ‘apolitical stance’ category, not wanting to ‘blame’ the client for her own views; ‘we typically interpret racist statements in terms of the patient’s frustration, insecurity or anger’. (Halsey & Patel, 2003)

However, a nagging doubt persisted which suggested that the real reason for not confronting the client was down to a belief that she could not change her opinions. Indeed, this was clearly a prejudice in itself. Is the reason we do not address such issues with our older clients because we believe that they are too old to change? This view contradicted the work we had done together. How was it possible to believe that she could change her depressive and anxious thoughts, but not her prejudiced views?

Finding ways to solve the problem was an ongoing struggle in supervision, and it was thought that it may be a good idea to ask other colleagues how they dealt with such issues. Therefore, the second author was approached by the Older Adult Placement Supervisor to lead a discussion on how these issues affected our team.

The second author was asked to facilitate the team in their thinking about these issues. She was approached as someone who provides some teaching on race and culture within an older adult module of a clinical psychology training course. She does not claim to have answers, especially as the aims of the university teaching covered a very different territory than the one embarked on here.

This was a different enterprise altogether, one about how to deal with racist comments from an older white client with a younger white therapist. The aim in the team meeting was to create a safe and non-judgmental space for the team to talk about their own experiences in relation to this issue.

The definition of culture used was that from Faliocov (1995) namely that culture is: ‘ Those sets of shared world views meanings and adaptive behaviours derived from simultaneous membership and participation in a multiplicity of contexts – such as rural, urban, suburban, language age, gender, cohort, family race, ethnicity, religion, nationality, socio-economic status, employment, education, occupation, sexual orientation, etc.’

These things operate at different levels, within therapy, within hospitals, trusts, organisations and the profession of clinical psychology. As can be seen age and cohort are examples of culture and, as such, working across the generations could be seen to be working cross culturally.
The second author also had in mind here something about white identity and where one is in one’s own journey here. It has been recognised for some time now that there is a need for white individuals to explore their own concepts of whiteness and explore their own racism. Carter (1995) has reviewed different identity models for white people. Rather than a stage model he says that there are three key tasks for white people to accept namely:

1. To accept whiteness;
2. To understand the meaning of being white;
3. To develop self concepts devoid of elements related to racial superiority.

As with any stage model there are problems. People oscillate between stages at different times. The stages discussed by Carter are as follows:

- **Contact** – Lack of awareness of whiteness – everyone is an individual.
- **Disintegration** – Become aware of whiteness and conflicts – may avoid certain situations.
- **Reintegration** – Into whiteness ‘blacks are to blame’.
- **Pseudo-independence** – Start looking again and begin to become aware of intentional and unintentional racism. See the benefits of being white – but ‘blacks’ need to assimilate ‘our’ values.
- **Immersion-emersion** – Embracing whiteness – proud of it say ‘we are all racists’ – but this alienates from both white and black people.
- **Autonomy** – New meanings are found which neither idealise or denigrate in terms of racial grouping.

The older client might be said to represent someone at the first stage. The authors and team members could be said to be at various stages after that (except probably for the reintegration stage). This model was not used explicitly at the time but as a way of the second author understanding the variety of reactions People know they feel uncomfortable but are not sure how to deal with it so do not. How can feelings of discomfort lead to action? This is not just about personal responsibility but also training and organisational issues that need to be addressed at all the levels described earlier (Patel et al., 2000; Fleming & Steen, 2003).

This piece of work is an example of a team taking their discomfort one step further to discuss what they might do differently and how they might support each other in those steps.

Situations were discussed in which team members had found themselves where racist comments had been made. Feelings about peoples’ reactions and non-reactions were aired. It was interesting how these varied depending on the context in which people found themselves. Some said they would have spoken differently had the person been a younger adult. In evidence again were the ageist assumptions that maybe the older person ‘couldn’t help it’ ‘it’s a cohort effect isn’t it?’. Some said it depended on if the contact was a one off assessment or ongoing therapy. Views were mixed here. Some thought it would be easier to do in a one off assessment as there was no ‘therapeutic alliance’ to be affected. Others said it would be less important to address in a one-off assessment but would need to be tackled in a an ongoing therapeutic relationship. Some felt it would be harder to comment in case it affected the ‘therapeutic alliance’. Yet as the first author noted the comments were affecting the alliance form her point of view. Things that people might have said had similar comments been made in their personal lives regarding these comments did not always feel possible in professional lives.

As people spoke a note was made of responses people had been able to give. This was fed back for more discussion and elaboration. While some of the conversation included discussion about racist comments made to therapists from other cultural backgrounds, and also what to do when colleagues make racist comments, these did not form the action points drawn up.

The following are some action points that began to be drawn up that afternoon in relation to therapeutic work with older people.
Possible action points

- Vent (with someone you know and trust);
- Talking in supervision;
- Feel more confident about setting boundaries;
- Owning feelings for self by saying to a client, e.g. 'I don’t feel comfortable with that';
- Rehearsing what you might say (often taken by surprise, but if know/dreading, it is helpful to have certain phrases up your sleeve);
- Be prepared;
- Not colluding;
- Pregnant/meaningful pause;
- Individual non-verbal responses;
- Not smiling/laughing nervously.

Some of these may seem passive and as still colluding, especially the last three. They were given as examples of actions taken within therapeutic context with older people which arose in a multiplicity of situations. By the end some people had made a decision to deal with comments as they would with a client of a younger age. Others still felt it was difficult to make overt statements. The desire not to collude was there but uncertainty still remained. As pointed out by Falicov, however, it is important that when therapists are in conversations that include cultural themes that they pursue them with ‘risk and respect’ rather than with covert judgements. Perhaps there needs to be an emphasis on risking curiosity?

Summary

This is not some great piece of scientific or experimental work but a group of therapists meeting to discuss the issues and dilemmas posed in daily practice and to offer each other some alternative ways of dealing with them. The list is not exhaustive nor is it necessarily a non-collusive one. It could be criticised for giving people the feeling that they had done something and just confirm them in current practices. It can also be seen as an attempt to move further along in one’s own awareness of whiteness and what actions might be possible. It is a beginning step. Both authors would be interested in how others tackle this situation.

Acknowledgements

We would like to thank Dr Jane Winter and the ‘Memory Clinic Team’ at Laureate House, Wythenshawe Hospital, Southmoor Road, Wythenshawe, Manchester, for all their help and support in thinking about this issue.

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References


A new look at fear of falling

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Approximately 30 per cent of community dwellers aged 65 or over fall each year (Tinetti et al., 1994) and a fifth of fall incidents require medical attention. Falls are a leading cause of death in older people, and in the UK alone approximately 14,000 die each year as a result of a fall (DoH, 2001). Standard 6 of the National Service Framework for Older People (NSFOP) requires the NHS to implement falls services, and both NSFOP and the National Institute for Clinical Excellence Guidelines on Falls (NICE, 2004) recommend that the psychological consequences of falls should be addressed. Fear of falling (FOF) is both a predictor and a consequence of falls (Friedman et al., ???), particularly amongst frail, older people. Previous research has indicated that between 29 per cent to 92 per cent of fallers and between 12 per cent to 65 per cent of older non-fallers report FOF (Legters, 2002), signifying that a fall is not essential to the development of FOF (Tinetti & Powell, 1993).

Over time, fear of falling has been defined in different ways by researchers, ranging from ‘a severe phobia’ (ptophobia) (Murphy & Isaacs, 1982) to ‘falls-related quality of life’ (Parry et al., 2001). Fear of falling has been operationalised as a restriction of activities out of proportion to any injury sustained from a fall (Tinetti & Powell, 1993), but although this may be the case, FOF appears to be a more complex problem that needs to be more clearly understood. Fear of falling has been measured using three main strategies. First, by asking a single or dichotomous FOF question, such as ‘Are you afraid of falling?’ Dichotomous questions lack sensitivity, report only on a global state and take no account of the consequences of a fall (Yardley, 2004). Furthermore, as reliability analysis cannot be carried out on dichotomous questions, the validity of such a question must be called into doubt. Second, are falls efficacy (FE) scales, such as the Falls Efficacy Scale (FES) (Tinetti et al., 1990) that indicate the levels of perceived confidence an individual has about carrying out everyday activities without falling. This scale was developed using health care professionals and, therefore, may not provide an assessment of the subjective state or attitudes of older people. Although FE scales are often used to measure levels of FOF (Jorstad et al., 2005), it has been suggested that FE and FOF are related but empirically and theoretically distinct constructs (Tinetti et al., 1994; McAuley et al., 1997) and rather than measuring FOF, FE is a mediator between FOF and functional ability (Li et al., 2002). Third, are scales that measure activity restriction, but additionally measure the negative consequences of FOF (Li et al., 2003). These scales, such as the Survey of Activities and Fear of Falling in the Elderly (SAFFE) (Lachman et al., 1998) and the Falls Handicap Inventory (FHI) were developed subsequent to the FES (Rai et al., 1995).

It is accepted, but not fully explained, why not all fallers develop a fear of falling yet others develop such a fear vicariously. FOF is a dynamic phenomenon (Huang, 2005), and as a result, individuals are not necessarily consistent in admitting to a fear of falling over time or from situation to situation. A possible contributory factor to such findings is the personality of the individual. Thus, some individuals may have a tendency to over-react to events in general, especially in terms of negative emotions such as fear or anxiety. As fear of falling has previously been
linked to anxiety (Yardley, 1998), it was decided to investigate a dimension of personality that has been well researched, that of neuroticism (N).

The present study investigating fear of falling was carried out using different scale strategies (outcome variables) in a group of patients who may be considered to have a high reason to be concerned about falling. This study group consisted of patients whose falls had resulted in a fracture and were subsequently referred for a bone scan (DEXA – Dual Scan X-ray Absorbtometry) to see if they had osteoporosis. Osteoporosis is a disease that leads to a reduction in the strength of bones, making a faller more likely to fracture, especially the hip, back, arm and wrist (Burke, 2004). Fear of falling was assessed using both a FE and a FOF scale (the FES and the SAFFE) in the same patients at the same time. The SAFFE has three subscales looking at levels of activity, worry about falling and restriction of activities within the last five years. The latter two subscales ‘worry’ and ‘restriction’ were analysed to measure FOF for the purposes of this study (Hotchkiss et al., 2004). The personality variable of neuroticism (predictor variable) was measured using the NEO scale from the NEO-PI-R (Costa & McCreae, 1992b). Functional status was determined by using a five-question scale assessing physical functioning and independence.

The sample consisted of 84 post-fracture patients attending for their first DEXA scan in an outpatient hospital department. Their ages ranged from 37 to 82 years (Mean=63.3; SD=9.86). There were 66 females (79 per cent) and 18 males (21 per cent). Statistical analysis showed that there were no gender differences for any outcome or predictor variable, and no age differences on any outcome or predictor, except that older people exhibited less neuroticism. Internal reliability analysis for the FES and the worry and restriction subscales of the SAFFE showed alpha levels of 0.96, 0.91 and 0.89 respectively.

The contribution of neuroticism to the variance of scores from the three outcome measure scales of FOF was explored using hierarchical regression analysis. No demographic variable (such as age, gender or health status) was significantly correlated with the outcome measures and were therefore not entered into the equations. Both neuroticism and functional status contributed to the variance for each measure of fear of falling. Neuroticism was the largest contributor for the SAFFE worry subscale, accounting for 26.6 per cent of the total variance, the functional status of the patient contributing a further 14.3 per cent. Personality contributed only 19.2 per cent for the SAFFE restriction scale, but functional status contributed 23.7 per cent. For the FES hierarchical regression, personality contributed 27.2 per cent and functional status a further 23.8 per cent.

Although functional status has previously been found to have a significant association with FOF (Kressig et al., 2001), these results indicate the influence the personality dimension of neuroticism contributes to all three FOF scales. Perhaps unsurprisingly, N accounts for more of the variance of the SAFFE worry scale than the SAFFE restriction scale. Worry is a psychological and cognitive dimension (Davey et al., 1992), whereas restriction measures activity limitation. However, the results measuring the contribution N makes to the FES is more equivocal. It might be assumed that the FES is measuring activity restriction but the questionnaire asks about ‘confidence’ in carrying out different activities, and Tinetti and Powell (1993) found that self-confidence was strongly linked to functional status. However, these results show that subjective salience on ‘confidence’ in response to the questions may be readily related to neuroticism. This questionnaire may be exploring both activity restriction (behaviour) and a psychological state (confidence), which may explain the relative relationship between personality and functional status found in the regression.
Further investigation is required to understand the contribution that personality has to the mechanisms and development of FOF and to determine whether FOF is a robust and specific concept. The analysis indicates that the concept of fear of falling needs to be clarified and specified more precisely, as it is possible that all FOF scales are in fact measuring a unitary dimension. This paper reports on the cross-sectional data of the first part of a longitudinal study, and it is hoped that when the study is completed and the full data analysed, some of the issues highlighted in this paper may be clarified.

References

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PEOPLE FROM VARIOUS DEPARTMENTS and clientele attended a seated Tai Chi demonstration at the PSIGE Conference at Chester in July 2005.

The gentle but stimulating exercises were met with great enthusiasm and interest.

Chris Wonder gave an introduction about his work. He has trained in Infinite Tai Chi for five years with a Chinese Master, Jason Chan, spending the last three years adapting/utilising Tai Chi specifically for a variety of groups:
- Elderly;
- Mental Health;
- Dementia/Alzheimer’s;
- Disabled adults;
- Those in need of rehabilitation;
- Stroke patients.

Chris also talked about the benefits of seated Tai Chi which includes:
- Increased circulation;
- Decrease in stress/the amount the client feels symptoms;
- Increase in co-ordination/feel good factor;
- Benefits to virtually all illnesses in varying degrees;
- Clients forming neural pathways (Chris’s own research has found this happens to a large percentage of clients in varying degrees) – concerning Chris, his way of working which is very unique and what a session involves so that they will remember what they do in a session of seated Tai Chi.

There is increasing evidence being attributed to Tai Chi being extremely worthwhile for body, mind and spirit.

Chris facilitates an accredited (Open College of the North West) five-day training course Level 1 for health care staff who wish to practise seated Tai Chi with their own clients around the UK.

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A psychological intervention to prevent depression and anxiety, and maximise recovery following hip fracture surgery

Yvonne Woodward

Introduction to hip fracture and depression

It is important to study the outcome of patients following hip fracture surgery, as the impact on both the individual and society as a whole is high. Post-surgery mortality is common, and the functional impairments that remain after discharge can have serious implications for the individual, as well as adding to an increasing financial burden to society.

Depression is very common following hip fracture, with estimates varying greatly between nine to 47 per cent (Holmes & House, 2000). Research has demonstrated that those who are not depressed at the time of fracture, may become so after a few months (Kempen, 2003).

Prevention and treatment of depression following hip fracture surgery

The larger research study, within which this intervention was undertaken (Burns et al., in press), employed a two-arm, double-blind, randomised controlled trial. During the recruitment period, all patients admitted to four Manchester hospitals with a hip fracture were assessed for depressive symptoms using the Geriatric Depression Scale (patients scoring six or below were eligible to be randomised to the CBT arm of the trial). Those with severe cognitive impairment were screened out, and measures of anxiety, pain and functional ability were undertaken with all eligible patients.

Preventing depression using a cognitive-behavioural intervention

The psychological intervention aimed to prevent the development of depression and anxiety using cognitive-behavioural therapy. Although CBT has been used successfully in the treatment of depression, we are unaware of existing examples of its use in a preventative capacity with an older adult population.

The focus of the intervention was to address challenges, and maximise coping strategies. It consisted of six sessions, and a booster session.

Brief summary: Major features of the intervention

Explaining the rationale for the therapy was of the utmost importance, as clients did not generally view themselves as having current difficulties (although some worries and anxieties were evident.) Thorough information gathering, and the teaching of pre-therapy skills, helped to build rapport with the client, and enabled comprehensive formulations.

The treatment manual specified issues to be addressed during each of the six sessions (although this was flexible, and adapted to the needs of individual clients). Decision trees were used to develop attention-focused coping strategies, helping the client to focus on the here-and-now. This was accompanied by relaxation training, and psycho-educational material on falls prevention. Activity scheduling and a diary system was also used where appropriate, for example, if a client reported fears about falling again and had restricted their activity.

Outcomes and lessons from therapy

Only six per cent of those who received our intervention became depressed at follow-up, as opposed to 15 per cent of the ‘treatment
as usual’ group. In addition the CBT intervention led to a greater number of clients regaining their pre-morbid (pre-surgery) level of physical functioning.

**Predicting those most at risk of developing depression**
If we can identify those most at risk of developing depression immediately post-surgery, we can allocate limited resources effectively, therefore preventing further suffering and enhancing functional recovery. Relationships identified in this study suggested that risk factors at baseline may include:

- More severe cognitive impairment;
- Higher anxiety levels;
- Poorer pre-morbid mobility levels.

The relationship found between baseline levels of depression and anxiety, and those expressed at six months is also very important, as it identifies the stable and enduring nature of symptoms which can lead to increased suffering, and poorer functional outcomes if left untreated.

**Reactions to hip fracture – models of recovery**
It has been possible to identify specific models of recovery exhibited by clients, which can negatively affect functional outcomes (Proctor et al., in preparation.) This can then inform and focus appropriate treatment allocation.

The three major models identified during this study are:

- **Fear of falling**: An exaggerated worry of falling again which can lead to reduced activity, muscle weakness, and poorer functional outcomes.
- **Over-exertion**: The client believes that they will be ‘back to normal’ immediately, leading them to engage in high levels of activity, which can result in exhaustion. The risk of falls and further fractures/dislocation if necessary precautions are ignored is very high.
- **Excess Disability**: A lack of activity and over-reliance on others to perform tasks which the client themselves should be able to do. This can lead to muscle weakness and poorer functional outcomes.

**Summary and implications**
The potential to identify those most at risk of developing depression, and models of the mechanisms of recovery that can lead to poorer functional outcomes, has important implications for resource allocation and targeted therapies following hip fracture surgery. Further research needs to be done in this area, and our clients are currently being followed up to chart the natural course of depression, and the impact of intervention over a two- to three-year period.

The research summarised here does demonstrate how the application of psychological principles and theory can have wide reaching positive implications with this client group.

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**References**
FOLLOWING A LUCKY IF TIRING trip up the A14 and M6, I arrived in Chester to follow a series of well-placed signposts guiding me to the University College Chester. Since I was navigating at the time these were a welcome relief from the multitude of maps that I’d used to guide us thus far. It was also a sign of how well organised the event was. As a virgin of PSIGE conferences, this organisation was very supportive – as were the many approachable/friendly conference organisers and delegates. We were immediately greeted (even with our 7.30 p.m. arrival) and headed for the dining hall and union bar to be fed and watered.

The next (and following days) began bright and early with breakfast followed by healthy portions of workshops, parallel seminars and lectures. My workshop (‘Using psychodynamic therapy to inform practice with older people’) provided an initial grounding (and many discussions) into the observation process (as used at the Tavistock) and the similarities, differences and changes in the parent-child and adult care giver-older adult relationships and containment processes. The afternoon examined the approach, practical issues and concerns of psychotherapeutic observation of a child and older adult. The case material used provided interesting discussions into potential biases in post-observation note taking, the similarities/differences and changes in relationship (from parent to child and adult care-giver to older adult) and the containment process in these relationships. Further interesting discussions took place on the difficult nature of containing older adults as opposed to children in terms of awareness of the developmental course of children (and, therefore, hope) versus the more existential issues and course of older people.

The afternoon took these observations one step further through the examination of a therapy case of an older adult with anxiety problems that had experiences multiple losses throughout their life. Discussions regarding the case material were interesting and varied ranging from Eriksonian perspectives on life-stage issues, to CBT, to an examination of the control the client was exerting and their resilience through many difficult life events.

The final discussion highlighted for me the interesting way in which the observations technique used required therapists to recall post-observation all of the content of the observations (from which group discussions, in a similar process to supervision, contained and reframed the processed that may have been occurring in the observations/therapy). Issues of the potentially idiosyncratically biased nature of such observations were discussed, as were potential research into such issues and the helpfulness of group
discussion/supervision of material in therapy/observations in discussing the causes of and interpreting such biases. I found it a very useful introduction to the use/incorporation of these ideas into day-to-day work. This first day was followed by rapid open-top bus-tour and a guided ghostly foot tour of the most haunted city in England.

My second day was spent learning more about Asperger’s in older people, the use of CBT with mild-moderately depressed older people in primary care and the feasibility of CBT for depression associated with Parkinson’s disease. A brief break was followed by a seminar on the use of hypnosis as an adjunct to therapy and a brief introduction to solution focused work with older people. The keynote speech by Mervyn Eastman was quite invigorating and you could tell by the response of those present that many of his feelings about the treatment of older people were shared by those present. The latter part of the afternoon for me was taken up by an intriguing discussion on supervision by and for clinical psychologists (including training and accreditation for supervisors) and the finale by Professor Woods following the history and changes to PSIGE over 25 years. My evening was filled with an incredibly social (if irregularly dressed) cohort of PSIGE delegates bopping to 80s tunes. Reminiscence therapy for me! It was a great and well-run evening with excellent live music.

My final day was spent in a number of seminars, from Graham Stoke’s ‘Person-centred approach to challenging behaviour in dementia’ to Jorien Van Paasschen’s ‘Cognitive rehabilitation for people with Alzheimer’s disease’. Over the three days I was surprised by how approachable and passionate the PSIGE delegates were about their field of expertise and the developments that are being made in the area. I look forward to attending future PSIGE conferences as I complete my final year and in future years post-qualification. The return trip home was arduous but the discussions regarding our experiences were long and interesting.

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IN MY CLINICAL PRACTICE MY special interest involves working dynamically with older adults. Because of this it seems only natural to offer my personal comments on the second workshop, namely ‘Using psychodynamic therapy to inform practice with older people’.

To begin with I will start with a general description of the day as I remember it. Following this I will attempt to offer some personal impressions of the day and perhaps make some recommendations for future similar workshops.

The workshop took place on the first day of the PSIGE Conference and lasted for the whole day. More specifically, the workshop took the format of a larger group, which consisted of 15 group members and had two group leaders.

The day was organised in two parts. During the first part, two detailed psychodynamic observations were presented. One described a mother and her infant while the other described an older adult in an EMI residential setting. Following this the group was invited to make contributions.

During the second part of the day a clinical piece of work was presented, after which the group was invited again to make contributions. The day ended with a general group reflections of the day.

To begin with I would like to express my appreciation to Marie Claire Shankland for agreeing to organise and lead the workshop. It was very encouraging to see the vast amount of interest that this workshop has elicited. To begin with the workshop appeared to have exceeded its limited intake capacity of 15 places even thought this was organised well in advance.

With respect to the content of the workshop, I felt that this was well thought-out and organised. Each observation presented was very stimulating and encouraged each member of the group to make contributions in terms of the way each felt about it. In turns the amount of interpretations accumulated collectively raised a number of very interesting points in relation to internal models of self, other and the relationship between self and other. However, more time could have been spend in reflecting upon the effects of the observer on to their observations.

In terms of future similar workshops I feel that it would be beneficial if this would also include a part in which the understandings gathered from the psychodynamic observations and clinical presentations are reflected more up on so that a deeper understanding of how these could be directly applied in the clinical practice with older people would take place.

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WHAT DO WE UNDERSTAND BY the term Mental Health? The Age Concern and Mental Health Foundation Inquiry into Mental Health and Well-Being in Later Life suggests that rather than well-being or even happiness, the term mental health is more often associated with mental illnesses such as depression or dementia. Their three-year, UK-wide inquiry aims to:

- Raise awareness of mental health and well-being in later life;
- Empower older people;
- Create better understanding and a base of evidence and knowledge;
- Influence policy and planning;
- Improve services; and
- Serve as a model of partnership and UK-wide working.

The half-day workshop at the 2005 PSIGE Conference, led by Michele Lee, provided an opportunity for those present to hear an overview of the inquiry, its findings and draft recommendations. Attendees were invited to give feedback on the recommendations, identify gaps and priorities and consider how clinical psychology may play a role in influencing policy makers, professionals and the public.

In conducting a wide literature and policy review, the inquiry found very little evidence for what keeps people well in later life. This lack of evidence makes it even more difficult to impact on policy and service provision. Via consultation with approximately 1000 older adults and professionals they were able to identify the following factors as helping to promote well-being in later life:

- Close family;
- Taking outings;
- Having plans;
- Good health;
- Feeling valued;
- Feeling respected;
- Pets; and
- Spirituality.

More likely to reduce well-being in older adults was:

- Having money worries;
- Health worries;
- Lack of mobility;
- Negative portrayals of older people;
- Fear of crime;
- Availability of food;
- Changing role; and
- Being isolated from family.

What influence may clinical psychologists have on policy makers, professionals and the public in promoting well-being in later life? Feedback from the group ranged from local opportunities to share the concept of mental health over mental illness with other team members or the extension/development of roles centred in the community around keeping older adults well, to the larger influence that the PSIGE representative taking part in the inquiry allows clinical psychologists to have.

The workshop provoked a great day of discussion and at just past its mid-way point the inquiry looks certain to provide a greater understanding of mental health and well-being in later life.

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My first PSIGE Conference

Katrina Neilsen

My first PSIGE Annual Conference proved informative and interesting and allowed me to reflect on some of the issues relevant to working as an assistant psychologist with older people. I found the lectures particularly helpful and relevant to my current work.

I attended a lecture exploring the principles of transactional analysis in working with older people, which proved illuminating in unravelling the implicit power balance within interactions, including those between client and therapist. I was struck by the impact that this approach can have on challenging this power balance and empowering the client and therapist to recognise and alter the ego position they may be taking in interactions.

The issue of power and culture motivated my next choice of lecture which examined the outcome of a cultural awareness programme for professionals working with families of Gujarati origin. The lecture reminded me of the necessity of understanding the wider systems around the client and their role within these systems, and to be aware of the impact that culture can have on the outcome of assessment and intervention. I was able to more fully appreciate the need for respect for cultural differences as essential for work to be relevant and successful for the client.

In my own work I have been unsure about how best to respond to prejudiced comments occasionally expressed by clients and so found the next lecture which examined working with clients who express prejudice both useful and encouraging. The issue was discussed of how far reluctance on the part of the therapist to challenge expressed prejudice may reflect assumptions about the extent to which change is possible with the older age group. The lecture highlighted the need for further research in this area, in particular around white clients working with white psychologists. The lecture sparked wider debate around the role of the therapist and the extent to which challenging prejudices should be included in therapeutic work, which I found particularly thought-provoking.

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To reflect on my experiences from this year’s conference, perhaps the most pertinent thing that comes to mind is how privileged I felt to be part of PSIGE on its Silver Jubilee.

This year was a special year, and there was certainly an air of sentimentality amongst many of the delegates whom I spoke to over the three days. This was made all the more poignant when Professor Bob Woods presented his keynote speech entitled ‘Still crazy after all these years: An examination of the PSIGE mentality’.

The ‘PSIGE mentality’ – of wishing to celebrate ageing – was made more apparent to me through attending a number of the workshops and presentations across the three days at the conference. I will go on to review what were for me, some of the highlights.

On the first day I attended a workshop on biopsychosocial approaches to challenging behaviour in dementia. The workshop effectively demonstrated examples of person-centred care in practice. Credible evidence illustrated that by ‘unpicking’ events and testing hypotheses about the behaviour of an individual, there is considerable scope for psychosocial interventions that can provide alternatives to a reliance on pharmacological interventions.

On the second day I attended a seminar on pre-diagnostic counselling in a memory screening service. I was particularly interested in discussions surrounding ‘diagnostic disclosure’. Again, much tied in with the theme of person-centred care – diagnostic disclosure in dementia should not be routine, instead it is the responsibility of the health care professional to understand the client’s preferences and to enable the client to have choices about what information they receive.

On the third day I attended a presentation on a service-user’s experiences of living with a diagnosis of dementia. As thought-provoking as it was moving, I felt particularly inspired by the gentleman’s positive approach towards his diagnosis. This was summed up when he concluded that he was ‘Living with dementia not dying from dementia’.

No longer a PSIGE conference ‘beginner’ and with my mentality well and truly ‘PSIGE-d’, I look forward to the developments over the next 25 years and the Golden Jubilee.

Correspondence
Paul Mason
Assistant Psychologist,
Worcestershire Mental Health Partnership NHS Trust.
Enthusiasm and innovation

Renata Hagan

ENTHUSIASM AND INNOVATION are words which spring to mind when I reflect on the recent PSIGE conference. Being a trainee clinical psychologist who has little experience of the area I felt inspired and welcomed into the PSIGE community! With a good balance of clinical and academic aspects I was very happy to have had the opportunity to come along.

The invited speakers were diverse and, in my experience, interesting and thought-provoking, and I was also struck by how the conference highlighted some of the wider debates within ageing and psychotherapy. I particularly enjoyed Jeff Garland’s seminar on ‘Myths, Counter-myths and Maxims’, when facing up to ageing. In terms of society’s views of ageing, his observation of the oscillation between negative notions of ageing and the ultra-positive ‘Third-Age’ perception of getting older was very useful in helping me as I embark on clinical practice in this area. This talk struck a chord with my own experience of exploring my views and beliefs about ageing and how they influence my practice and my clients. His reference to autobiographical memory inspired me to explore this as a therapeutic tool to enable clients to understand the relationship between their own ageing and mood difficulties they experience.

The conference offered an opportunity for a wider understanding of different perspectives and ways of working with older people. From Tai Chi and Transactional Analysis to Hypnosis, PSIGE were clearly open to exploring creative ways of working with older people and teams involved with them. The workshops were also interesting and diverse and whilst a little disappointed with not having been able to go along to the workshop of my choice, I enjoyed the debate and discussion generated in the ‘Biopsychosocial’ approaches to dementia. Mike Bird presented a diverse array of case material which stimulated useful debate and conversation, I wonder though had it focused in on a smaller number of case examples in greater depth would the insights have been greater.

I thought the keynote speakers were excellent. I laughed at Professor Woods’ account of PSIGE’s growth and development over the years and was particularly inspired by Dr Eastman’s speech on the importance of truly involving older people in the determination of the type of services they receive.

What really jumped out at me, however, was the passion and commitment of many people who work in this area, oh yes and in view of the Conference’s entertainment agenda, their commitment to enjoyment and dancing also!!

Correspondence
Renata Hagan
Trainee Clinical Psychologist, Leeds Clinical Psychology Training Programme.
As a first-year trainee, I felt rather lucky to be attending the PSIGE conference for the third time (and this time for all three days!). We were in the beautiful city of Chester, the weather was perfect – warm and sunny – and the programme was full of fascinating workshops, presentations and seminars.

I attended the workshop ‘Working with diversity in older age: A systemic approach’. The workshop required a level of personal engagement and a willingness to share ideas with the rest of the group through participation in smaller ‘overheard’ discussion groups. It also included valuable opportunities to watch the presenters work systemically as a reflective team and to learn about the techniques used as part of this approach. This modelling was punctuated with reflection on the process, explaining what they were doing and why, which I found particularly useful.

There were too many presentations and seminars to mention individually, but I found that all those I attended were highly relevant to my clinical work (or potential future work), or excited curiosity and interest about subjects and approaches I had previously known little about. As always there was the inevitable problem of concurrent streams of presentations and some difficult choices had to be made about which to attend.

I found myself much more engaged in the social programme this year, perhaps encouraged by knowing so many people (including my present supervisors and some of my training cohort). The ghost walk around Chester was good fun but rather ‘spiritless’ and not very scary. The 80s disco was fantastic, though in future I will avoid drinking too much of the free wine before dancing. The costumes of those who made the effort to dress up were great and added to the fun.

The only low points of the conference this year were the standard of the accommodation and the lack of menu choice at meal times, which I found problematic. However, in all other respects the facilities were excellent and overall the conference was thoroughly enjoyable and informative.

Correspondence
Daniella Wickett
Leicester University.
Driving along the M56 to the PSIGE conference in Chester, I was seized by an overwhelming urge to turn off early and visit the McArthur Glen outlet village to pick up some bargains and another pair of winkle picker shoes. I wasn’t holding out much hope for the conference, and was convinced that it would be like most other conferences I’d been to – dull, tiring and uninspiring.

I arrived, registered and was given a key to my room. I opened the door and nearly started to sob as I was reminded of my claustrophobic cell at University. But there was a shower, and no mould on the wall so that heartened me a bit. I thought ‘let the hell begin’, and stomped off to the first workshop.

I’m not sure at what point the black cloud lifted, but at some point I started to think ‘this is actually alright’. By dinner time, I was almost beginning to enjoy myself, particularly when I realised I would be fed three meals a day for three days and not have to cook any of it myself. Plus there was pudding, and I’d been told a cooked breakfast every morning. I found myself actually running with excitement to get on the big red bus that was taking us for a ghost walk around Chester.

I was a bit shocked the next day when I found there were psychologists working with older people who were actually passionate about what they were doing, cared about the client group, and really wanted to make a difference to the way older people were perceived and treated. I suppose I felt a bit ashamed of myself for feeling so fed-up and jaded after just two years of clinical training, when there were people who had been working in the field for 10 or 20 years plus and were so enjoying sharing their ideas and thoughts with other like-minded psychologists.

By the time I attended the champagne reception on Friday night, I’d stopped working out how I could get off the clinical training course and become an aromatherapist, and I’d started thinking about what I’d learnt each day, and how I was going to put it into practice both as a trainee and when I finally qualified. I’d also started to think differently about older people, even about ageing itself, and was no longer dreading turning 27; maybe even looking forward to turning 77.

I could go on describe in detail the content of the workshops I found most interesting and useful, but in the tradition of Big Brother, I’ll just give you my best bits.

Lesley Allen: Preventing crime against older people: A role for health and social services practitioners? – A really interesting introduction as to what our role might be in helping our clients become more aware and more empowered against distraction criminals.

The Ghost Walk: A brilliant opportunity to see more of Chester, as well as learn more about the history and archaeology of the city with a few grisly tales thrown in for good measure. (Finishing up at the pub was quite good too!)

Chris Wonder: Seated Tai Chi training courses for NHS/professional staff who work with people experiencing various debilitating or restrictive issues – when a guy turns up in a Chinese silk outfit and a roll-up mat, you’re bound to feel apprehensive, but I really enjoyed this hands-on approach and...
a chance to briefly try seated Tai Chi and experience the benefits it can bring.

**Alistair Smith:** Hypnosis: Black sheep in the family or useful tool? – A thought-provoking presentation, which let me challenge my own assumptions about hypnosis, and consider when and where it’s practice may be helpful.

**The 80s disco!** – A really good laugh, I couldn’t believe the effort people went to with their costumes, it was great. Such a good idea and a brilliant way to celebrate 25 years of PSIGE. (I did have to explain it was an 1980s disco to my partner, and not a disco where we all dressed up as though we were 80-year-olds.)

**Jeff Garland:** Facing up to ageing: Myths, counter myths and maxims – This was the workshop I enjoyed the most, partly because I thought Jeff did brilliantly to capture the imagination and interest of everyone there, despite it being the morning after the night before. This workshop did most to challenge my own assumptions about ageing, and to consider our prejudices and preconceptions about older people.

I only wish that more people from my year on the Leeds course had known about the conference, and had been able to come. It was a great conference, really innovative, thought provoking and insightful. Older people’s psychology may not be considered the sexiest area to go on to work in, but for those undecided trainees I really feel this year’s PSIGE conference would have been something of an eye-opener.

**Correspondence**

*Shelly Morris*
Trainee Clinical Psychologist,
Leeds Clinical Training Course.
An excellent conference
Sarah Beech

As an assistant psychologist, this was my first Psychology Special Interest Conference I have attended and I very much enjoyed the whole experience. The overall quality of the workshops, speakers, seminars and posters was excellent. I thought that the organisers and fellow delegates were very friendly, and welcoming, and were all very open to discussions regarding the diverse range of psychological issues concerning older adults. I enjoyed meeting delegates and fellow assistants and discussing the types of activities and roles they undertake with older adults in different settings.

I particularly enjoyed the workshop on the systemic approach to working with older people. I thought the way in which the workshop was delivered was very interactive, which harvested lots of valuable discussion. I learnt a great deal regarding the different types of diversity issues that surround older people. I gained a greater awareness of how our culture and values can influence our work, and will definitely take away the acronym GRACES, and the art of being more curious when exploring diversity issues through my work with older people.

I thought the talks and seminar groups I attended were very thought-provoking, I gained a greater insight into areas I did not know much about. I enjoyed hearing about the current research that people were undertaking. The posters enabled me to find out about current research and practical work that people are applying in the field. This was particularly helpful to find out, and will spur on ideas in our own service.

The social side of the conference was great fun too! I very much enjoyed seeing delegates by day turning into 80s goers by night and the outrageous outfits people wore! The ghost walk was also a fantastic idea, and allowed people to see the beautiful attractions of Chester.

Correspondence
Sarah Beech
Assistant Clinical Psychologist,
Peterborough and Cambridgeshire
Older Adult Mental Health Service.
PSIGE KNOWS HOW TO CELEBRATE in style! Many thanks for the hugely enjoyable champagne reception, cake and wine-accompanied dinner followed by a slightly less composed, but highly entertaining 80s night. I was quite delighted to note that meal times and, in particular, refreshments including biscuits punctuated the lectures.

All that said, I think the conference itself is by far the most interesting conference I had yet managed to attend. I was not left to a diminishing concentration span or wandering mind, despite the promise of yet more tempting nibbles between presentations. Reading previous issues of PSIGE’s Annual Conference Special Newsletter, it seems delegates are always subject to tantalising decisions between which presentations to attend. I found myself no less hard-pressed to choose.

My own personal favourites, apart from Mervyn Eastman’s moving if not impassioned speech, were Catherine Dooley’s and Rebecca Lockwood’s promising-looking home-based CBT depression intervention, and Jorien Van Paasschen’s cognitive rehabilitation for people with AD. A special mention must be given to the surprisingly engaging talk given by Ian James (who stepped in to give the talk) focusing on staff’s toileting habits. I doubt I shall regard staff toilets, public toilets or any other toilet in quite the same way again. It succeeded in being very educational. It has resulted in my equal fascination with possible causes of patient’s toilet avoidance. My only gripe can be that there was not enough time for a short discussion or questions after the most emotive presentations. They were sadly missed, especially after Kate Ross’ sectioning people: impact and outcome, and Caroline William’s critical evaluation of Tom Kitwood’s work. These two provoked much discussion that could have made lively debates.

To close, I am most impressed with the friendliness of all PSIGE members. Everyone was very approachable and welcoming. When I hear you all talking about coming for your annual PSIGE fix, I can’t help but think that it is less likely to stem from the difficulties of your chosen careers but rather from the pleasurable nature of the conferences you throw for yourselves. My thanks and appreciation to the Bursary Committee for sponsoring my attendance, I hope their behavioural management techniques result in greater compliance this year.

Correspondence
Nicola Creamer
St Andrew’s Hospital.
This was the first PSIGE Conference that I have attended. The combination of being able to attend for the whole duration of the conference, with a number of my colleagues from within the trust (thanks to the bursary) as well, made the experience even more rewarding for me. You could say that having my colleagues there gave me a ‘secure base’ from which I could explore, and our discussions helped me to think through how the new information could be incorporated into my day to day work.

The first day involved attending a full-day workshop titled ‘Working with diversity in older age: A systemic approach’ (Isabelle Ekdawi & Eleanor Martin). I have since found out that full-day workshops are not the norm, but I would urge conference organisers to consider them.

This workshop was planned so that it used systemic ways of working, by using smaller groups in the centre of the room for specific tasks, upon which we could reflect as a large group. The large group parts also included some theoretical information, to explain why tasks were completed in the way they were.

This approach gave me (someone not familiar with using systemic principles formally) the opportunity to experience both the theoretical background of systemic work and the ‘how to’ element by being able to see what systemic work looks like.

The time flew by, and I appreciated having the full day so that both areas could be explored in a much greater depth than if only one hour was possible. However, I suspect that people who were more experienced in systemic ways of working and diversity might not have gained as much from the workshop as I did, leading me to suggest that having some information in relation to the ‘pitch’ of the workshop/who the workshop is aimed at would be helpful for future events.

Correspondence
Lisa Peppercorn
Assistant Clinical Psychologist.
Memory Clinic, Peterborough.
Workshops, posters, social events...

Pavan Bassra

As a first-time attendee to a PSIGE event, this year’s conference in Chester, set the standard. The combination of workshops, poster presentations and social events made the experience thoroughly enjoyable.

The workshop that that every clinical psychologist would have benefited from was ‘Should we get our own box?’

Doreen*, a user of mental health services, described her experiences of care following post-natal depression (PND), when the label of PND did not exist. She said that at the time she was a single mum, with very little family and few friends, living in unsuitable accommodation. She discussed her time in an inpatient unit (she did not know why she had been admitted) her view that psychiatrists do not listen, being given Lithium without being told what it was for and how she was refused cognitive-behavioural therapy on the grounds that she already had ‘coping skills’ (Doreen was bemused as to what ‘coping skills’ she actually had). Doreen felt mental health professionals put people in ‘boxes’ and ‘took away years of my life’. She commented that her life was ‘chaotic’ but her mind was not.

Doreen’s account highlighted important issues for me such as: power inequalities between clients and professionals, the pathology of her ‘chaotic’ life, the withholding of information, the usefulness of applying a wholly medical model to peoples’ difficulties, the absence of understanding Doreen in the context of her social situation and the social construction of mental illness.

It also highlighted the notion that people with ‘mental health problems’ can have the clearest insight and are the experts when it comes to their own problems.

Maybe, seeing every client as an individual, and having an empathic and not just an intellectual understanding of their problems will enable each client to have their own box.

Correspondence

Pavan Bassra

Trainee Clinical Psychologist, Peterborough District Hospital.

* The name has been changed to maintain confidentiality.
Finding my niche with PSIGE – reflections on the Chester Conference

Joanna Cunningham

I RETURNED FROM CHESTER HAVING enjoyed a great conference, but also feeling that I had found my niche. I was a little apprehensive on my way there, questioning my decision to voluntarily subject my research to further scrutiny only a fortnight after my project deadline. What I found, however, was not a lion’s den of researchers waiting to tear apart my humble offerings, but a group of applied psychologists who valued my contribution to the knowledge base and who were eager to develop their practice. My experience of presenting at the conference was rewarding and painless, and I would recommend it to other trainees.

I was very impressed by the standard and breadth of the academic programme. Reflecting my own special interest in challenging behaviour in dementia, my highlights were the sessions on biopsychosocial approaches given by Mike Bird, who travelled from Australia for the conference. I was also inspired by the keynote speaker, Mervyn Eastman, who gave a poignant address about including older people in government decision making. The enthusiasm and commitment of PSIGE delegates was contagious. This enthusiasm was evident in both the academic and social programmes, and there were some great costumes at the 80s disco.

Throughout the clinical course, trainees are exposed to many different areas of working and potential paths to follow. My decision to begin a career working with older people was based not only on an interest in the client group, but also on the wider system within which this work would take place, namely the PSIGE network. My experience at Chester has assured me that I have chosen the right path and found my niche.

Correspondence
Joanna Cunningham
Trainee Clinical Psychologist,
University of Newcastle.
WE ARRIVED LATE TUESDAY evening wondering whether we would find our rooms and get a drink before bedtime. My fears were unnecessary since reception was well prepared and my key was ready and waiting for me. My accommodation was lovely, clean and well equipped. After a hot drive up the M6 it was nice to settle in without any hiccups. Finding the student union bar was surprisingly easy. I wonder why?

On Wednesday I attended the workshop ‘Working with Diversity in older age: A systemic approach’. A very well-organised day which involved open discussion, role plays and group work. It raised many questions about the levels of diversity in my clinical work and provided the theoretical framework in which to address such issues. I particularly appreciated observing the role plays involving systemic questioning.

Our Wednesday evening was capped off with the Ghost walk around Chester. What a great idea. I saw parts of Chester I would never have found on my own. Our guide was very knowledgeable if a little spooky herself!

Thursday and Friday provided a huge array of topics to listen to and I was spoilt for choice. Instead I settled for ‘Therapy in Action’ on Thursday. The short 30-minute presentations were really informative but left me wanting to hear more. The conference needed to be two days longer!

Mervyn Eastman – what can I say – a truly captivating speaker. It was worth coming to Chester just to hear him speak. His passion for getting older peoples’ voices heard is undeniable. If he can’t motivate government to make changes I don’t think anyone can.

Professor Bob Woods provided an interesting perspective of PSIGE over the years and some amusing anecdotes as well. It’s great to hear how PSIGE has developed and this year’s conference is proof that the hard work and dedication continues in its members.

Thursday evening’s events proved great fun. A great disco and band playing 80s music. Everyone seemed to enjoy themselves and I think there were some very sore heads in the morning.

Friday again offered a great array of topics to listen to. Most memorable for me was Steve Davies’ talk on ‘Transactional Analysis’. A very new topic to me which I will definitely do some more reading on.

Overall, my experience of the PSIGE conference was overwhelmingly positive. It was a great three days. It almost felt like I was on holiday, is that allowed?

Correspondence
Sarah Bell
Second Year Trainee Clinical Psychologist, University of East Anglia.
PSIGE 2006

EQUALITY AND DIVERSITY IN THE THIRD AGE

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Papers for this conference will be accepted through online submissions only.

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Conference Themes:
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New challenges, new possibilities and new solutions: The National Service Framework for Older People

Chris Allen

THE NATIONAL SERVICE FRAMEWORK (NSF) FOR OLDER PEOPLE (2001) attempted to ‘set out national standards and service models; local action and national underpinning programmes for implementation; and milestones for progress.’ The NSF was based upon evidence of effectiveness and importantly has a strong psychological underpinning; this may have been aided by the presence of clinical psychologists on the advisory board.

The NSF was welcomed by services for older people and by clinical psychologists within these services. The planning of services prior to the NSF had been fragmentary at best, and older people’s services development was often not the top priority for mental health, acute, social services and primary care trusts. The NSF offered an opportunity for a coherent development of services. The NSF was developed in the context of an approach to care based upon improving standards, extending access, supporting independence, helping people to stay healthy and tackling issues surrounding long-term care.

So what did the NSF suggest and what has been its impact four years on? This is a purely personal response, based upon my experience as a clinical psychologist in Buckinghamshire and those reported to me by other members of PSIGE (The Faculty of Clinical Psychologists Working with Older People). I will do this by commenting briefly on each of the standards of the NSF and adding my impression of what has occurred in relation to those standards. More detail will be available in further issues of the PSIGE Newsletter as each standard and its progress has been reviewed by an invited author (Dr Gavin Newby’s first article on ‘Standard 1: Rooting out age discrimination’ is printed later in this Newsletter).

Finally the article will close with suggestions about the new challenges, possibilities and solutions emerging in the post-NSF world.

Standard 1: Rooting out age discrimination
Aim – ‘To ensure that older people are never unfairly discriminated against in accessing NHS or social care services as a result of their age’.
This has been approached in the majority of trusts via carrying out an audit of all policies and taking action to remove age discrimination. Older People’s Champions were also appointed.

Problems seen with this standard: New protocols and services outlines are continuing to be produced which are age discrimi-natory, suggesting embedded ageism. Services are sometimes using the standard to cut older people’s services arguing that, for example, functional problems such as anxiety and depression can be treated by adult services but ignoring the specialist skills and age-related factors associated with these problems for older adults.

Standard 2: Person-centred care
Aim – ‘To ensure that older people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries’.
This has led to the integration of health and social services, leading to improved inte-
Chris Allen

integrated working practices. In Buckinghamshire, for example, social services physically moved from County Hall to the mental health teams offices at the hospital improving informal liaison and allowing attendance at team meetings. Most areas are moving towards implementing the single assessment process (SAP), although currently still using the care programme approach (CPA) in their everyday practice. Carers’ assessments have been introduced and there is an increased emphasis on users’ views. However, changes have not always been transmitted clearly to older people themselves, carer assessment uptake is currently low, and it is not clear how and when SAP will replace CPA.

Standard 3: Intermediate care
Aim – ‘To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living’.
The main thrust of intermediate care services have been to reduce bed blocking in acute hospitals. As such their focus has been on physical health. It is disappointing that similar efforts have not been applied to mental health problems. Some progress has been made with clinical psychologists/mental health workers advising intermediate care teams how to identify mental health problems.

Standard 4: General hospital care
Aim – ‘To ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital’.
The implementation of this standard has again focused upon physical health with multi-disciplinary teams, geriatricians and nursing consultants being put in place. There has been a recent increase in liaison mental health services via liaison psychiatry or liaison community psychiatric nurses. These posts have often been funded via short-term monies though and mental health needs are under-identified in general hospital settings (Who Cares Wins – RCP 2005).

Standard 5: Stroke
Aim – ‘To reduce the incidence of stroke in the population and ensure that those who have had a stroke have prompt access to integrated stroke care services’.
Specialist stroke teams have been established and there has been improved links with primary care. Few stroke teams have considered the mental health issues surrounding having a stroke or employed clinical psychologists at present.

Standard 6: Falls
Aims – ‘To reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen’.
This standard has led to the creation of falls clinics, some of which have been innovative and included clinical psychologists as part of there staffing.

However, the experience of Buckinghamshire is indicative of one of the major problems with this NSF as a whole. A falls clinic was established at Stoke Mandeville Hospital, which did liaise with the mental health service. Clinical psychology trainees observed the clinic as part of their placement and discussions commenced concerning a bid for clinical psychology input. However, due to financial problems this did not occur as the falls clinic was closed. This underlies one of the major difficulties with the NSF for Older People as although it outlines good practice no money was earmarked by the Department of Health for its implementation.

Standard 7: Mental health
Aim – ‘Older people who have mental health problems have access to integrated mental health services, provided by the NHS and Councils to ensure effective diagnosis, treatment and support, for them and for their carers.’
This standard has had the biggest impact on mental health services and clinical psychologists. The focus has been on attempting to offer a seamless service incorporating primary care, mental health and social services. Protocols have been established in particular for depression and dementia identifying pathways between services. In Buckinghamshire these were provided to all GPs and primary care practices on CD Roms, and a prior project identified brief usable screening instruments which were also made available on the CD Rom. Service modernisation led to the establishment of a memory clinic to offer a service to older people identified as having a possible early dementia. Graduate psychologists have been employed by the PCTs to offer screening and brief interventions in primary care. However, problems still remain. Graduate psychologists often do not have a clear remit for how they will operate, and it is arguable that memory clinics would be better placed in primary care rather than mental health trusts. Nationally some memory clinics have had a narrow remit and basically been a prescribing service for cholinesterase inhibitors. The National Institute for Clinical Excellence (NICE) draft guidance (2005) has queried if there is sufficient evidence to make these medications available to older people. This may lead to a return to a postcode lottery for their prescription. Additionally there is still a need for a greater emphasis to be placed upon psycho-social interventions.

New challenges, new possibilities and new solutions
What are the key issues in the post-NSF world? I would suggest the following issues will be key:

- **Demographics** – It is well known and often reported that the population profile is changing with life expectancy increases and birth rate falls leading to a population with a significantly larger proportion of older people. However, this needs to be seen within the context of other social changes. Women in previous generations have either never worked or been willing to stop work to provide care. This is unlikely to continue, and there is a new sandwich generation of professional women who have delayed having children, continue their careers and now are being faced with parents who live longer and may require care. Women are less likely to give up lives to care. This will lead to significant new challenges to health and social care agencies.

- **Attitudes** – Ageism is rampant throughout society. Older people are less valued and less likely to be offered care. NICE’s April 2005 comment in relation to its review of anti-dementia medication, ‘where age is an indicator of benefit or risk, age discrimination is appropriate’ would suggest that ageism is institutionalised. Older people are invisible within the media, and when they do appear they are stereotyped and made comic. Challenging these negative stereotypical views and influencing the media is a vital priority.

- **Education** – Primary care is a key area to educate in relation to older people. Too many problems that older people could be assisted with are either just not recognised or ascribed to ‘old age’. Similar problems are also apparent in both acute and intermediate care settings. Involving older people in the education of these professionals and schoolchildren would also help address
ageism and an age gap apparent in society with different generations not mixing.

- **Care provision** – Standards of care vary widely and unfortunately there are likely to be scandalous examples of poor care in residential and nursing care settings. Medication is over used and staff are often poorly paid and trained. Training staff, and improving the range and quality of care is a pressing challenge.

- **Clinical psychology** – My impression is that we remain dominated by a model which emphasises individual therapy for younger (under 65) people. Recent changes to our training and a shift to a competency model may be in danger of further compounding this problem and produce qualified clinical psychologists who have had minimal contact with older people. As a profession we are out of touch with some of the challenges I have identified above which I believe are issues that will impact on our society. We need clinical psychologists to produce innovative solutions to these issues. Come and join us in that challenge.

**Correspondence**

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A copy of this article is also being published in *Clinical Psychology Forum*

**References**

The challenges of meeting NSF Standard 1: Rooting out age discrimination

Gavin Newby

Introduction and aims

THE TEXT OF THIS ARTICLE HAS been developed from the slides and subsequent discussion from my talk on Standard 1 at the PSIGE NSF update day on 29 March 2004. The main aims of this article will be to:

- Help remind the reader about the content, aims and rational of Standard 1.
- Review the affects of age discrimination.
- Set out the central role of audit within the process of routing out age discrimination.
- Review the nationally-collated results of age discrimination audits.
- To consider potential roles for clinical psychology within the audit process.

The content of Standard 1

The official aim of NSF Standard 1 is to ‘ensure older people are never unfairly discriminated against in accessing NHS or social care services as a result of their age’. The Standard itself suggests that NHS services should be provided regardless of age, should be on the basis of clinical need and that social services should not use age in eligibility criteria or policies to restrict access to available services. The overall official rational seems to be that fair access equals good public services. The Department of Health are particularly keen that decisions about treatment should not be made on health not age grounds and that older people can benefit from treatment. The authors of the NSF for older people were particularly aware of the considerable geographical and ethnic variation in the use and uptake of services.

By selecting rooting out age discrimination as the first standard, the authors of the NSF clearly recognise the pernicious effects of age discrimination. These effects include: low rates of provision, low rates of access to specialist services, low referral rates to other services and unthinking and insensitive treatment with low expectations (Levenson, 2003). Not surprisingly, given the size and complexity of the NHS, there are many and varied types of age discrimination that can occur. Levenson (2003) particularly points to at least two broad types – overt and implicit. Overt discrimination is relatively rare and includes written restrictive access policies. Implicit discrimination is much more pervasive and more common. This type of discrimination includes unwritten policies that are driven by custom and practice, ageist attitude of staff and unfair delivery system, older people not being considered in the development and planning of services and environmental barriers that restrict physical access to services (e.g. clinics without access ramps or lift).

How the NSF sets out to tackle age discrimination

According to Levenson (2003) the NSF key interventions in tackling age discrimination are centred around raising institutional awareness of age discrimination, chief decision makers within organisations taking responsibility for ensuring age discrimination does not take place, changing policies and making sure staff are trained. As most readers will be aware, the chief organisational intervention has been to ensure that Trust Boards have a lead for older people, key clinicians are invited to become clinical/practice champions and that patients and carers are also given the opportunity to be represented in the process. It is
expected that scrutiny groups are to be created in each organisation to help drive the review and monitoring process. The rules were to identify drivers within each organisation. As such audit has a central role in highlighting age discrimination and being a benchmark against which to measure change. It has been suggested in NSF that the audit should include a review of the complaint and views of staff, users and voluntary organisations. The actual implementation of audit and its structure has generally, until fairly recently, been left fairly vague (Department of Health, Desmon, Levenson, 2003).

A number of milestones were set with Standard 1. These included:

- October 2001 – policy audits were to be completed and the outcome shown in annual reports.
- April 2002 – joint implementation planning groups were to have initiated initial action to address any discrimination found and Councils were to review eligibility criteria.
- October 2002 – an analysis of the levels and patches in services were to have been completed to establish benchmarks for demonstrating change.

**Outcome from a national perspective (Interim Reports, 2002)**

The interim reports published from the Department of Health in 2002 did, positively, suggest the various audits completed around the country had raised awareness of age discrimination and helped to gain support for the values of the NSF. The audits did suggest that only a small number of policies were explicitly discriminatory although these covered a wide range of services. There was a considerable geographical variability in the levels of discrimination and that there were age related national policies – such as access to various benefits.

Not surprisingly, given this was a huge exercise, a number of problems were suggested about the outcome of the audit process from a national prospective. Many trusts missed deadlines and there was a huge variability in the approach, thought and effort in the audits with some trusts providing complex analysis whilst others produced a very brief summary document. Interesting issues were brought up which suggested that the old, i.e. people over 75 years of age, tended to get fairly comprehensive services but that older adult services in general suffered from poor comprehensive services but that older adult services in general suffered from poor comprehensiveness. Similarly research often missed older people so that drugs were often not considered suitable. Similarly research often missed older people and hence new innovations were often limited. Finally the audit did also pick up that employment practices were also rather discriminatory with compulsory retirement being implemented.

Interestingly, such a large-scale effort did give us more information on the effect of implicit discrimination. The interim report suggested implicit discrimination affects:

- Access to community rehabilitation and alcohol services.
- Increased waiting times.
- Reduced access to specific treatments such as cataracts.
- Abuse was often misdiagnosed or under reported.
- There is reduced resources for drugs.
- Depression was poorly identified in treatment.
- Many drugs such as tranquillisers were over prescribed.
- There is extremely variable levels of home care available.
- Poor rates for GP referral.
- Clients often had to travel long distances to assess a service.

Overall, the National Interim Report, 2002, found that there is a lack of a common definition and a wider understanding of age discrimination and indeed suggested that its complexity makes it difficult to retain it. They felt that the main problem was implicit rather that explicit discrimination. Audit was clearly seen as an organisationally complex and time consuming enterprise. Many organisations found it difficult to meet the milestones and
many organisations suggested that many senior managers as well as clinicians were more focused on coping with organisational change rather than the audit. Indeed, on further discussion with those attending the PSIGE NSF day, local experiences suggested that the audit was often not taken seriously by clinicians, manager or chief executives. There is often delays in identifying champions and leaving the process without a strong lead. There is often a slip in moral and lack of progress and action. The milestones appeared rather toothless and often provide more an embarrassment rather than organisations being forced into the process. Indeed much of the discussion seemed to suggest that many scrutiny groups seem to run out of momentum once an audit was completed. This left many of the attenders at the conference feeling worried that there were often no organisational appetite to keep the audit process going and that once the box had been ticked ‘the organisation merely moved on’.

As a further point, Age Concern produced a critique of older people’s champions in 2002 which provides further food for thought both about whether the age of discrimination monitoring process will continue but also more worryingly about whether drivers for changes in older people’s access to service will continue. Age Concern noted that there is no hard and fast commitment as to how long champions will be in place, there is no process for reviewing their effectiveness, no requirement for prior experience with older people, no clear ideas on how to link with other organisations and outside the professional network such as PALS. Indeed there is no clear support network for champions within their own organisation.

Also, whilst progress on the NSF as a whole is shown on the website, good practice examples have only been shown for Standards 2 to 8 (Good Practice Examples in the Older People’s NSF Standards, Department of Health website)

Potential solutions
From the above, one of the main concerning short falls has been lack of guidance and how to actually do an audit. The King’s Fund and Age Concern have stepped into the void to some extent. Firstly the King’s Fund have developed an audit tool through the work of Levenson (2003). The tool attempts to provide clearer guidance and a framework and recognises the fact of blocking identification of age discrimination. The tool begins by getting auditors to think about questions for agreeing an audit framework. These include outlining action to planning, how will you review the relevance of an audit, does everyone know about it, it then goes onto suggest questions to judge fairness and justifiability of age-related criteria. Questions here include: is there flexibility to reflect individual needs? Is there research evidence for the particular service delivery? Do older people prefer the present model? Is it organisationally justifiable? Is the service organised in this way for monitory reasons only? As regards the audit itself they suggest that auditors should seek a wide source of information that would include staff, client, community and voluntary groups and that these can be brought together pictologically by such as teleconferencing. They suggest we should access Chi reports, look at research and other clinical audits that have been completed alongside age discriminational audits. In the audit should also encourage observations both from staff and also auditors themselves as well as looking at complaints forwarded by staff and clients. Secondly Age Concern and the King’s Fund have organised a series of age discrimination workshops that are ongoing – they are organised by Age Concern with a presentation by the King’s Fund on an audit process. The training is generally around a day and includes plenaries on turning policy into practice, challenging age discrimination, involving older people and respecting diversity.

At a national level the Department of Health has developed a bench marking tool. This consists of a series of Excel worksheets
for the user to make comparisons and to allow comparisons of health authorities. Much of the work so far has looked at age specific treatment rates for different (mostly elective procedures and gives information length of stay, waiting times, life expectancy and healthy life expectancy).

At other level, the Department of Health have issued some guidance for champions in 2002 which mostly appears to include a worksheet and guiding questioning of an organisation including where to target questions, has an audit been undertaken and has a scrutiny group been established? This encourages champions to check whether a report from the scrutiny group has been made and whether the group is still meeting. Champions should also check whether older people have been included in the membership and what plans there are to rectify any age discriminatory policies. They also encourage champions to check whether age discrimination is included in local training plans. At a more local level, the recent initiative by Wirral Partnership Trust could definitely be seen as an example of good practice. (Information to be included later.)

**Challenges/roles for clinical psychology**

Given that much of the above discussion would suggest that many of the changes in interventions required in this standard should be aimed towards the macro level of organisational change, I feel there is a real need for active engagement in the policy process by national BPS level organisations. Chief amongst these would be the DCP and PSIGE. Helpful contributions at this stage would be to continue to suggest that rooting out age discrimination is an active ongoing process and to reiterate the benefits of rooting out age discrimination. At a more local level, senior clinical psychologists could take the role of advocating for older people in the policy planning and implementation level. Within our own organisations clinical psychologists, given our research training, can contribute to ensuring affective and meaningful audit takes place. At a more micro level, given that we are highly educated, verbal and vocal, we can help to facilitate maintaining behavioural and attitudinal change. This can be wherever we work in all of our organisations and with individual work and we can contribute to training of clinical psychologists and other professionals, we can model good behaviour and advocate for our clients.

**Conclusions in the future**

Given the slightly ephemeral nature of age discrimination, I feel it is always going to be a battle to keep the rooting out process in the forefront of those working in health and social services right from the clinician coalface up to the policy planning level. Experiences so far would suggest that there is often a problem in maintaining the momentum of effort with organisations either doing the bare minimum or forgetting about the process once they have organisationally ticked the box. Worryingly, the discussion after my talk suggested the Department of Health is still much more interested in initiatives for younger working age adults and I think that we all, as a profession and as individuals will need to keep the rooting out age discrimination flag waving for some time.

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EAST ANGLIA

The news from our branch is fairly brief as we have had quite a quiet year. Kathryn Sams and Vanessa Garfoot have continued to chair the branch over the past year.

Meetings are still being held bi-monthly at Fulbourn Hospital, Cambridge, and have been fairly well attended of late. The branch has around 20 qualified members, as well as various assistants and trainees who attend.

In our regular meetings, presentations have been heard on topics such as cognitive behaviour therapy with staff groups; driving and dementia; and a presentation about a catatonic patient. It has been hard to find speakers, mainly due to funding, so many of our speakers have been internal ones from the branch and our meetings have often had more of a business focus.

A great deal of focus continues to be placed on liaising with the local clinical psychology training course at the University of East Anglia and ensuring students are able to have at least one older adult placement during their training. There have been the usual difficulties in terms of numbers of supervisors due to psychologists changing posts locally and also difficulties with room space for trainees on some placements. Links have also been forged with the course to influence the teaching timetable and ensure there are relevant older adult modules. Several people in our branch were involved with the short listing and selection processes for the next intake of trainees.

In our meetings we have also included a regular case presentation slot, to offer the chance for peer supervision, mainly for neuropsychology case material and this seems to be working well.

Kathryn Sams
Geographical Convenor – East Anglia

NORTH EAST

The group has continued to have the five business meetings this year (average 15 to 20 people) as well as holding our interesting away day, which covers planning placements for the Newcastle and Teesside courses and a supervision workshop. We have maintained the membership and interest from the local area with a good mix of qualified, unqualified and doctoral students from the two local courses.

The majority of the year was taken up with planning and evaluating the Durham Conference and many thanks go to all of the team here in the north who worked so hard to make this happen.

We also covered a range of topics at business meetings:
- Psychodynamic psychotherapy group for older people;
- Behavioural observation;
- Worry in older adults project;
- The use of dolls for people with dementia;
- Reports back from local/national conferences and workshops;
- Reports back from local and national subgroups;
- Doctorate courses, teaching and placements.

Representatives of PSIGE have continued to be active on a variety of groups associated with the two local courses, as well as providing a range of teaching. Also local representatives have worked on the various national committees, for which we thank them for their work.

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

Neil Sabin
Geographical Convenor – North East
SOUTH THAMES

The South Thames region includes South London, Surrey, Kent and Sussex. There are three training courses, Surrey, Salomons and the Institute of Psychiatry in our region.

There are currently 74 PSIGE members in the South Thames region. The South Thames PSIGE committee organised four training days between July 2004 and July 2005:

1. Presentations of local research and service developments alongside an opportunity to discuss local clinical psychology training issues – organised by Padmaprabha Dalby.
3. Update on Capacity Bill and Working Systemically with Older People. Speakers: Catherine Dooley and Dorothy Cameron.

Two of these events were partially funded by South Thames DCP. Our next event is planned for September hosted by Salomons (South Thames) Clinical Psychology Training Scheme. Regional psychologists will have the opportunity to present their research and service developments, also the three regional courses will provide an update of training issues. The South Thames PSIGE AGM will be included in this training day.

We are organising the National PSIGE Conference in 2006, ‘Equality and Diversity in the Third Age’, at the University of Sussex in Brighton. The keynote speakers have been confirmed as Professor Simon Biggs, Director of the Age Concern Institute of Gerontology, King’s College, London, and Professor Sara Arber, Co-director of the Centre for Research on Ageing and Gender, University of Surrey. We formed our 2006 conference organising committee in 2003 and this year plan to merge the conference organising committee and the local PSIGE committee. This group will focus on organising the conference, local psychologists have been asked to organise the local training events which are usually arranged by the committee. Caroline Williams and Adrienne Little have very kindly offered to arrange local training events for the region during 2005–2006. The 2006 conference organising group is as follows: Tina Lee, Chair, Susan Whiting and David Gracey, Sponsorship, Padmaprabha Dalby, Venue, Jo Cook, Idit Albert, Rachael Buxey and Grace Wong, Academic Programme, Reinhard Guss and Elizabeth Field, Treasurer, Corrie Meesters, Stewards and chairs, Tracey Lintern and Helen Mann, Social Events, Patrick McGuiness, Press and Publicity Officer, Louise Robinson, Posters and Displays, Sian Critchley-Robbins, Jane Vinnicombe, Adrienne Little, Melanie Place. We are currently meeting monthly and liaising with the BPS Conference and Events Team to assist with planning and organisation. The conference dates are 5 to 7 July 2006.

South Thames PSIGE are also repeating a six-day event entitled ‘Clinical Neuropsychology with Older People’ at the Salomons Centre in September–November 2005.

We have formed links with a new group called ‘Neuropsychology with Older People Network’ which is organised by Carmel Lum, telephone no: 01273 696011 (ext 3362) and Caroline Williams.

Tina Lee & Padmaprabha Dalby
Geographical Convenors – South Thames

TRENT

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

Two of our meetings have been aimed at trainees and arranged at times which fit with the training courses.

We continue to try to meet at a central location; this seems to maximise attendance. Lunch is available at four of our six meetings and members are encouraged to meet early for informal support.
Average attendance in 2004–2005 has been around 10: this is down on the 2003–2004 levels. It is unclear why this might be but the movement of venue as a result of room booking difficulties may be responsible.

Presentations have been as follows:

**July 2004:** Discussion on use of video to present case material in training.
**September 2004:** Psychotherapy for people with dementia. Barry Greatorex.
**November 2004:** Psychologists in primary care working with depression. Cath Burley.
**January 2005:** The new Nottingham/Lincoln course. T. Shroaeder.
**April 2005:** Teaching – discussion re teaching on local training courses.
**May 2005:** Working with diversity. Louise Bergen.

As usual, the business component of our meeting has generated wide ranging discussion. Popular topics have been: training courses, teaching content, placements and development of accreditation criteria; copying correspondence to clients; and the 2007 conference due to be hosted by our region.

**Rhona Nicol**  
*Geographical Convenors – Trent*

**WESSEX**

We meet quarterly in Salisbury. The first half of the meeting is for business matters and in the second part there is a presentation. We are a small group with a total membership of 17 paid up members. Attendance at meetings is usually 10 to 12 (including trainees).

Issues discussed at the business meetings over the last year include the change in clinical psychology training to core competencies and reorganisation of placements and teaching, the NICE dementia guidelines, links with the DCP and planning the Wessex edition of the PSIGE Newsletter which was published in July 2005.

**Presentations:**

**November 2004:** A qualitative study of coping in early stage dementia. Laura Preston.
**January 2005:** The role of the clinical psychologist in the ‘Distress and Well-being Project’ (a project funded by a charity, Hope and Care, who offer advocacy and support to people over 55). Nicola Ford.
**April 2005:** Social, psychological and behavioural features of institutional care. Paul Whitby.
**June 2005:** The role of imaging in cognitive failure. Paul Kemp (Consultant in Nuclear Medicine).

**Workshops:**

**February 2005:** CAT and later life. Jason Hepple.
**July 2005:** Psychosocial approaches to challenging behaviour. Mike Bird.
*(Both workshops were held jointly with the University of Southampton Clinical Psychology Training Course)*

**Ann Marshall**  
*Geographical Convenor, Wessex.*

**WEST MIDLANDS**

The West Midlands PSIGE Group meets regularly six times per year.

The meetings are well attended (on average 15 people attend, qualified psychologists, trainees and assistants) and continue to discuss relevant issues regarding the development of Older Adult Mental Health Services across the Region.

The first half of each meetings is a business meeting, discussing developments within the Region, and contributing to the specialist training on the two local doctorate Clinical Psychology courses of Birmingham and Coventry and Warwick Universities.

The second half of the meetings have a clinical focus. A number of topics have been discussed, outcome measures, models of intermediate care, the new Mental Capacity Bill, as well as issues arising from Agenda for Change.
The Branch has hosted two successful study days.

In March, Dr Drew Allcott ran a very informative study day on ‘Neuro-Anatomy and Differential Diagnosis’, which was felt to further develop the neuro-psychological skills within the Region! Dr Dawn Brooker provided a half-day in May on ‘Advances in Person-Centred Care’ and again instilled much enthusiasm for psychological contributions in the care of older people with difficulties arising from dementia illnesses.

The meetings continue to act as a focus, within the region, for psychologists often working in small departments, or scattered services, to discuss examples of good clinical practice and gain peer support from one another.

The post of Chair is currently held by Caroline Sincock, Consultant Clinical Psychologist – Older Adults, Malvern (e-mail: Caroline.Sincock@worch-tr.wmids.nhs.uk) and the post of Secretary by Dr Judith Bond, North Warwickshire PCT (e-mail: Judith.Bond@nw-pct-nhs.uk).

Caroline Sincock
Geographical Convenor, West Midlands.

YORKSHIRE/HUMBERSIDE

We have made two significant changes to our meetings over the last year aimed at improving links between clinicians across the region and encouraging sharing of the diverse range of clinical experience and expertise in the region.

The first was to hold a whole-day event focused upon the sharing of clinical practice between psychologists. This consisted of a series of workshops, rather than lectures, facilitated by local clinicians around an area of particular interest to them. The workshops covered working with older people in a health setting, resolution therapy, and challenging behaviour.

The second change has been to increase the length of our quarterly meetings from two hours to three hours. The business section has been cut down to half-an-hour leaving two hours for a talk/workshop and half-an-hour for people to catch up with each other. It is hoped that the longer overall meeting time and greater emphasis on clinical rather than ‘business’ matters will encourage members from across the region to attend.

Membership: Around 35 members at present with some new faces – mainly clinical.

Meetings:
Quarterly meetings: Well attended, especially since the new format was adopted.

Talks on:
● Cultural niches and transient neuroses;
● The Developmental Challenge Model of Development;
● Update on the work of the Bradford Dementia Group.

Extraordinary meetings:
Two meetings held. Used to evaluate and plan the older people teaching on the Leeds DClin course and to allocate placements across the region for the Leeds course. All placements offered by clinical psychologists working with older people were taken up by the course and there is a continuing policy of using all such placements before considering any other options for second year trainees. The teaching will be formally planned around the competencies framework over the next year.

Future plans:
Join up with local branch of DCP to offer a day conference on psychosis across the lifespan.

Liasing with NW GG around offering events that might interest both GGs.

Further whole-day event for sharing practice/learning from each other.

Michael Jubb
Geographical Convenor, Yorkshire/Humberside.
Dear Sinclair

NEWS RELEASE
Edited by Tessa Perrin, *The New Culture of Therapeutic Activity with Older People*, was awarded first prize in the Health Care of the Elderly category of the 2005 British Medical Association (BMA) Medical Book Competition. The award was presented by Professor Dame Barbara Clayton DBE, Honorary Research Professor in Metabolism, University of Southampton, at the awards ceremony at BMA House on Wednesday 2 November, 2005.

From the judges: ‘New thinking about care of the elderly is spawning a new speciality supported by its own professional body, the National Association for Providers of Activities for Older People (NAPA). On the evidence of this book, many of whose authors are members, we are likely to witness a benign revolution in the way elderly people are provided with care tailored to their needs. Examples of schemes already in existence in Harlow, Leicester and Westminster are provided. This seems likely to be one of the most important advances in the care of the elderly. I have not come across Speechmark Publishing before and commend them for the quality of this book.’

Notes: *The New Culture of Therapeutic Activity with Older People*, Tessa Perrin (Ed.), Speechmark Publishing Ltd. Published November 2004, £25.95.

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Editors’ Note: Please let us know of any changes or errors.
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.

Submission Procedure
Where possible, please submit articles as a Word file via e-mail to sinclair@ltshelford.freeserve.co.uk. If this is not possible please send an electronic version on disc to the postal address below. 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:
E-mail: sinclair@ltshelford.freeserve.co.uk
or
Sinclair Lough & Penny Fooks
Psychology Services, 10 Cornwall Road, Dorchester, Dorset DT1 1RT.
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