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

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PSIGE is the Faculty for Old Age Psychology
(British Psychological Society, Division of Clinical Psychology).
HOPEFULLY BY THE TIME YOU read this Spring will have sprung – although whilst we write that doesn’t look likely as it is sleetting outside and this is April in the ‘Sunny South’.

A big thank you to all of this edition’s contributers. The April edition can sometimes be difficult to fill. However, this time round there is a good broad collection of papers for your perusal.

Thanks in particular to Bobbie Petford who has contributed two articles to this edition. Her enthusiasm for the written word should be an inspiration for all. Please keep the copy rolling in.

Sinclair & Penny

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Dawn Schubert
Administrator, Publications & Communications Directorate
Tel: 0116 252 9581; E-mail: mediatraining@bps.org.uk
By the time this newsletter arrives on your desk it should be Spring and I’m sure that your thoughts will be shifting towards the annual PSIGE conference ‘Equality and Diversity in the Third Age’ that is being held in Brighton this year. The conference organising team have been working hard, with the support of the BPS Conference office, to put together what should be another great event (if anyone hears me say anything about dressing up in fancy dress you have my permission to sit on me!). Please note that registration forms are now available on the PSIGE website (www.psige.org).

Once again I would encourage you all to look at and make use of the PSIGE website. We are adding relevant documents (e.g. mental capacity guidelines, training guidelines and commissioning of Clinical Psychology services) and useful links, but please let us know if you can think of other additions, or improvements that you would like to see. I would encourage you to visit the ‘Message Board’ facility and to contribute to any of the topics that are live. Thanks again to Patrick McGuinness for developing and maintaining the site.

Watch out for a special PSIGE edition of Clinical Psychology Forum that should be published soon.

PSIGE will be responding to the consultation for the NICE Dementia Guidelines when this is published (due out in April). Please send comments to Nicky Bradbury who will lead on this response.

Finally I would like to congratulate Dr Carmel Lum on her appointment to the Division of Neuropsychology Committee. Carmel is also a PSIGE member and will help to provide a useful link between us and the DoN.

Steve Boddington
PSIGE Chair
National PSIGE Conference 2006 at Brighton

‘Equality and Diversity in the Third Age’
University of Sussex in Brighton
5-7th July 2006

Keynote Speakers: Prof Simon Biggs, Kings College London
Prof Sara Arber, University of Surrey

Registration for the conference is now open.

There will be one day of a choice of workshops allocated on a ‘first come first served basis’
and two days of four parallel academic streams.

For further details and to download a registration form please see
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IN THE UK BECAUSE OF THE progressing ageing of the population and the lack of appropriate services for elderly people from black and ethnic minorities, the mental health needs of this client group have started causing concern to those elders, their family members, statutory and voluntary services. In London, for example, in certain areas such as Hounslow, it is expected that an increase of 200 per cent will take place in the population of ethnic elders by 2011. Despite the fact they are a growing age group in society, they have received little attention regarding their mental health so far with major implications for the services in the future (http://www.hounslowpct.nhs.uk/cgi-bin/documents/HCS_for_OP_2004-07_Summary.pdf). In the next decade it is entirely plausible for the build up of a shortage of appropriate mental health services for the ethnic elders, both in primary and secondary NHS care, in order to meet the increased demand from potential service users. This may also result in the burnout of their families who are currently taking on the burden of care. The reasons behind this neglect of mental health services for ethnic elders are many; a simple practical one is the reality that certain minorities are scattered in different geographical locations; most frequently though the lack of information about how to access the services particularly due to language barriers; and traditional beliefs and stigma associated with mental illness which prevent ethnic elders from verbalising the problem. All these reasons appear to contribute to the lack of availability of appropriate mental health services for elders from black and ethnic minorities.

A way to deal with the under-representation of ethnic elders in mental health services is to create multi-cultural professional teams who are well aware of the various different cultures (Council Report CR103, 2001). A characteristic of such teams is that they should comprise members who clearly understand the needs of the population they are serving so that any cultural, traditional beliefs and language barriers would not be an obstacle to their objectives. Another potential way to take action is the example of some ethnic minority societies, which established community day centres to occupy their elderly people where they offer a series of services, facilities and activities for their attendees on a daily basis. Successful examples of such interventions are in some Asian and Afro-Caribbean day centres in the London area (www.mind.org.uk; www.multikulti.org.uk). These centres are community day centres only, but they can also act as advocates for the ethnic elders whenever they face difficulties.

A walk-in psychology service for elderly Cypriot day centre users

Maria Zioga, Simon Gander, Evanthia Lychrou & Vassilis M. Mouratoglou

The aim of the project was to screen and offer psychological support to Cypriot elders attending a community day centre. Twelve individuals were interviewed for the pilot part. Two other elders received individual assessment and completed CBT therapy, and three others received group therapy. It was found that there are some statistically significant differences indicating that this particular ethnic group of elders faces up significant mental health issues, which were undetected and untreated.
Another example from an ethnic minority is the Southwark Cypriot Day Centre (CDC) which is located in south London, with a registered number of 320 users. The CDC provides a variety of services, such as chiropody, aromatherapy, financial benefits advice and ophthalmology screening and is an important cultural outlet and social lifeline for the elderly Southwark Cypriot community. The motivation to conduct the present project came partly because local psychologists, as a result of their clinical practice, increasingly became aware of the needs of this ethnic group, the lack of any culturally appropriate statutory services to address those elders’ mental health needs and CDC’s staff members raising similar concerns. The aim was to focus on this ethnic non-clinical population and to develop a profile of their psychological difficulties and needs. A pilot screening was conducted to identify whether there are any such needs and in case there were any, a free walk-in clinic would be developed providing assessment and interventions to self-referred elders at the CDC.

Methods

Subjects

Twelve CDC users participated in the pilot phase of the project and these were compared to a general non-clinical population of similar demographic characteristics (SLAM 2003). Afterwards, during the walk-in service at the CDC, two users received and completed individual therapy, one group of users received group therapy, and there was also one user who received support at home. Comparisons were made before and after treatment for these clinical psychology sessions.

Design

Independent and paired t-tests were used for comparisons of the continuous variables (SPSS version 10 for Windows (Field, 2001) and STATA 6.0 for Windows (STATA Corporation, College Station, TX).

Materials

The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) measures global distress (Leach et al., 2004); the Hospital Anxiety and Depression Scale (HADS) detects the presence of mild degrees of mood disorder, anxiety and depression, and their respective severity (Zigmond & Snaith, 1983); the Geriatric Depression Scale (GDS) screens for the clinical severity of depression and for the monitoring of treatment (Shiek & Yesavage, 1986). We also used other tests such as Dementia Screening based on changes in the performance of everyday activities and habits, and also the Mini Mental State Examination testing cognitive abilities. Feedback questionnaires were also used and consisted of 10 questions on a seven-point Likert-type scale.

Procedure

In the pilot study, the participants were interviewed on a one-to-one basis on the following measures: Dementia Screening, (CORE-OM), Mini Mental State Examination (MMSE), and general problem assessment based on their opinion, the interviewer’s own clinical impression and the CDC staff’s opinion (Zioga & Mouratoglu, 2004). Each interview lasted approximately one hour, and all the participants were volunteers.

In the individual therapy, the meetings were held in private areas at the CDC once per week or fortnight. The CORE-OM test was used before and after therapy, HADS and GDS tests were also used during therapy. The clients were treated with Cognitive Behavioural Therapy (CBT) and were self-referred. Two participants have attended one-to-one sessions with an assistant psychologist: participant one attended 14 sessions, and participant two attended 16 sessions. Both attendees completed the CORE-OM scale at the start and at the conclusion of their course.

In the group therapy both attendance at the meetings and completion of the
questionnaires were voluntary. The meetings were also taking place with the same frequency and duration as the individual therapy. Five sessions were conducted. Attendance was variable (from three to one participants per session). CORE-OM, HADS and GDS were also used here accordingly. Upon conclusion of the therapy sessions, attendees were asked to complete a 10-item feedback questionnaire in order to gain insight into whether the meeting was useful for them. The feedback and evaluation was carried out by another assistant, independent from the assistants who carried out the therapy sessions. This questionnaire allowed the clients to express how relevant and useful the meeting was, and the therapist to plan ahead for following meetings tailoring them accordingly. The group meetings were designed to address the psychological needs of the CDC users on common issues and problems they faced.

Results

Pilot study

The dimensions of global distress according to CORE-OM, were above the national average for the elderly population (see Figure 1). There were statistically significant differences in subjective well-being ($t(11)=-5.00$, $p=0.00$), in functioning ($t(11)=-7.87$, $p=0.00$), and in global distress ($t(11)=-1.76$, $p=0.01$).

Individual Interventions

A paired-samples $t$-test was carried out on the two sets of results (see Figure 2). No statistical differences were found between the scores before and after the individual therapy for each client. However, there was a trend for benefit after therapy for Client 1 particularly at the risk dimension, and for Client 2 there was a reduction in the problems, while there was a better social function after therapy.

Figure 1: CORE-OM scores (global distress) for CDC attendees in comparison to a non-clinical population. (In Dimension 1, the higher the score, the more problems/distress the individual is reporting.)

![Figure 1](image_url)
Group Interventions

The results show that the mean scores for the CORE questionnaire are consistently higher than those of a non-clinical sample (see Figure 3 overleaf). This outcome is actually consistent with the pilot study’s findings. There were statistically significant differences in problems/symptoms ($t(7)=-2.60$, $p=0.03$), in functioning ($t(7)=-4.18$, $p=0.00$), in total minus risk ($t(7)=-3.85$, $p=0.00$), and in global distress ($t(7)=-3.84$, $p=0.00$).

Moreover, although the mean scores for HADS (the anxiety and depression subscales) do not indicate any problems, individual analysis indicates that two participants show mild anxiety symptoms, and two scored within the range for mild depression. No individual scores from the GDS suggest depression.

By analysing the results over time, a general decline is shown in the scores for the CORE, the HADS, and a slight decline in GDS. This is illustrated in Figure 4 (overleaf), the change is shown by the line of best fit shown in each graph.

Analysis of the 10-item feedback questionnaire showed that the participants found the meetings to be highly positive and useful. This is shown by the average score of 51.8, out of a maximum of 56.0, when attendees scored the Likert-type feedback form.

Discussion

The purpose of this project was to screen and offer psychological assessment and support to Cypriot day centre elderly attendees in Southwark, London. Currently, there is an increase in the population of ethnic elders in the UK and it appears that there are not adequate mental health services to assist with their individual needs (Council Report CR103, 2001).

The results of the pilot study suggest that these ethnic elders may present with greater psychological difficulties than the general elderly population in terms of their well-being, symptoms, social functioning and health risks they take. Only one person of this population had previously received help from mental health services. Although the

<table>
<thead>
<tr>
<th></th>
<th>C1 Before</th>
<th>C1 After</th>
<th>C2 Before</th>
<th>C2 After</th>
<th>Mean (SD) Before Therapy</th>
<th>Mean (SD) After Therapy</th>
<th>$p$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global distress</td>
<td>73</td>
<td>69</td>
<td>44</td>
<td>45</td>
<td>53.5 (27.58)</td>
<td>57.0 (16.97)</td>
<td>0.72</td>
</tr>
<tr>
<td>Minus Risk</td>
<td>67</td>
<td>69</td>
<td>44</td>
<td>43</td>
<td>50.5 (23.33)</td>
<td>56.0 (18.38)</td>
<td>0.36</td>
</tr>
<tr>
<td>Well-being</td>
<td>11</td>
<td>8</td>
<td>11</td>
<td>9</td>
<td>11.0 (0.0)</td>
<td>8.5 (0.71)</td>
<td>0.13</td>
</tr>
<tr>
<td>Problems</td>
<td>26</td>
<td>31</td>
<td>18</td>
<td>5</td>
<td>22.0 (5.66)</td>
<td>18.0 (18.38)</td>
<td>0.73</td>
</tr>
<tr>
<td>Function</td>
<td>30</td>
<td>30</td>
<td>15</td>
<td>29</td>
<td>22.5 (10.61)</td>
<td>29.5 (0.71)</td>
<td>0.50</td>
</tr>
<tr>
<td>Risk</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3.0 (4.24)</td>
<td>1.0 (1.41)</td>
<td>0.71</td>
</tr>
</tbody>
</table>

Figure 2: CORE-OM scores (global distress) for clients both before and after they received therapy. The $p$ values at 0.05 level are provided.

(C1=Client 1, C2=Client 2)
Maria Zioga et al.

Figure 3: A comparison between the mean CORE-OM scores (global distress) of group session attendees, and those of a non-clinical sample.

Figure 4: Charts showing scores for the CORE, HADS and GDS for each questionnaire completed from the beginning to the end of the sessions.
individual therapy did not suggest any statistically significant differences before and after CBT, it indicated that there was a trend after therapy for some benefits on the two clients. The results of the group therapy showed that there was a decrease of symptoms over time in terms of global distress, depression and anxiety. In addition, the participants themselves responded that the group meetings were indeed useful. Larger samples may be able to show greater statistically significant differences.

A limitation of the walk-in psychology service was the fairly low and sometimes sporadic attendance of the attendees resulting in a self-selected group of individuals. Thus, the results may not be representative of the CDC community as a whole. It seemed that although the CDC attendees were showing an interest to interact with the service team, in practice they did not use the service as much as it had been anticipated. This may be attributed in the lack of awareness about mental health issues and specifically in the social stigma of mental illness. Despite the fact that a campaign was launched using an informative pamphlet and giving a short presentation at the CDC about the facilities offered in order to raise awareness of the service available and to reduce any stigma attached to receiving therapy, there was not any increase in the number of people requesting to use the service.

Another explanation could be that the attendees appeared to provide support for each other and they were using religion to comfort themselves and others. Another reason may be the rather communal venue of the sessions because it was easy for any service user to be seen by the rest of the community while they were heading towards specific rooms where a member of the psychology team was waiting for. In addition, at the group meetings participants did not complete the HADS and the GDS. A greater number of completed questionnaires would have provided a more accurate picture of the CDC as a whole, and may have produced greater correlation between all of the measures. This is shown by the high scores given on the feedback questionnaires, which were completed at the end of each meeting.

Another limitation is the fact that to our knowledge there is no published data on the specific group of Cypriot elders living in the UK. Therefore, the comparisons which were made to a non-clinical elderly population were based on the age factor alone (ignoring the confounding effect of ethnicity and culture), and as a result they may be less reliable.

A future intervention in a similar population may focus on changing attitudes towards mental health problems and acting pro-actively through open days in the day centres and also by informing the local GPs about any mental health services in the area as it appeared that the present attendees visited their GP regularly. It can be hard for a mental health professional to gain the trust of a non-clinical group when a new service is introduced into an established community with elderly who might have certain core beliefs about mental illness for many years. Additionally, it may prove beneficial to hold separate groups for the two genders, because it appeared that mostly women were requesting to use the service. This attitude may derive from traditional beliefs about the social role and behaviour of men and women. Lastly, improving the privacy of the therapeutic venues may be useful.

Conclusions
Cypriot day centre ethnic elders may face mental health problems which adversely affect their everyday living. Due to lack of information, traditional negative attitudes towards mental illness and also lack of outreach community intervention, these difficulties may go undetected and as a result untreated, which is a particularly worrying issue in the face of a progressively ageing population in the UK. Ethnic minority day centres may provide the opportunity for screening and therapy for these populations, by building a supportive network, strengthening the user’s social, and thus personal health.
Acknowledgements

We would like to express our gratitude for the tireless efforts of the CDC staff who facilitated the whole project.

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References

www.rcpsych.ac.uk/publications/cr/cr103.htm


www.mind.org.uk
www.multikulti.org.uk


The quality of care provided for people with dementia in nursing homes is the subject of serious concern (Department of Health, 1999; Ballard et al., 2001). In a survey examining the level of care provided in 17 care homes in the north of England, using Dementia Care Mapping (Kitwood & Bredin, 1992) as a research tool, all were rated as either ‘requiring major improvement’ or ‘requiring radical improvement’ (Ballard et al., 2001). The reason for this unsatisfactory situation is multi-factorial. Factors include the complex needs of the residents, staffing issues and resource issues. Additionally there is a paucity of effective pharmacological treatments, which is the topic of the current paper. In order to provide a context to the work a brief review of residents’ needs are outlined below.

Complex needs of residents
In EMI homes all residents suffer from some form of cognitive impairment. In non-EMI care homes (residential, nursing, dual registered homes) this is not necessarily the case, although levels of dementia can be as high as 75 per cent (MacDonald et al., 2002) or 80 per cent (Dempsey & Moore, 2005). Such levels are problematic, as there is a high association between dementia and psychological distress. Indeed, the point prevalence and life-time prevalence of neuropsychiatric symptoms for residents with dementia is 60 per cent and 90 per cent respectively (Finkel et al., 2001; Lyketsos et al., 2002). Further, it is estimated that 30 to 40 per cent of residents with dementia develop psychosis with paranoid delusions or hallucinations associated with aggression and violence. Hence, it can be concluded that the needs of people with dementia residing in UK care homes are highly complex and their levels of distress great.

Treating the high levels of complexity with psychotropics
High levels of distress in people with dementia can manifest in terms of challenging behaviours (aka Behavioural and Psychological Symptoms of Dementia, BPSD, or Behaviour problems Associated with Dementia, BAD). Traditionally, such behaviours have been treated by psychiatrists and GPs with psychotropic medication. Table 1, overleaf, outlines some of the common forms of medication used in UK homes.

Despite their frequent use, it is evident from a series of recent meta-reviews and studies that there are problems with the drug regimens; some of these difficulties are outlined below.

Neuroleptics (aka anti-psychotics or major tranquilisers)
Research has highlighted that a high proportion of care home residents with dementia receive treatment for challenging behaviour with major tranquilisers (Margallo-Lana et al., 2001). For example, prior to the introduction of guidelines in 1987 in the US, it was estimated that 43 to 55 per cent of residents were receiving neuroleptics. In recent surveys conducted on the use of neuroleptics in nursing homes in the UK, it was found that between 24 per cent (McGrath et al., 1996) and 36 per cent (Dempsey & Moore, 2005) of residents were prescribed such medication. In residential homes, the rate of...
prescribing was also high, at 29 per cent (Dempsey & Moore, 2005). See Table 2 for combined totals for non-EMI homes.

These rates are particularly worrying owing to the modest level of evidence for the efficacy of this medication. In a recent systematic review, which examined five double-blind, randomised controlled trials assessing atypical anti-psychotics, limited evidence was obtained in favour of their use. The authors concluded that: ‘Further trials are needed before atypical anti-psychotics can be recommended for BPSD’ (Lee et al., 2004). The researchers also noted that work needed to be conducted on the side effects, as the use of neuroleptics has been associated with an increased risk of falls, drowsiness, Parkinsonism, akathisia, tardive dyskinesias, neuroleptic sensitivity reactions and accelerated cognitive decline (McShane et al., 1997). Furthermore, there are specific concerns about the cardiotoxicity of thioridazine, and the increased risk of cerebrovascular events in patients taking risperidone and olanzapine.

**Benzodiazepines (sedatives)**

Whilst neuroleptic drugs are most commonly used for the treatment of ‘challenging behaviour’ (Jackson, 2005), benzodiazepines are often used, either alone or in combination with anti-psychotics. As they are sedatives, they are commonly used to reduce anxiety, agitation and promote sleep. However, use of these drugs for this purpose is unlicensed (i.e. ‘off label’ use – they are not being used for their intended purpose). Meehan et al. (2002) conducted a placebo-controlled, randomised trial on the use of lorazepam for the treatment of psychiatric symptoms of dementia. Lorazepam and olanzapine (a neuroleptic) were compared,
via intra-muscular administration, and it was found that these medications did significantly reduce incidences of problematic behaviour. However, the olanzapine reduced symptoms after 30 minutes whereas lorazepam took effect after one hour.

Despite some favourable findings, case reports and anecdotal evidence suggest that benzodiazepines may paradoxically lead to increased agitation, confusion and falls in dementia (Hogan et al., 2003; Wagner et al., 2004). Furthermore, Lenzer (2005) suggests that some of the fatalities and severe adverse reactions associated with the use of olanzapine may be due to co-comitant use of benzodiazepines. On balance, Sink et al. (2005) suggests that benzodiazepines should be avoided in the treatment of challenging behaviour, especially for long-term management. The latter view is an echo of an earlier report published by the Expert Consensus Panel for Agitation in Dementia (1998), which recommended that benzodiazepines should not be prescribed except for occasional, short-term use for anxiety symptoms. In a similar vein, Jackson (2005) suggests that these sedatives should only be considered after non-drug management has failed.

**Anti-depressants**

Anti-depressants are often used to treat depression in people with dementia, but are sometimes used to treat challenging behaviours. Indeed, Pollock et al. (2002) reports that some psychotic symptoms respond to the use of anti-depressants. Clearly this effect may be indirect, as highlighted by Steinberg (2005), as many people experiencing psychosis display comorbid depressive features. A study by Pollock et al. (2002), employing citalopram, is one of the few RCT’s which has shown an anti-depressant to be beneficial. This trial resulted in a significant reduction on the Neurobehavioural Rating Scale (NRS) for hospitalised patients (Levin, 1987). However, the positive findings were only evident on the agitation and liability subscales of the NRS. Furthermore, based on the findings of Sink et al.’s systematic review, which identified five quality studies, the available evidence is that anti-depressants are ineffective in treating neuropsychiatric symptoms of dementia (see also Anchus & Bissey-Black, 1997; Porsteinsson et al., 2001; Teri et al., 2000). In addition to this, side effects (stomach upset, dry mouth, constipation, blurred vision and dizziness) are noted for many anti-depressants.

**Mood stabilisers**

Whilst a less common treatment for challenging behaviour, mood stabilisers are sometimes used when there are signs of mood swings or epileptic seizures. However, once again, the evidence suggests that mood stabilisers are ineffective in the treatment of challenging behaviour (Sink et al., 2005), and in some cases cause significantly more adverse effects (e.g. drowsiness) than placebo (Tariot et al., 2001; Sival et al., 2002). Indeed, Porsteinsson et al. (2001) reports no improvement between sodium valproate and placebo groups, but adverse effects such as sedation, weakness and respiratory problems were significantly more frequent in the drug

<table>
<thead>
<tr>
<th>Area and study</th>
<th>Neuroleptics</th>
<th>Benzodiazepines</th>
<th>Anti-depressants</th>
</tr>
</thead>
<tbody>
<tr>
<td>South of England</td>
<td>15 per cent</td>
<td>24 per cent</td>
<td>25 per cent</td>
</tr>
<tr>
<td>(MacDonald et al., 2002)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yorkshire</td>
<td>31 per cent</td>
<td>21 per cent</td>
<td>22 per cent</td>
</tr>
<tr>
<td>(Dempsey et Moore, 2005)</td>
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</table>
group. In Sink’s review, she found that the three RCT trials that had investigated the use of valproate revealed a lack of efficacy with its use (Sink et al., 2005). Further, evidence for the use of carbamazepine is insufficient to recommend its use for treatment as the two RCT trials undertaken had conflicting results (Olin et al., 2001; Tariot et al., 1998). The lack of evidence is compounded by the black box warning for haematological toxicity and the possible interactions between other drugs commonly used with elderly patients.

**Good practice guidelines**
A number of good practice guidelines have been published regarding the pharmacological management of challenging behaviour in dementia (e.g. Omnibus Reconciliation Act OBRA 87; Lantz et al., 1996; SIGN, 1998; Howard et al., 2002). The OBRA guidelines were enacted in the US, restricting the use of neuroleptics in people with dementia. These guidelines also recommend that the responsibility of monitoring medication should be with the care facility rather than the prescribing physician. Since OBRA was introduced, the use of neuroleptic medication has reduced by a third. The most recent guidelines in the UK (Howard, 2002), recommend that unless a problem is causing severe distress or puts the person or others at risk, psychological or environmental management options should be the first line approach. Furthermore, as many of these challenging symptoms are transient (including evidence of a high placebo response rate of up to 60 per cent), it is recommended that a discontinuation of pharmacological treatments occur after symptoms have been absent, or are minimal, for three months.

**Discussion**
This brief paper has outlined some of the concerns raised in recent surveys conducted generally by medical practitioners and researchers, regarding the use of psychoactive medication. Clearly there are major issues that have been widely recognised by clinicians; hence, the introduction of a number of guidelines. However, despite such guidelines, a recent survey conducted by Dempsey and Moore (2005) suggests that the use of neuroleptics is actually increasing in the UK. Why is this the case?

One of the reasons for the continued use of drugs is that prescribers may doubt the clinical applicability of the research findings to their work. Indeed, they may think that the ‘blanket’ prescribing practices undertaken in empirical studies are inconsistent with their own more idiosyncratic methods of prescribing – which may be more formulation-led. Hence, the medical practitioners may feel that the findings of the empirical studies, including the meta-analytic reviews, should be treated with caution.

Jackson (2005), a consultant old-age psychiatrist, articulates a number of interconnected reasons for the continued use of medication. He claims some of these issues relate to the nature of the care homes: low staffing levels; management rather than therapeutic cultures; low levels of staff training. He also cites issues to do with the culture, practices and training of the medical practitioners. He suggests that some practitioners fail to look for ‘other’ treatable causes of the problem behaviour, such as infection, depression and pain. Additionally, they may fail to review the impact of their prescribing – it is not uncommon that once ‘on’ a medication, the person will remain on it for many years without review (Furniss et al., 1998). The latter is a concern for a number of reasons, for example, without a review many potential side effects may be missed. Another reason for the continued use of drugs is that the many practitioners have ‘first hand’ experience of achieving success via drugs – always a powerful influence. However, from our reflections on this issue, it is evident that on some occasions they are being unduly influenced by the ‘therapeutic attribution’ bias (i.e. perhaps taking credit for ‘spontaneous remission effects’). This bias is particularly relevant
with respect to this area of work because of the very high level of spontaneous recovery with respect to behavioural problems (DeDeyn et al., 1999; Street et al., 2000). Finally, and perhaps the main reason for the continued use of medication is the lack of a credible alternative:

‘It is suggested that the high levels (neuroleptics and benzodiazepines) are primarily due to a failure of medical staff to consider or to feel able to suggest alternatives when medication is first considered and a subsequent failure to adequately review the continuing need for medication and to attempt trials without medication.’ (Dempsey & Moore, 2005, p.13)

Dempsey and Moore (2005) have highlighted an important issue here, as many medical practitioners do not view biopsychosocial models of treatment to be ‘realistic’ alternatives to medication. And who can blame them, as neither psychology nor any other discipline has yet to establish a good evidence base (large N, controlled studies and RCTs) for non-pharmacological treatments – with relatively few exceptions (e.g. Fossey, et al., 2005; Proctor et al., 1999; Moniz-Cook et al., 1998; Rovner et al., 1996; Smyer et al., 1992).

Conclusion
Further trials need to be conducted into pharmacological and non-pharmacological treatments for challenging behaviour in dementia. With respect to psychotropic medication, current findings point to a number of major problems. This has led to the development of a number of guidelines, many suggesting that non-pharmacological approaches should be used in most cases prior to the use of medication (Howard et al., 2002). To this effect, Sink et al. (2005) has produced a useful algorithm sequencing the use of psychological interventions with medication, suggesting that ‘drug use’ should follow psychological approaches. However, in those situations where pharmacotherapy is considered necessary, it should be tailored to the individual (Gill et al., 2005). It should also be carefully monitored and reviewed, in order to detect side effects, and assessed regularly concerning whether the person still requires the medication and dose in question (Jackson, 2005). Jackson summarises his approach to the use of medication as: start low; go slow; regular view; stop as soon as possible.

To conclude, and to put the above matter into perspective, concern in the US regarding the use of neuroleptics is so great that US Food and Drug Administration have asked manufacturers to label drugs with a statement that ‘anti-psychotics may lead to increased death rates’ and that they ‘are not approved for treatment of behavioural symptoms in elderly patients with dementia’.

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References


Treating challenging behaviour in dementia


The past as a metaphor: A clinical note
Stéphane Duckett

The criterion of post-traumatic stress disorder (PTSD) is well established and will be familiar to all readers particularly within the field of older adult psychology. Dr Steve Davies has thankfully done much to heighten our awareness of prevalence of PTSD particularly for the generation of older adults we currently care for. I, however, feel that we should draw a distinction between what I term ‘proximal’ and ‘distal’ PTSD. Proximal refers to post-traumatic symptoms that are a response to relatively recent events, let us say arbitrarily within the past 10 months and distal to a period where the post-traumatic events have arisen from events that occurred, let us say a dozen plus years before particularly when there has been a period of time that was wholly symptom-free and fully functional for the client.

Example 1
All American soldiers wear what are called ‘dog tags’. They specify your name, serial number, blood type and religion. The reason for specifying religion was that in case last rites had to be given to you, your fellow comrades-in-arms would know whether to call for the Minister, priest or Rabbi. German soldiers in World War II quickly were able to learn that ‘H’ stood for Hebrew and, therefore, some American soldiers captured by the Germans who were identified as being Jewish were sent to concentration camps.

Lionel was captured in the last month of the war at the Battle of the Bulge. He was sent to one of the smaller concentration camps and sustained significant beatings and hardships but remarkably survived. After an extended period of recuperation he was repatriated at the end of the war. He married in the early 1950s and had three children. Perhaps, not untypically for many veterans, he wanted to put the horror of his experience behind him and, therefore, did not tell his family that he had been in a concentration camp. By all accounts he had had a successful career and family life and was purportedly wholly symptom-free. However, shortly after his retirement in the 1980s he began to develop an excruciatingly painful bone condition. He had not in all his years subsequent to the war experienced this level of pain although he had in the beatings he sustained in the camp. He started having nightmares, thrashing about in bed and calling out in German much to the alarm of his wife. Memories of his wartime experience began to re-emerge and re-haunt him.

Example 2
Louis came to the UK in the 1970s as a refugee from Central Africa. He had lost everything including witnessing the arrest of family members following racial ‘purges’. His first experience of his host country was enormously difficult and traumatising for he was alone, grieving, impoverished and facing racial discrimination. Remarkably he rebuilt his life particularly with the help of a fellow refugee he met in the UK. She subsequently became his wife and together they built a successful business but, regrettably, no children for them.

Unfortunately Louis’ wife died shortly after they sold the business on retirement. Self-neglect led to significant health problems from which he first came into contact with the health services subsequent to concerns raised by his neighbours. Louis began to develop PTSD-like symptoms on the ward; fear of persecution, isolation, vivid memories which would trip over into flashbacks perhaps secondary to delirium brought on by dehydration.
What both of these patients have in common in their presentations is how the traumatic event is separated from the re-emergence of symptoms by a period, which is by self-report and the report of family wholly symptom-free. What would appear to trigger the re-emergence are current events from which the past acts as a metaphor. This ‘distal’ PTSD, I believe, to be very different from ‘proximal’ although clearly they share similarities in the way symptoms arise. The critical difference resides in the relative innocuousness of the triggers in the proximal form.

Example 3
Josh was a passenger on a bus several months ago which ran over a tourist in central London. Josh remembered thinking just before the incident occurred that the driver was driving too fast and that two buses appeared to be playing tag. When the bus hit the pedestrian the force was such that the front windshield was completely shattered. Josh reported hearing the gasp of a passenger just before the pedestrian was hit and the sound of the smashing safety glass and both sets of wheels going over the body. Although Josh did not look back to the body he reported seeing the faces of the frozen pedestrians looking on in disbelief and silence from the halting traffic. In subsequent weeks and months Josh found himself engaging in symptoms that would have met the criterion for PTSD. In particular he reported how seeing a pedestrian from a bus window who was standing on the kerb and looking away from the bus resulted in his heart palpitating and laboured breathing. These symptoms persisted to varying degrees whenever he saw a bus over the coming months but have diminished at least in their physiological intensity with time.

To summarise, several factors appeared to distinguish proximal from distal PTSD.
1. Extended lengths of time between the traumatic event and the re-emergence of symptoms.
2. The trigger for the re-emergence of the memories from the first trauma is a secondary traumatic event, which may be close to the first in its level of severity.
3. Relative innocuousness of the trigger in proximal PTSD.

Discussion
What is the significance of making this distinction between proximal and distal? The answer lies with intervention; with ‘proximal’ PTSD focussing on current symptoms will be appropriate, however, with ‘distal’ whilst acknowledging the client's current experience or narrative for some clients trying to understand the current factors that are re-invoking painful memories may be called for. In some instances clients may choose distant memories because they are safer to contemplate than current events particularly when those events may be irreversible. Attempt to determine what is safe for your client to proceed with and then bridge to the current agenda if it is safe to do so. This brief clinical note again highlights how older adults presentation on relatively well-defined pathological conditions may be subtly different but different nevertheless enough to justify sub-classification since it may carry implications with respect to intervention.

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Long lives and learning: The impact of education on the psychological well-being of people in the third and fourth ages

Bobbie Petford

This article reviews contemporary debate about the influence of ‘lifelong learning’ on quality of life for older people. It explores the positive impact of education on the psychological well-being of older people in the third age who are attending courses, and on those in the fourth age in terms of learning opportunities in residential care, and the training of care workers.

‘Old age: the crown of life, our play’s last act!’ Cicero.
‘In youth we learn; in age we understand.’ Marie von Ebner-Eschenbach.
‘Old age ain’t no place for sissies.’ Bette Davis.

These three quotations, written many centuries apart, illustrate how contemplation of later life can incur mixed emotion, invoking feelings about wisdom, contentment, maturity, apprehension and antipathy. Even in the best of circumstances, old age still presents a set of very significant challenges in terms of health, independence, finances, sense of place and purpose, loss, bereavement and mortality. This article attempts to review contemporary debate about the influence of ‘lifelong learning’ on quality of life for older people. It explores how education impacts on the psychological well-being of older people in the third age who are attending courses, and on those in the fourth age in terms of learning opportunities in residential care, and the training of care workers.

But why make an association between ageing, education and well-being in the first place? Is it right to assume that older people should study to feel well? As older people are undervalued in an ageist society because they are no longer economically productive, notions such as these could be said to diminish their capacity for self-sufficiency even more. However, research evidence suggests that these are legitimate questions as engagement with learning does enhance the quality of later life (Soulsby, 2002), and there is an association between low educational attainment and early age admission to an institution (Soulsby, 2002; NIACE, 2005). Policy makers speak of an ageing population who must plan and save for a successful retirement, and promote engagement in lifelong learning to increase ‘social capital’ in society, but statistics show that during the last decade, participation in education by people aged 75 and older has actually fallen by a third (Clennell, 1995; NIACE, 2005). The subtle relationship between learning and well-being has been documented across all age groups (Aldridge & Lavender, 2000; Soulsby, 2002; Jackson, 2003), but fierce argument continues about whether or not an improvement in well-being is, or should be, the principle goal of education (Jackson, 2003; Ecclestone, 2004; Ecclestone & McGivney, 2005; Hyland, 2005; Janssen, 2005; Parrott, 2005).

‘Third age’ and ‘fourth age’ are terms with flexible meanings, used to define the later half of the human lifespan, and when interpreted chronologically they refer to a lifespan of one hundred years divided into four. The European Commission cites the third age as beginning at 50 years. The fourth age however, relates more to social role than age, beginning when an older person makes the transition to dependence...
on personal care (Clennell, 1995). The concept of ‘well-being’ is difficult to define exactly, but the word is often used to mean the combined states of physical, psychological, social and existential/spiritual health and growth. ‘well-being’ is now used by professionals to represent a multidimensional ‘biopsychosocial’ perspective that extends health practices beyond treatment of disease into health improvement and promotion (Cronin de Chavez et al., 2005).

The Third Age – older people as learners
As already mentioned, there is a widely accepted relationship between educational participation, attainment, and the good health of people of all ages, established by both research-based and anecdotal evidence (Aldridge & Lavender, 2000; Janssen, 2004; NIACE, 2005). A survey of about 500 respondents, half of whom were aged between 40 and 60 years, found the most frequently reported health benefits from learning were increased confidence, reduced stress and depression, and new skills and opportunities. Other benefits included improved self-awareness, raised self-esteem through affirmation of talents, and better family relationships. Interestingly, only a small proportion of respondents cited an improvement in physical health whereas the majority felt benefits in mental and emotional health. Those who reported negative health effects talked about increased stress and fatigue, family disharmony, money problems, and a sense of displacement and dissatisfaction (‘the Educating Rita effect’) (Aldridge & Lavender, 2000). The findings of another survey, conducted amongst adult students attending non-accredited courses in one college, were very similar, and in addition students said they felt less need to see health professionals, an improved sense of personal agency, and increased social opportunities and skills (Janssen, 2004).

While research has revealed the possible health gains of engagement with learning, and informed the recent and heated debate in the adult education press, it has not brought about any consensus between the protagonists. One side of the argument has it that improvement in well-being, the soft outcome, should not be the aim of education, and that any attempt to make it so results in a ‘diminished self’ and a ‘reduction in self-efficacy’. The so-called ‘therapeutic ethos’ serves only to extend government interference into people’s emotional lives (Ecclestone, 2004). The other side of the argument holds that self-esteem is a legitimate and integral concern of education that aids achievement of hard outcomes such as examination passes (Ecclestone & McGivney, 2005). Improved well-being, when seen as ‘social capital’, is at least as important as economic capital, but gets overlooked in an education system obsessed with skills and competencies (Hyland, 2005). Educators should take a non-dualist approach to learning that does not separate mind from body and psyche (Parrott, 2005).

There is much passion from both sides, but some writers draw very grand conclusions from minimal evidence. One claims her view is based on research, but turns out to be a review of mainly opinion-based work (Ecclestone, 2004). None of the writers discuss any other variables that might affect their findings, such as the degree of motivation, consent or coercion students feel when embarking on courses, or other demographic factors that might influence their perception of well-being (Ecclestone, 2004; Janssen, 2004; Ecclestone & McGivney, 2005; Parrott, 2005; Hyland, 2005). No comparison is made with the impact on the well-being of those who find themselves excluded from education (Jackson, 2003). Some inaccurate statements are made about evidence for the benefits of stoicism versus talking about feelings, which are contradicted by extensive and longitudinal psychological research (Murray-Parkes, 1998; Ecclestone, 2004; Ecclestone & McGivney, 2005).

The merging of health and educational disciplines in mainstream mental health activities, such as Psychoeducation, is
ignored. Instead the debate slips drearily into the hackneyed and false tramlines of hard science versus soft, political versus psychological, positivist/modernist versus phenomenological/postmodern, and thus no new terrain is explored and no tangible and meaningful improvements to practice are proposed. As if to make the point, in a 30th birthday overview of the British Educational Research Journal (Bera) Furlong (2004) decries what he sees as the contemporary advancement of ‘government methodology’ and the ‘big science’ approach. He advocates diversity in research and evaluation of teaching and learning, with the involvement of individuals and sub-communities, to avoid a re-emergence of such ‘paradigm wars’.

Some larger scale surveys and reviews focused on the needs of older people suggest the specific benefits of learning include extended independence and a reduction in other health and social care costs (Clennell, 1995; Soulsby, 2002; NIACE, 2005). If such research is accurate, then it begs the question: why is participation in education by older people falling? The reasons remain unclear, but fingers point towards later retirement age, increased caring responsibilities, fewer courses, higher fees, and a sense of disaffection because the rest of society fails to acknowledge the contribution of older people to it (Clennell, 1995; NIACE, 2005). The potential impact on psychological well-being of the fall in participation has yet to be investigated.

**The Fourth Age – learning opportunities in care homes and training for carers**

The fourth age refers to older people who, because of physical or mental frailty, receive personal care in residential, nursing or domiciliary settings (Clennell, 1995). In a rare study of learning opportunities for people in residential care, Soulsby (2002) states that contrary to popular belief, people in the fourth age continue to have learning and development needs, and concludes that ‘there is almost universal acceptance that…learning…enhances well-being’, but such needs of the frail elderly are largely ignored, and what provision exists for them is patchy. He adds that improvement in practice requires further funding, meaningful dialogue between agencies and disciplines, and a significant shift in attitude so that care practice is modelled on the best in his study, in which:

‘…The work was carried out by people who believed in the continued personal development of older people, no matter what their degree of frailty or incapacity.’

(Soulsby, 2002)

The needs of very elderly people are more often approached from a treatment and care perspective, and evidence-based developmental and learning activities such as life review and reminiscence are utilised for their direct therapeutic potential (Ferguson & Keady, 2000). Ideally, people in the fourth age should have access to stimulating and validating learning opportunities (Clough, 2000). However, in residential and nursing homes, learning activities are seen as separate from other caring tasks, the staff responsible for providing such opportunities rarely receive any relevant training to equip them for their role, and there is no consistent application of standards, assessment or evaluation (Soulsby, 2002).

Clearly, the training of care workers is a key element in the relationship between education and psychological well-being of older people. A review of evidence- and practice-based papers suggests that if carers are to provide a ‘good enough care environment’, then their training should contain adequate and relevant theory but remain firmly grounded in research findings about the experience of residents (Clough, 2000). An interview survey compares different approaches to the training of carers in two European countries, and recommends that training providers should distinguish emotional from functional labour, and give equal value to both. They must also determine what skills are required and by what methods they should be acquired (Eyers,
This assumes however, that care workers are motivated to engage fully in training, and the same study contends that this is not always the case because there are almost no extrinsic rewards for care workers to do training, hence participation is low. Nonetheless, provision of training did improve care standards in the residential homes studied (Eyers, 2000).

Other studies have examined the impact of staff training on care standards with mixed results. One found that training did not reduce the frequency or intensity of challenging behaviour from elderly residents with dementia, but considerably improved the care workers’ ability to manage them effectively. However, the improvement had not been maintained when the researchers returned a year later, in part due to high staff turnover (Moniz-Cook et al., 1998). An action-research study evaluated how training affected standards across care homes within an NHS Primary Care Trust area, and simultaneously catalysed improvements. The staff in the study reported increased knowledge and confidence of caring skills and interventions (Furniaux, 2004).

Even given such contradictory and ambivalent findings, the key issues that arise from albeit limited literature on the relationship between learning, well-being and the fourth age can be identified. Training has a positive, but possibly short-term, effect on care standards provided that staff are motivated and co-participation is encouraged (Moniz-Cook et al., 1998; Eyers, 2000; Billett, 2002; Furniaux, 2004). A shift in attitude and interdisciplinary dialogue is essential for further improvement (Eyers, 2000; Billett, 2002). Frail elderly people can benefit from access to learning opportunities provided by competent carers who value their past experience and future potential (Clough, 2000; Soulsby, 2002).

### Conclusion

It is apparent from the literature that older people continue to have learning and developmental needs and potential throughout the lifespan, and that engaging with learning can have considerable benefits to mental health in particular. However, participation in education by people in the third age is falling, and there is scant provision of opportunities for those in the fourth age. Training for care staff can improve the well-being of frail elderly people, but it is under-resourced and not always appropriately planned or evaluated. Whilst very few of us have any direct influence on government educational policy, or on economic and demographic trends, there are some ways in which psychologists and other health workers can make tangible improvements:

- Develop better information for patients on providers of learning opportunities, particularly local initiatives such as ‘Art for Health’ classes (Aldridge & Lavender, 2004).
- Extend psychoeducation services for older people and their carers.
- Develop training for care staff that: (a) enables them to provide learning and development opportunities for frail elderly people in residential care; (b) helps foster a shift in attitude towards one that values the past experiences and future potential of older people (Clough, 2000; Soulsby, 2002); and (c) promotes improved well-being of both residents and staff to managers to encourage participation (Eyers, 2000).
- Ensure a balance between theoretical, skills-based, affective and reflective components in course design (Clough, 2000), and incorporate long-term supervisory and consultative support into the training programme (Moniz-Cook et al., 1998; Eyers, 2000).
- Conduct an action-research evaluation with older people in residential and nursing care on the impact of the training on care workers on their perceptions of well-being.
- Conduct retrospective analysis of the participation in education by older people in comparison with their use of health services, and a longitudinal study.
of the current cohort of people in the third age through to the fourth age to assess the impact of falling participation in education by older people on their psychological well-being.

Needless to say, achievement of any of these objectives is reliant on resources, and the enthusiasm of colleagues and managers. But before cynicism gets the upper hand, it is worth remembering how the well-being of a large number of older people can be affected, even if only minimally, by the realisation of just some of the objectives.

If training is delivered to 300 mental health workers who each care for 30 frail elderly people in a year, then over 9000 older people will receive care influenced by the training, and an improvement in their quality of life and psychological well-being should follow.

‘Age is opportunity no less,
Than youth itself, though in another dress,
And as the evening twilight fades away,
The sky is filled with stars, invisible by day.’

Henry Wadsworth Longfellow.

References


Scottish Branch
DRIVING AND DEMENTIA CONFERENCE
Heriot-Watt University, Edinburgh.
Friday 16 June 2006.

Programme
9.15 Registration and Coffee
10.00 Introduction to the Conference
   Liz Baikie, Consultant Clinical Psychologist, NHS Lothian.
10.10 Service user’s experiences of driving with dementia
   [Speaker to be confirmed]
10.30 Regulations and processes
   [Speaker to be confirmed – DVLA, Swansea]
11.05 Coffee
11.25 The process of driving assessment in Scotland
   Dr Lynne Hutton, Consultant in Rehabilitation Medicine,
   Scottish Driving Assessment Centre, Astley Ainslie Hospital, Edinburgh.
12.00 Incidents involving drivers with dementia
   [Speaker to be confirmed – Department for Transport]
12.30 Discussion
12.45 Lunch
13.45 Relationship between performance on neuropsychological tests and on-road test
   Janice Rees, Consultant Clinical Psychologist,
   Older Adult Mental Health Team for Caerphilly Borough, Gwent.
14.20 Memory Clinic Protocol for driving and dementia
   Dr Jennifer Borthwick, Consultant Clinical Psychologist, NHS Lanarkshire.
14.55 Coffee
15.15 Thoughts and feelings about discussing driving and dementia with clients:
   Results of a staff survey
   Sandy McAfee, Consultant Clinical Psychologist, NHS Lothian.
15.50 Discussion and Close
16.15 End

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Visit www.eccscotland.com for maps, accommodation and travel directions.

Please note that timing, topics and individual speakers may be subject to change.
PSIGE is a faculty of the British Psychological Society, Division of Clinical Psychology.
A protocol for the assessment of dementia

Andrew Roberts, Louise Bergin & Shonagh Scott

This article aims to outline the development and content of the Dementia Protocol that is used by the Older Adult Clinical Psychology Division in Sheffield in order to assist in the assessment and diagnosis of dementia. The Division currently consists of nine (mostly part-time) clinical psychologists who work into a variety of services where they may be required to conduct dementia assessments, i.e. Community Mental Health Teams, Day Hospitals, In-Patient Wards, and a Memory Clinic.

The Dementia Protocol has been used in the Division since 2001 but continues to be an evolving and thought-provoking development. When we presented the Dementia Protocol at a regional PSIGE meeting we were amazed by the amount of questions and requests for the Dementia Protocol that the presentation generated. This suggested to us that other clinical psychologists working with older people were struggling with similar issues to us in relation to dementia assessments. Hence our motivation for sharing this work with a wider audience.

Process of development
Contributing to the assessment and diagnosis of dementia has always been a significant element of the workload of clinical psychologists working with older adults. This role is likely to continue to increase with the trend towards earlier diagnosis and the need for professionals to share the diagnosis with people in order that they can give informed consent before starting cognitive enhancers. It will be hard to justify retreating from this clinical work even if cognitive enhancers are restricted in their use or indeed withdrawn.

The Dementia Protocol was originally developed in the Sheffield Memory Clinic and pulled together the ‘best practice’ that had built up in this service over a decade. The Sheffield Memory Clinic is a multidisciplinary service (clinical psychology, psychiatry, and nursing) that was set up to facilitate early diagnosis of dementia. The Dementia Protocol was then shared with the other clinical psychologists working in the Division which stimulated much discussion. From this discussion it emerged that within our individual services we all set about our dementia assessments in different ways: some of us already did pre-diagnostic counselling whilst others did not; we all had our own specific cognitive assessments that we preferred; some of us were very active in feeding back the assessment results to clients whilst others usually left it up the psychiatrist. The Dementia Protocol not only provided us with some structure and minimum standards to work to but has also helped us to reflect on our practice and address the ethical, moral and professional dilemmas that are inherent in dementia assessments.

Content of the Dementia Assessment Protocol
The Dementia Protocol has evolved from initially comprising of just the Best Practice Checklist (see Figure 1) to now include associated guidelines for best practice around collecting the required data, e.g. pre- and post-diagnostic counselling. The guidelines have evolved out of systematic audit and review. The following presents: (i) the Best Practice Checklist Checklist and how it is used in practice; and (ii) the Guidelines:

(i) The Best Practice Checklist
The majority of the items on the checklist were included because the diagnostic criteria
we adopted require specific data to reach a diagnosis. The Dementia Protocol was based on the diagnosis of the four most prevalent dementias: Alzheimer’s type, vascular dementia, Lewy Body type and fronto-temporal dementia (Feldman & O’Brien, 1999; Pryse-Phillips & Wahlund, 1999) and drew on internationally recognised diagnostic systems (e.g. DSM-IV, NINCDS-ADRDA1, ADUTC2, NINDS-AIREN3, Proposed Consensus Criteria for the Clinical Diagnosis of probable and possible Dementia with Lewy Bodies (McKeith et al., 1996). The following briefly summarises why each item on the checklist was included, firstly listing those items that inform the diagnosis and secondly the items that are considered to represent good practice:

(a) Diagnostic Information
- **Onset and Progression of Difficulties**
  One of the features that distinguishes ATD from VaD is the onset and progression of the disorder, contrasting

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1 National Institutes of Neurologic and Communicative Disorders and Stroke-Alzheimer’s Disease and Related Disorders Association.
2 Alzheimer’s Disease Diagnostic & Treatment Centres.
3 National Institutes of Neurological Disorders and Stroke with support from the Association Internationale pour la recherche et l’Enseignement en Neurosciences.
the ATD typical ‘gradual onset and continuing cognitive decline’ (DSM IV) with the ‘abrupt deterioration in cognitive functions, or fluctuating stepwise course’ (NINDS-AIREN) more typical of VaD. Similarly, DLB is characterised by fluctuating cognitive impairment.

- **Medical factors**
  All of the diagnostic systems partly work on a process of excluding other possible diagnoses and the dementia blood screen is designed to highlight medical factors that could account for cognitive and behavioural changes otherwise associated with dementia. For example, the dementia blood screen looks for evidence of B12 and folate deficiency which can induce mental disturbances such as cognitive impairment and confusion (Pryse-Phillips & Wahlund, 1999).

  The use of CT/MRI Scan results are included in a number of diagnostic criteria both to provide evidence of vascular change or to rule out conditions such as space occupying lesions.

- **Other psychiatric conditions**
  Given the cognitive impairment that can present concomitant with depression (Morris, 1996) it is not surprising that many classifications of dementia refer to the cognitive disturbance not being better accounted for by depression of other psychiatric disorders.

- **Cognitive testing**
  All of the diagnostic criteria refer to multiple impairments across various cognitive domains. An assessment battery that measures a range of cognitive functions is, therefore, necessary. In our clinical practice we have favoured the CAMCOG-R (Roth et al., 1998) as the first assessment of choice as it is easy to administer and quite accessible for clients. However, obviously other assessment tools are used if more in-depth exploration of particular cognitive domains is required, for example, the AMIPB for more detailed memory assessment and the BADS or Hayling and Brixton for executive functioning. The National Adult Reading Test or Wechsler Test of Adult Reading is used to assess pre-morbid functioning so that current cognitive impairment can be interpreted in light of former functioning. This allows cognitive decline, necessary in all diagnostic criteria for dementia, to be measured.

- **Additional information**
  Most dementia criteria require evidence that there is significant impairment in social or occupational functioning. Hence questions are asked about activities of daily living.

- **Collateral history**
  Due to the very nature of the dementias, clients may not be able to give reliable or accurate information and so data is sought from carers to corroborate the client’s information.

(b) **Non-diagnostic information collection and practice**
  Certain items are included in the checklist as a matter of good practice, even though they do not contribute towards the diagnosis *per se*. These are:

- **Pre-diagnostic counselling:** There is a growing body of clinical literature that advocates sharing diagnoses with clients diagnosed with dementia (Johnson, Houman & Pinner, 2000; Pinner, 2000; Post & Whitehouse, 1995). This appears to be driven both by necessity for patients to give informed consent to cognitive enhancer medication and also by a change in practice across other medical disciplines such as oncology and HIV & AIDS diagnosis which has permeated the field of dementia. The practice of pre-diagnostic counselling is considered to
enable the client to consider the pros and cons of the diagnostic process and to begin to think about what it might be like to receive the diagnosis. It is believed that this is an important piece of preparatory work that may facilitate better adjustment to the diagnosis (Seymour & Lamers, 2003).

- **Driving:** Clients are routinely asked about their driving status because of legal requirements to inform the DVLA about being diagnosed with dementia. It is considered good practice to inform clients prior to assessment of this obligation in case they choose not to go ahead with the diagnostic process.

- **Carer stress:** Collected at the same time as collateral history, information on carer stress is asked using questions about what they are finding difficult about their loved one’s condition and what strategies they use, if any, to cope.

- **Feedback process:** Due to the multi-disciplinary nature of dementia diagnosis it has been found to be useful to have a prompt to clearly record who will take responsibility for sharing the diagnosis.

- **Intervention/Follow-up:** Again, a prompt to consider post diagnostic counselling and to delineate responsibility for follow-up.

### Issues using the Checklist in practice

The Best Practice Checklist is now put in every dementia assessment case file. It does not have to be completed but is referred to in each case as a prompt to encourage thoroughness. The Checklist reflects the breadth of information required in order to reach or exclude a diagnosis of dementia. Audit and review of the Dementia Protocol (see section below) confirmed that it is not and should not be the sole preserve of the Clinical Psychologist to gather all of this information. We have no training in the interpretation of blood test results, nor are we educated in making meaning of CT/MRI scan results, and we should only comment upon our own area of expertise.

Thus, in order to feel confident about the final diagnosis it is important that there is multi-disciplinary involvement in the diagnostic process, such that all test results (be they medical or neuropsychological) are interpreted within the context of the others. Most commonly within our services the request for clinical psychology assessment comes from a CPN, Social Work, or Psychiatry colleague within the CMHT. This usually means that information around onset and progression, medical factors, and other psychiatric conditions has already been gathered, and so our role is to gather data from neuropsychological tests and to identify any additional relevant factors.

The most tangible first product of our assessment work is the neuropsychological assessment report. Again, the Dementia Protocol is of great value as this provides a guide for every summary and conclusion section. Where information is missing from a diagnostic work-up, we are able to document this and be clear about what we think needs to happen next (e.g. blood tests required and medic needs to decide if CT scan required). When the diagnosis is established we record who will tell the client and carer(s) – providing this has been decided with our colleagues – and when and where this will be done.

While much of our work is community based, it is worth pointing out that the diagnostic process in the Memory Clinic is slightly different. The clinic has a system for reviewing all of the assessment information conjointly within a multidisciplinary meeting. Thus, the diagnosis is reached by consensus and a plan is formulated for feedback and future management with all of the professional groups present.

Obviously there are times when the diagnosis is unclear, even when the appropriate information has been gathered. From the psychology point of view, lack of clarity of...
diagnosis often revolves around insufficient evidence of cognitive decline, either in more than one domain (e.g. there is evidence of new learning deficits but all other cognitive domains appear intact) or in relation to pre-morbid ability (i.e. when the NART/WTAR predicts a certain IQ level and this is comparable to current WAIS III IQ scores). Inability to reach a diagnosis can also reflect a confounding mood problem, e.g. depression is interfering with cognitive performance. Such scenarios usually result in follow up cognitive re-testing at an appropriate interval: three- to six-month follow if treatment of depression needs to take effect, or nine- to 12-month follow-up to allow progressive deterioration to be picked up.

(ii) The development of the Guidelines: Audit and Revision

As described above, the Dementia Protocol in its entirety now comprises of the Checklist and associated guidelines. The guidelines have evolved as a result of three audit cycles. In each audit, two files were chosen per psychologist to be scrutinised. The case notes were selected for being representative of the psychologists’ work, rather than random selection. Each audit has been guided by specific criteria such as:

- Can all of the information required in the Best Practice Checklist be located in the case notes?
- Where the information is not present, is it identified as missing and/or requested?

However, the overall standard we have worked towards is that of trying to provide a diagnostic ‘trail’ that could be read and understood by another psychologist.

Audit 1 (2001)

One of the key areas addressed by the first audit was with respect to a lack of documentation about medical factors. Further analysis of this highlighted the diversity and complexity of some of the cases we were involved with. There was a range of working models in evidence, for example, some cases reflected close liaison with multidisciplinary colleagues where the diagnostic process was ‘owned’ jointly and responsibility for sharing the diagnosis was negotiated. Such cases yielded more accessible diagnostic ‘trails’ of data. Other cases reflected less cohesive models of working where the cognitive report was the last piece of data to be collected and there was no information in the notes about the rest of the diagnostic work being carried out.

As a result of first audit, guidelines were added to clarify that:

- It is not the responsibility of the Clinical Psychologist to collect all of the data on the checklist but they should comment on the presence or absence of any data that has been (or is yet to be) collected, e.g. medical information, collateral history. There should be clear documentation about how the cognitive assessment has been fed back in to the multidisciplinary diagnostic process.
- It is not necessarily the Psychologist’s responsibility to feedback the diagnosis to the client but it should be clearly documented in the notes whether they will share the diagnosis or if that role has been handed back to another professional involved.

Audit 2 (2003)

A little over 12 months later, the second audit highlighted that while improvements in reporting were evident, pre-diagnostic counselling was an area that was not being consistently reported on. Further analysis showed that this reflected some ambiguity about whether pre-diagnostic counselling should always be carried out. Again the ambiguity reflected the diversity of diagnostic work and settings we are involved with: from early onset, community cases to cases where the aim of assessment was to get baseline cognitive functioning data to inform staff interventions or rehabilitation plans. These latter cases are more common to medical settings or inpatient services.
Where the aim of assessment is not diagnosis, guidelines were developed to clarify that:

- Clients should be given pre-test rather than pre-diagnostic counselling.
- It should be clearly stated in the notes or report what the reason for referral is (i.e. not diagnosis for the client)

Also with clients who were quite advanced in their dementing illness, the issue of consent to diagnostic cognitive testing was reviewed. An additional guideline was agreed that:

- Where client consent is considered to be hampered by lack of insight, an attempt at pre-diagnostic counselling should still be made and such clients still have the right to decline testing.

We have found in practice that services can become stuck when clients refuse a diagnostic assessment. The label of ‘dementia’ is often the key to accessing other services and the desire to access these forms of support can often drive clinicians to coerce clients into an assessment or even to carry out assessments without an honest explanation about the function of the interview. After we had acknowledged this trap (which at one time or another we had all fallen into) we found it useful to think of alternatives to the diagnostic route. A further guideline thus states that if assessment is declined:

- Other service input could be explored to address the needs and risks of clients and carers, e.g. through CPN support or Social Services.
- Even if cognitive testing is declined, this should not be a barrier to it being re-offered again later. We have to think of pre-diagnostic counselling as a process rather than a one-off event, such that the issue of diagnosis may be revisited a number of times.

Audit 3 (2005)
This recent audit showed a number of areas of development since the last audit cycle, most notably:

- There was evidence of a continued increase in the recorded attempts to conduct pre-diagnostic counselling with all clients. Up from 50 per cent in 2003 to 74 per cent in 2005.
- There was a marked improvement in documentation around follow-up plans, up from 75 per cent to 83 per cent.
- All other areas of practice were otherwise at a similar level to the standards observed in last audit cycle in 2003.

However, the audit also raised a number of questions for us to consider in future. There was some divergence within the division about where information was recorded (e.g. clinical notes, correspondence, or written on the best practice checklist) and how easy this information was to locate. There needs to be greater clarity about what constitutes a record and what standards we wish to set.

Furthermore, this audit raised an issue about the difficulty in obtaining certain types of information (e.g. collateral history) with some clients who were on wards. It may be that there needs to be a modification to the protocol to allow flexibility depending on the constraints of the setting – although it is expected that reasons for deviation from the protocol would have to be recorded. These concerns will be again evaluated in the next audit cycle.

Discussion and Conclusion
A number of points need to be made in this section as we consider of the implications for using this type of protocol. Firstly, and perhaps most importantly, the Dementia Protocol is there to serve us and not the other way around. It is a framework derived from current and best practice, and as the audit section describes it requires regular review and updating to ensure that it does not become stale or redundant.

Secondly, the Dementia Protocol is only a set of guidelines; it is not a short-cut to or a guarantee of a diagnosis. In the oft talked about ‘real world’ the clients and carers that we see do not always conveniently fit into the tick boxes that we design for them, and we must remember that this is a framework for thinking, not a substitute for it. Only by
sensitively building relationships and gathering relevant information can we hope to engage clients and carers in the process of reaching and managing a diagnosis of dementia.

Thirdly, the value of this approach must partly be seen within the context of the division of older adult psychologists who have contributed to it. We are a relatively large (and growing) department, and we all input into different parts of the service with little overlap. Thus, it is useful for us all to have a way of being clear about our role within this type of assessment and to feel that this approach is standardised across the city.

Finally, outside of the memory clinic, this set of standards is only used by clinical psychologists at present. Whilst it would be extremely difficult (politically and practically) to impose this protocol across all of the other disciplines who are involved in the diagnostic process, there are more subtle ways in which it can influence others to reflect on their own practice. Written reports and discussions about the use of the protocol and pre-diagnostic counselling, for example, tend to provoke curiosity and enquiries from our professional colleagues about what we do and how we organise ourselves to go about it. Also, more recently there has been a city-wide steering group set up to look at the Trust’s approach to sharing a diagnosis – the protocol has been an invaluable tool in shaping the policy and standards that are likely to be adopted for all workers in this field of activity.

In summary, the Dementia Protocol that we present in this paper is not necessarily seen as definitive, complete, or superior to all other approaches to the process of dementia diagnosis. However, it does represent a clear structure for thinking about the information required, the stages in the overall process, and the realistic limits of the clinical psychologist’s role. It provides a map through the often confusing morass of information, and frees us up to be available to the concerns of the clients and carers who sit at the centre of the venture.

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On a cold night in November, colleagues, friends and family gathered at a hotel just outside Cardiff to celebrate Charles Twining’s retirement after nearly 30 years as a clinical psychologist. I had the honour of toasting Charles on behalf of PSIGE, recognising his great contribution to the development of our specialism. Charles specialised from the outset in work with older people, and was one of the founder members of PSIGE in 1980. He was the first Membership Secretary of PSIGE, taking us over 100 members by the time of the first residential conference, at Leicester University, in July 1981. Charles made a presentation on ‘The support of relatives’ at that conference; this has proven to be a recurring theme for Charles in his professional and personal life.

After completing his psychology degree at Cambridge University, Charles spent a year at Boston University, USA, working with Nelson Butters, and, no doubt, reinforcing his interest in memory and its disorders. Charles then undertook his clinical training at Oxford, qualifying in 1976. He fitted in a PhD alongside clinical work, on the topic of disability and mortality in older people. Most of his career has been spent in Cardiff, where he has been associated with significant areas of innovation, which greatly influenced a number of his PSIGE colleagues. Three examples will suffice. At a time when most clinical psychologists working with older people were closely linked to old age psychiatry services, Charles pioneered work in the context of geriatric medicine, working on psychological issues across a range of health problems. This built on a fruitful collaboration with Professor John Pathy, who headed the Geriatric Medicine department in Cardiff (and who still today, in his 80s, is as active and committed as ever in his role with Age Concern Cymru). This work led to the development of the Community Memory Project, again working with geriatricians, which provided what should have been the definitive model, if we had not all somehow retreated into ‘Memory Clinics’. Finally, there was innovative work with carers; I recall Charles describing an Adult Education course providing training for carers in a non-clinical context; again, an innovative model, ahead of its time. His two books, Helping older people: A psychological approach (Wiley, 1988) and The Memory Handbook (Winslow Press, 1991), attest to his clinical acumen and experience as well as to his easy, direct, well-grounded style of communication.

Charles contributed valuable service in a number of areas; on the PSIGE Committee and a term as Chair; as the BPS representative on the governing body of Age Concern England; and on the groups developing the National Service Frameworks for both England (2001) and, belatedly, Wales (2006), where he co-chaired the group charged with developing the chapter on mental health in older people. Charles
carried out these responsibilities with engaging good humour, and influenced many a discussion with subtle persuasion and encouragement. His OBE (a first for a PSIGE member?) was richly deserved. His admirable qualities of commitment, dedication and quiet determination have achieved much and attracted much respect.

Latterly, Charles served as Clinical Director and Head of Psychology and Counselling Services with Cardiff & The Vale NHS Trust, whilst retaining some clinical involvement in services for older people. His retirement will allow him more time for his wife and family, and to master the lathe that was one of the retirement gifts he received. Charles is the main carer for his wife, Barbara, who has suffered from MS since 1987. This experience, and that of supporting his mother, who suffered from Alzheimer’s in the last few years of her life, has equipped him in his role as Chair of Carers Wales, where he is involved in campaigning on behalf of carers, and contributing to extending the support available.

I am personally delighted that Charles will be representing Carers Wales on the Wales Dementias and Neurodegenerative Diseases Research Network, so that we will continue to be able to work closely together. Everyone in PSIGE will join me in wishing Charles and Barbara much happiness in this new phase of their lives.

Bob Woods
READERS OF THE PSIGE Newsletter will be only too well aware that therapy with older people does not have much of a presence in psychotherapeutic literature, and the supervision of therapists working with older clients is even more neglected. This is perhaps because therapy for older people receives much less funding than do many other specialities, despite no evidence to suggest they are less likely to benefit from therapy than people of younger ages, and it is perceived to be unpopular with practitioners (Garner, 2002). However, as we live in a society with an ageing population, it would seem timely to turn our attention to what is very likely to become a growing area of interest in therapy and its supervision.

The experiences of psychotherapists working with older clients were explored in one rare research study. The themes that arose were ‘perceptions of old age and ageism; changes to practice; culture and experience; and awareness of loss, time, decline, and mortality’ (Atkins & Loewenthal, 2004). This article attempts to present a discussion of the implications of these themes for the supervision of therapy with older clients, from an integrative perspective.

Clearly, most old people lead full and contented lives, and later life should not be assumed by the young to be a time of decay and despair. Therapists and their supervisors should avoid misinterpreting distress and depression in an older person as inherent to their great age, yet they need to recognise that old age does bring an increased risk of emotional distress.

Some of the concerns that older clients bring to therapy fall into three permeable categories of Absence, Loss and Misappropriation (Petford, 2004). Absence, or ‘that which was never there’, comprises of issues that will be familiar, as they appear in therapy with all age groups. For example, the absence of nurturing care in infancy, of opportunities to make satisfying relationships or to develop one’s potential. The cohort differences only become apparent in the client’s response to the absence, and their strategies for coping with it. Loss, or ‘that which is going or gone’, refers to loss such as bereavement, but can also be the loss of a limb, bodily function, independence, and sense of purpose. Of course, loss is often part of therapy with younger people, but elderly clients are more likely to experience multiple and complex losses that can have a significant and detrimental effect on their mental health. Misappropriation, or ‘that which is taken away’, relates to how older people are treated in society, and the impact of ageism, loss of role, status and visibility (Petford, 2004).

Older people do have some needs in therapy that are specific to their time of life, and both therapist and supervisor are required to make some adaptations to practice. The law now insists that therapy venues are accessible to people of all abilities, but for some frail clients, home visits are the most appropriate solution, and supervision should pay careful attention to issues of safety and boundaries in this instance.

Joint work and communication between the therapist and other services can be necessary for older people with multiple health needs, and working within the medical and personal care culture sometimes presents challenges to professional boundaries. Supervision can assist the therapist in...
deciding when to assert the discrete boundaries of the therapeutic frame and relationship, and when to minimise barriers to collaboration. One witty supervisor described ‘bouncy castle boundaries’, which are flexible and sensitive but clearly defined.

Therapists may also need to negotiate a delicate balance between the boundaries of therapy and a temptation to advocate for, or even ‘rescue’ clients. A 90-year-old client asked his counsellor if she could take him to visit his daughter’s grave, as no alternative was available, and he was worried his failing health would soon prevent him from going at all. The counsellor used supervision to reflect on her role and its limitations, the therapy, and the client’s best interests, and arranged to take her client to the cemetery during the time allocated for their session. At the next appointment, he said he felt a profound easing of his grief for his daughter, as he had been able to make one last act of fatherly duty and care. He died three weeks later.

Therapeutic work often presents dilemmas such as this. In the encounter between older clients and their usually younger therapists, supervision offers a supportive and reflective space for participants to address such dynamic and contextual matters. Transference and countertransference may, for instance, reveal a client’s desire to nurture or compete with the therapist, or an idealisation by the therapist of the older person as sage or grandparent (Garner, 2002). Issues of difference, culture, and power in an ageist society, also require explicit but tender exploration. Supervision is essential for helping the therapist understand and manage powerful feelings, such as pity and guilt that can be evoked in therapy with older people (Garner, 2002). Reflection within and upon to the supervisory relationship, as a contrast or parallel to the therapy relationship, can be a useful window onto a deeper understanding of the client and the therapeutic processes.

One of the biggest challenges is working in the ‘here and now’, with those who are nearing the end of life, and for whom the future may be brief. The pace, frequency and intensity of therapy may vary. One client said she wanted her therapy to be slow and ‘gentling’, whereas another felt time was very short and wanted to hurry up. Ageing and mortality, the paths that lie ahead for us all, are painful issues to address, and supervisors can help therapists explore and accept their relative helplessness in this context. Solution-focused goal setting and ‘miracle questions’ are of little use. It may be more appropriate in bleak circumstances to seek out the potential ‘silver linings’ instead. In our youth-oriented culture, Arden (2002) points out how the Department of Health’s ‘National Service Framework for Older People’ prizes independence, when perhaps the toleration of dependence might be a more ‘healthy’ adaptation to the end of life.

Supervision can foster the therapist’s confidence to try out creative techniques such as ‘life story work’, and ‘memory boxes’. A versatile and creative attitude can make the most of serendipitous therapeutic opportunities. A client in her 80s, who had become depressed and regretful in the wake of a debilitating stroke, was seeing a counsellor at home, and one session comprised of a journey around her china cabinet. Her whole life story unfolded as she reverently held out each of the treasured items to the counsellor, and reminisced about the occasion or people they represented. She concluded that the cabinet was ‘testament to a life lived fully enough, all things considered’, and her self-esteem was somewhat restored.

Attention needs to be paid in supervision to endings in therapy with older clients, as they can be emotionally loaded for those who have experienced multiple or traumatic loss, or who are nearing death. Careful planning of the end of therapy, including consideration of how it will feel, can be beneficial and the therapist, client and supervisor can usefully reflect on the question: ‘are things as good as they can be for this person at this time?’ when deciding the timing of endings. However, some endings will impose them-
selves as a result of the illness or death of clients. For example, a therapist, in one year, had three clients die shortly after their penultimate therapy sessions, and understandably felt a mix of emotions at the turn of events. Her supervisor supported her in untangling these feelings of satisfaction and distress, and she was then able to manage them more easily.

Supervision can affirm pleasures and rewards of working with older clients. Therapy with older people is a richly textured place, full of history, long life stories, and depth of character. There are opportunities to work on spiritual and existential levels, and the privilege of learning from elders, the wise and the not-so-wise, about our own futures. Supervision can enable therapy for older people by assisting practitioners in genuine encounter with their clients, and full engagement with the real rather than assumed possibilities and limitations of later life. Its contribution to the resilience of the therapist comes from a supportive and honest supervisory relationship, in which the therapist is not inhibited from addressing some of the starker aspects of living and dying. Its challenges for the supervisor parallel those for the therapist, but its value lies in a combination of humanity, collaboration, and care.

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The Division of Clinical Psychology is pleased to announce the Call for Papers for its new Annual Conference. The conference will be held on 14-15 December 2006 at the Congress Centre, Great Russell Street, London WC1.

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Notes for Contributors

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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).

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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.

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

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or
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Psychology Services, 10 Cornwall Road, Dorchester, Dorset DT1 1RT.
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